

LEARNING FROM KOPANGA:

INTERVIEWS WITH CLINIC STAFF, WOMEN IN THE COMMUNITY AND TRADITIONAL BIRTH ATTENDANTS

Results from Phase One of the Kopanga Community Health Assessment
on Prenatal, Delivery and Postnatal Care and Practices in Kopanga: a
Qualitative Data Analysis

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Location of the Kopanga Clinic & Dispensary

Suba West Division, Migori District,
Nyanza Province, Kenya

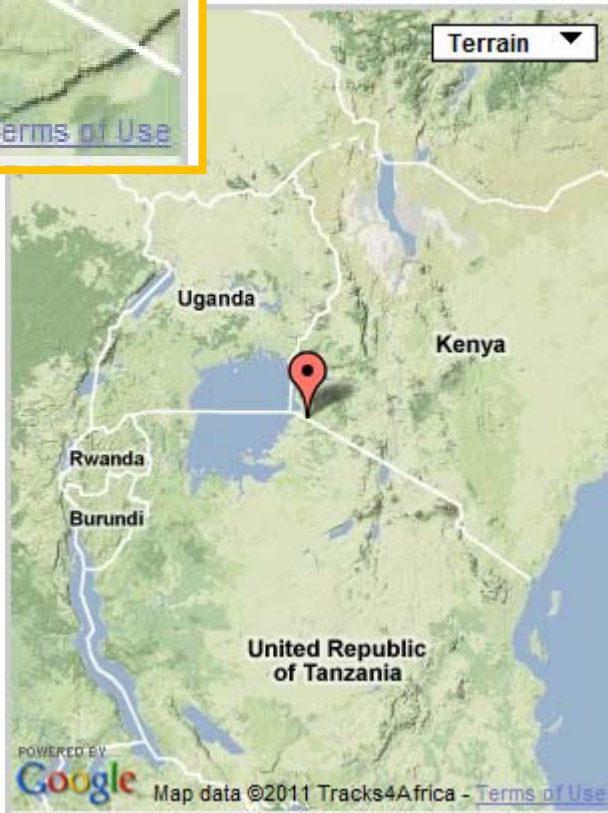


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EXECUTIVE SUMMARY

Background and Assessment Objectives

The Kopanga Dispensary and Clinic, built in 2008 is located just outside of a small village called Kopanga, in the Suba West Division of the Nyanza Province's Migori District in Western Kenya. The clinic was built as a result of a partnership between Partners for Progress, (P4P) a Spokane, Washington-based non-profit organization and the Kenyan-based Comprehensive Rural Health Project. Now serving 900-1000 patients per month from nine area villages and neighboring Tanzania, the partnering organizations and the Clinic Nurse Manager Alice Wasilwa Otieno want to improve the quality of health care services at the facility by tailoring services to meet community needs and preferences while striving to ensure offered services are culturally appropriate. In order to achieve this goal, P4P initiated the planning of a community health assessment to better understand the health needs, existing resources and preferences of the community around a health issue of community concern.

The Nyanza Province has the one of the highest maternal mortality rates in the country, with one-quarter of all maternal deaths in Kenya recorded in the province. While the Nyanza Province infant mortality rate is a staggering 95 deaths per 1,000 births, Migori District rates are estimated at 137 deaths per 1,000 births. Recognizing the poor indicators of maternal child health in the area, and responding to the Clinic Nurse Manager's concern of the low rate of deliveries occurring at the Kopanga Clinic, (only 3-4 per month, with 30-40 births estimated to occur in the area monthly) the health assessment was focused on the prenatal, delivery and postnatal care and practices of the community. By completing the assessment, P4P and the Kopanga Clinic both aim to improve and potentially refocus prenatal, delivery, and postnatal care, practices and services offered at the clinic to best meet needs and preferences of the Kopanga community, and ultimately, to improve maternal and child health outcomes.

Methodology and Data Collection

The health assessment was designed in two phases; the results of the completed first phase are described in the enclosed report. The first phase of the assessment included qualitative data collection over an eleven-day period in December 2010 through a series of interviews conducted with clinic staff, women and traditional birth attendants (TBAs) from the Kopanga-area community. The second phase of the assessment will include a quantitative survey to be delivered to a representative sample of about 300-400 homes in the entire Kopanga Clinic service area. The assessment was designed in two parts to allow for input from clinic staff and community members on maternal child health issues of interest; preliminary data collection to inform the content and questions included in the second assessment phase; and to identify resources and strategies for completion of the second phase, while laying the initial groundwork to complete subsequent assessment activities.

The first phase of the assessment used interviews to explore health beliefs, practices and preferences for care from pregnancy through the postpartum period. Interviews with clinic staff and TBAs were conducted on clinic grounds by two P4P volunteers. Interviews with women were conducted at the home or family compound of the respondent, and were primarily conducted in the local dialect, Luo with the help of interpreters from the clinic. In total, seven clinic staff members, 41 women from three villages in the clinic service area and 12 TBAs participated in either one-on-one or group interviews.

Results

Prenatal Care & Practices

According to national statistics available through the 2008-2009 Kenyan Demographic and Health Survey, rates of receiving prenatal care from a health facility are high, 93.6%. For Kopanga women, this initial assessment found:

- The clinic staff is happy with the number of women seeking prenatal care at the clinic, and the majority of women and TBAs emphasized the importance of seeking care at the clinic when you learn you are pregnant
- All respondent groups emphasized the need for balanced diets during pregnancy
- Women in Kopanga sometimes use traditional medicinal herbs to remedy a problem during pregnancy. Most often though, herbs are only used as they are available for free, or cheaply in comparison to care available at the clinic, rather than strictly out of preference
- Women responded that complications or problems during pregnancy are common

Delivery Care & Practices

National statistics show 43% of births in Kenya occur in a health facility while 65% occur at home. Migori District estimates show only 23% of babies are delivered in a health facility. The initial assessment found:

- The clinic staff is concerned with the low rates of deliveries at the clinic, and recognizes the high risks associated with deliveries that occur without the assistance of a well-supplied and trained skill provider
- The clinic staff assumed most births in the Kopanga area take place at home, or with the assistance of a TBA. In their opinion, women trust the TBAs, and may prefer to deliver with them than come to the clinic. The clinic staff believed deliveries with TBAs are more expensive than clinic deliveries (500-800KSH compared to 300KSH), and women may perceive costs of the clinic to be higher than they actually are—keeping women from delivering at the clinic. The clinic also emphasized a lack of education or “ignorance” on the importance of clinic delivery served as a significant barrier to clinic deliveries
- All women responded they preferred to deliver at a health facility than any other location. Women confirmed they do frequently give birth with TBAs or with other women, not necessarily out of preference, but because of the accessibility of TBAs or other women.
- The most commonly identified barriers to facility delivery included cost, distance, lack of transportation, and the lack of awareness of knowledge of women on the importance of clinic deliveries. Many women said the clinic cost of 300KSH was too expensive. Thus, TBAs are more accessible to women as they can pay a TBA in-kind, or when they have money after delivery and TBAs live close to the women
- TBAs confirmed they play a large role in performing deliveries in the area, but they lack the knowledge and clean supplies to always perform successful and safe deliveries

Postnatal Care & Practices

Available statistics show that 53% of women do not receive postnatal care in Kenya, and in the Nyanza Province, 65.8% of women do not receive postpartum care. Information collected from the initial assessment phase show:

- The clinic staff report many women come for care after delivery, regardless of delivery location. However, this care is mostly for their babies, rather than for themselves. The clinic staff would like to see more women seeking care for themselves, as well as the opportunity to help further educate women on health practices and care after delivery
- Women respondents identified going to the clinic as an important practice after delivery. Most respondents only cited this as important for their babies, rather than for themselves. Few women reported TBAs as significant sources of care after a delivery, and most women identified the importance of rest, and staying close to home after a delivery to gain their strength
- TBAs confirmed they play a limited role in postnatal care for women and their children. They reported that women should go to the clinic after delivery to check their health and the health status of their baby

Next Steps

The preliminary findings reported here can be considered as P4P and the Kopanga Clinic determine future directions for supporting the health and wellbeing of mothers and children in the Kopanga area. However, by completing the second phase of this assessment, the clinic and partners will have a more comprehensive picture of the prenatal, delivery and postnatal care practices and preferences of women in the area. With more complete information provided by a larger, more representative sample of women throughout the Kopanga Clinic's catchment area, the results from the survey will give essential insights for improving, adapting or even expanding maternity services while making them more accessible and acceptable to the Kopanga community.

Although the initial findings from this first phase of the assessment need to be supplemented by more comprehensive data, the information gathered thus far provides some important insight into next steps that the clinic and P4P may want to consider taking to further support the health and wellbeing of mothers and children.

- **Expand community education efforts on available services, associated costs and supplies received with care at the Kopanga Clinic.** From these initial interviews, it was clear that in general, knowledge in the community about the services and costs of service available at the Kopanga Clinic was quite limited, and perhaps because of this, are underutilized. By increasing efforts to publicize information about available services and associated costs, the clinic may very well see an increase in those attending the clinic throughout pregnancy and delivery.
- **Expand community education efforts on maternal child health issues.** A resounding concern among clinic staff and community members was the "ignorance" or lack of knowledge among women and men about the harms associated with deliveries by unskilled or under-supplied providers. Responses from women and clinic staff suggested that increasing education on maternal child health in the community may indeed improve

general awareness and understanding of pertinent health issues and risks associated with childbearing, and may increase clinic delivery rates.

- **Look to Kopanga-area women as allies to the clinic, and to lead community-based education efforts.** When asked how the clinic could help support the health and wellbeing of women and their babies, and to address the aforementioned “ignorance” of women, many women reported they would want to participate in educating their peers. Although the clinic could improve their own outreach and education efforts, partnering with women in the community and tapping into existing social and information-sharing networks may prove to be a very successful approach in spreading information.
- **Support an equal partnership between the clinic and Kopanga-area TBAs.** The clinic has a newly-formed partnership between the clinic and TBAs in the area, where TBAs are encouraged to bring women to the clinic for delivery. In exchange, the TBA will receive half of the delivery fee and can observe the delivery. As TBAs will continue to remain more accessible to women due to proximity and ability for women to pay in-kind, the clinic may want to consider increasing the capacity of TBAs to preform safe deliveries by providing training and needed medical supplies.
- **Expand the ability of the Kopanga Clinic to offer mobile clinics in the surrounding area.** The clinic staff reported that the Kopanga Clinic currently offers limited mobile clinics around the area. As distance to the clinic is a significant concern of the clinic staff, and a real barrier for women in accessing clinic services, “bringing the clinic to the women” would be a valid approach to improving access to the clinic. Furthermore, by offering mobile clinics, the overall presence of the clinic in the community would be strengthened.

Once the second phase of the assessment has been completed, P4P, the Comprehensive Rural Health Project and the Kopanga Clinic will have taken a significant step towards better understanding the needs, existing resources and preferences for care during pregnancy through delivery and after birth.

INTRODUCTION

In 2008, a Spokane, Washington based non-profit organization Partners for Progress (P4P) joined forces with the Comprehensive Rural Health Project to build the Kopanga Clinic and Dispensary. Located in Western Kenya, Kopanga is a small rural town within the Suba West Division of the Nyanza Province's Migori District. Just a few kilometers from the Tanzania border, the Kopanga Clinic and Dispensary serves eight major villages surrounding the village of Kopanga, as well as patients from Tanzania. The clinic provides care to 900-1000 patients a month, and offers a range of services including immunizations, health education, HIV testing and counseling and maternal child health services including family planning.ⁱ Now that the clinic has been built, P4P, the Comprehensive Rural Health Project and the Clinic Nurse Manager Alice Wasilwa Otieno want to improve the quality of health care services at the facility by tailoring services to meet community needs and preferences while striving to ensure offered services are culturally appropriate.

Of specific concern to P4P and Nurse Wasilwa Otieno is the low rate of babies being delivered at the Kopanga Clinic. As of November 2010, only around three to five babies are born in the clinic each month.ⁱⁱ Estimates suggest that 30-40 babies are being born in the Kopanga area each month. The Nyanza Province suffers from some of the highest maternal mortality rates in the country with estimates ranging from 1,300 to 2,000 deaths per 100,000 live births and almost one-quarter of all recorded maternal deaths in Kenya occur in the province.ⁱⁱⁱ Furthermore, the Nyanza Province has the highest rate of both under five and infant mortality rates in the country—almost one in five children in the province will die before its' fifth birthday, and the infant mortality rate is an alarming 95 deaths per 1,000 births. Nyanza Province estimates show the perinatal mortality rate¹ (of 37 deaths per 1,000 pregnancies, which is on par with national rates. The Migori District shows some of the same poor indicators of maternal and child health, with only 23% of women giving birth in health facilities and an infant mortality rate of 137 per 1,000 live births.^{iv} Recognizing these poor indicators of maternal and child health, P4P and the Kopanga Clinic wanted to learn more about the prenatal, delivery and postnatal care and practices of the Kopanga community, with a specific emphasis on answering the question of why more women aren't delivering their babies at the clinic. By gathering such information, P4P and the clinic both aim to improve and potentially refocus prenatal, delivery and postnatal care, practices and services offered at the clinic to best meet needs and preferences of the Kopanga community, and ultimately, to improve maternal and child health outcomes.

To collect such information, a two part community health assessment was designed.² The first phase of the assessment included qualitative data collection through conducting a series of semi-structured in-depth qualitative interviews with a limited number of women and traditional birth attendants (TBAs) in the Kopanga area, as well as with clinic staff members. The second phase of the health assessment will consist of a larger, quantitative survey which will reach a wider audience in order to provide a more comprehensive understanding of the prenatal, delivery and postnatal care practices, preferences and needs of women in the Kopanga Clinic service area. In

¹ The perinatal mortality rate is derived from a combination of reported stillbirths and early neonatal deaths—deaths to live births within the first seven days of life

² Sources used for development included: Petersen, Donna J., and Greg R. Alexander. *Needs Assessment in Public Health a Practical Guide for Students and Professionals*. New York: Kluwer Academic, 2001. Print.; Johnson, Donald E. *Needs Assessment: Theory and Methods*. Ames: Iowa State UP, 1987. Print.; Connell, Fred. *Community Health and Needs Assessment*. Textbook created for HSERV 523, University of Washington, School of Public Health. University of Washington, Seattle, WA.

In addition to describing care and practices in these areas, the overarching goal of this combined assessment is to identify barriers to access (cultural and physical) and community preferences for care, using a participatory structure. This report will focus only on the initial phase of the assessment: the qualitative interviews, as the second phase has yet to be completed.

The intention of conducting the first phase of the assessment using qualitative interviews was multifaceted. The objectives of conducting qualitative interviews were to:

- Allow for input from clinic staff and community members on maternal child health issues of interest
- Provide preliminary information on care and delivery practices to shape content and questions to be included in the second phase of the assessment
- Identify available resources and strategies for implementation of the second phase of the assessment; and to
- Lay the groundwork for subsequent assessment activities by contacting potential community researchers, survey translators, and key community leaders

In order to design a well-informed, culturally appropriate quantitative survey that adequately measures the issues, needs and preferences representative to the area, this preliminary phase was deemed as an imperative first step in the survey development process. Furthermore, P4P has a limited presence at the clinic as volunteers are only able to work at the clinic on a few short trips per year. Thus, the chance for two non-medically trained volunteers (Cate Clegg and Elana Mainer) to go to Kopanga to conduct this preliminary assessment allowed for a unique opportunity to build rapport with clinic staff, and to connect with key community leaders and to deepen existing partnerships. By laying this foundation and strengthening relationships, the feasibility of planning and conducting the larger quantitative survey was heightened.

METHODOLOGY AND DATA COLLECTION

OBJECTIVE OF ASSESSMENT PHASE ONE – QUALITATIVE INTERVIEWS

As noted, the purpose of conducting the first qualitative phase of the assessment was to increase the understanding of care and practices in the area, solicit clinic and community input on relevant issues to be addressed, and to lay the groundwork to conduct the second, quantitative phase of the assessment.

RESEARCH METHODOLOGIES

The research methodology used for this phase of the assessment was semi-structured, in-depth interviews conducted with three key categories of respondents: clinic staff, women in the Kopanga Clinic service area and known traditional birth attendants (TBAs). Interview guides were created in advance by P4P volunteers (Cate Clegg and Elana Mainer). The questions were developed by using validated maternal child health survey instruments,^v advice and direction from maternal and child health and health assessment experts, and reviewed for cultural appropriateness by Clinic Nurse Manager Alice Wasilwa Otieno. These guides focused on the following themes and question areas:

PRENATAL HEALTH QUESTIONS:

- What should a woman do for the health of her baby when she is pregnant and why?
- What are women in the Kopanga area doing to keep themselves and their babies healthy during pregnancy and why?
- Who do women go to during pregnancy to keep their babies healthy during pregnancy and why?
- What problems do women in Kopanga have during pregnancy?

DELIVERY/LABOR QUESTIONS:

- Where and who should deliver babies in Kopanga and why?
- Where and who do women want to deliver their babies and why?
- Why don't women come to the clinic to deliver their babies?
- How can the clinic help women during delivery?

POSTNATAL HEALTH QUESTIONS:

- What should a woman do for the health of her baby after it is born?
- Where do women take their babies when they are born to receive healthcare, if anywhere?

Because of time constraints, interview guides were not pre-tested. However, in order to improve the effectiveness of the questions, at the end of each day in the field, the interview team met to review the responses from each interview, and to discuss issues with questions and the overall process. Based on these discussions, the interview guide was adapted and changed as needed. The final interview questions used in the field for the majority of interviews are available in **Appendix A**.

SAMPLE DESIGN

As noted above, the first phase of the assessment targeted clinic staff, women and TBAs in the Kopanga Clinic service area. No formal selection criteria were used to select women participants for interviews, aside from location. Nine villages (including Kopanga) were identified in the primary service area of the Kopanga Clinic, and all participants were located in one of these areas. Once the service areas of the clinic were established, (see **Appendix B** for the service area map) the research team relied on a convenience sampling method lead by interviewers, or interview team escorts. As stated, one of the crucial components to conducting this first assessment phase was to gain participation and input from community members and to lay a foundation for conducting the second phase of the assessment. Therefore, before entering into the field, the P4P volunteers and clinic representatives met with the Kopanga Chief's office to gain permission to conduct the study. As a result of this meeting, the Chief provided an escort from his office to accompany the research team on two of the days in the field. Thus, on these days, interviews were conducted at homes that were in areas familiar to the Chief, Deputy Chief, or the accompanying board member from the Rural Comprehensive Health Project. The homes visited were therefore either inhabited by people they knew, or in proximity to homes where they knew someone. On the days in the field without an escort from the Chief's office, the research team visited homes familiar to the interpreter.

DATA COLLECTION

The interviews for the first phase of the assessment took place between December 12 and December 23, 2010, and were conducted by two P4P volunteers with the assistance of interpreters. The P4P volunteers alternated responsibilities as the interviews were conducted, with one responsible for conducting the interview and the other responsible for taking detailed notes on responses to each question. When interviewing women in the community, interview questions were asked in English by P4P volunteers, with the questions and answers interpreted by a Luo-speaking member of the clinic staff. Three different interpreters assisted with the interviews over the course of the interview period. Staff interviews were done entirely in English, and thus were conducted only by the P4P volunteers, again with rotating responsibilities for conducting and documenting the interview. When at all possible, during interviews conducted with women in the community, men were asked to leave the room in order to help facilitate an open, honest discussion among women. The appropriateness of this approach was validated in background research as well as by clinic staff, and interpreters. On the two occasions where men were present, the quality of the interview suffered. Based on this experience, it is recommended that the second phase of the assessment should also be conducted out of the presence of men.

Interviews with clinic staff occurred at the clinic, or on clinic grounds. The vast majority of the interviews with women from the community occurred at the respondent's home or within the

family compound. The group interview with TBAs took place on clinic grounds. Staff interviews were in-depth, and one-on-one. Although all interviews were originally intended to follow the same format (one-on-one, in depth), when visiting the homes of women in the community, interviews were sometimes conducted in small groups to allow for the participation and input from various women present. Details on the interviews conducted can be found in Table 1.

Table 1: Respondent Group, Number and Location of Completed Interviews

Respondent Group	Number of Respondents	Location of Interview
Clinic Staff	7	Kopanga Clinic
Women*	12	Kopanga
Women	20	Masrura
Women	9	Mombache
TBAs	12	Kopanga Clinic

*total number of women participants = 41

In total, 7 in-depth interviews were conducted with clinic staff, 41 women in the community participated in either a group or one-on-one interviews, and 12 TBAs participated in one group interview. Women were located in three of the nine villages within the clinic service area (12 in Kopanga, 20 in Masrura, 9 in Mombache). The aim of the second phase of the assessment is to refine the sampling criteria and to expand the survey to reach women located in each of the nine villages in the service area.

DATA ANALYSIS

Upon returning to Seattle, the author typed up all of the hand-written notes from all of the interviews, and performed a qualitative analysis. To complete this process, first, all of the transcripts were reviewed to identify relevant themes within each area of interest (prenatal, delivery and postnatal care and practices) and then a code book was created for these themes. This codebook and thematic codes were created based on the research questions, research goals and qualitative instrument used. Examples of the themes used for coding were: practices during pregnancy; the motivation behind these practices (for the health of baby, tradition, etc) delivery location; facilitators for the delivery location (distance, cost, etc) and barriers to clinic delivery (cost, transportation, fear of clinic staff, etc). The entire code book and all themes examined can be found in **Appendix B**.

Once the codebook was created, each interview transcript was reviewed, and codes were assigned to blocks of text, a process called “open coding” or “topic coding.”^{vi} Once codes were assigned to the text, the codes were used to compare and analyze trends, themes, similarities and differences among and across respondent groups.

LIMITATIONS

The primary scope of this initial phase of the assessment was to identify issues of importance around prenatal, delivery and postnatal care and practices, to gather information and to lay the groundwork for the second phase of the assessment. The study design was qualitative and intentionally limited in scope with a small sample size and was not intended to provide data for rigorous statistical analysis. While hopefully representative, the information gathered is based on a

convenience sample and therefore has some level of inherent bias. Additionally, the fact that the interview team was openly associated with the clinic could have influenced respondents to attempt to satisfy the interview team by answering the questions in a certain way.

Relying on interpreters further affected the information collected. The P4P volunteers relied on clinic staff to serve as interpreters, which meant the interpreters varied based on the availability of staff. As a result, three different interpreters were used at different times throughout the field work, with inconsistent skill levels. Thus, as information can easily become "lost in translation" while using untrained interpreters, some interviews ended up providing richer, more detailed responses than others.

RESULTS

This section will cover the relevant areas discussed within prenatal, delivery and postnatal care, practices and preferences by respondent group. Each section will also provide statistical context from the Kenyan national, provincial and district levels when available. Statistics come from the 2008-2009 Kenyan Demographic and Health Survey^{vii} unless otherwise noted. As statistical information available at the district level is very rare, by comparing national trends with additional demographic data available at the district and subdivision levels, broad conclusions can be drawn about the likely care seeking behavior and practices of women in the Kopanga area. The following demographic information available for the Migori District helps inform conclusions drawn about Kopanga area women in each introductory area for the subsequent results sections.

Migori District education statistics show only 18.5% of the total district population attends secondary school, with average attendance being only 3 years.^{viii} The poverty level is quite high, with 58% of the households living in absolute poverty. The Sub West Division (the administrative division where Kopanga is located) has a population of 52,876 and 0% of this population is considered urban.^{ix} Thus, the majority of women in Kopanga are likely to have low levels of education, experience high rates of poverty, and reside in a rural area.

PRENATAL CARE AND PRACTICES

Relative to antenatal coverage rates in Kenya (estimated at 92%), available estimates on the use of prenatal care at health facilities in the Migori District are low, around 60%.^x Furthermore, as available data shows, many women first seek antenatal care during late pregnancy, and almost half have only one visit during the antenatal period in this area. As of December 2010, about 66 women attend the Kopanga clinic per month for prenatal care services—at the time of writing, no additional, more specific data was available on the average number of prenatal care visits during pregnancy.^{xi} Thus, with incomplete information on how many of these visits are repeat antenatal visits, and how many are first time visits per month, it cannot be determined if 66 visits per month exceed or fall short of the district rates for prenatal care. However, available estimates do suggest that in the Kopanga area on average there are 412 pregnancies annually.³

As for source of prenatal care, province estimates show that 93.6% of pregnant women seek care from a skilled provider, (doctor, nurse or trained midwife) with the majority of visits to a nurse or midwife (73.2%). Only 1.2% of women report seeking prenatal care from a TBA and 5.2% of women report receiving prenatal care from no one. National demographic trends show that rural women are less likely to receive care from a doctor, and are more likely to receive care from no one during pregnancy than women in urban locations. As education and socio-economic status rises, so does the likelihood that a woman receives antenatal care. National data shows that one-quarter of women with no education receive no antenatal care at all, and one in seven women in the lowest quintile of wealth receives no antenatal care. Considering the aforementioned demographic information available on women residing in the Migori District, the majority of women in Kopanga are likely to have low levels of education, experience high rates of poverty, and reside in a rural

³ Estimate of annual Kopanga area pregnancies was derived from population data, and fertility rates available through the 2008-2009 Kenyan DHS data.

area. Thus, rates of seeking antenatal care at all may very well be lower than shown in province-level estimates.

PERSPECTIVE OF CLINIC STAFF

The clinic staff all responded that women in the area for the most part are coming to the clinic for care during pregnancy, which includes testing for HIV, the provision of needed medications (such as malarial meds) and supplements, education on a balanced diet and hygiene, determining the position, health of the baby and mother, and estimating a due date. The clinic staff expressed that from their perspective, women in the area are generally healthy during pregnancy, especially in comparison to women who come from Tanzania for care. The clinic staff did not seem to think women were visiting TBAs much during pregnancy for care, but acknowledged that women do use traditional herbs during pregnancy available from TBAs, or by foraging.

“In Luo tradition – women believe in traditional medicines, they are often told not to go to hospital. Luo use local medicines. [For] example – women take the leaves from a tree to protect the baby, and will drink water boiled with leaves.”

The clinic staff did express their concerns with the use of the herbs during pregnancy, both for the health of the mother and the baby,

“90% of herbs are dangerous—can lead to miscarriages, or can negatively affect the fetus. Herbs are problematic as they can dilate [a mother’s] veins and can make IV drugs difficult to administer. Herbs can even lead to drug resistance.” [sic]

PERSPECTIVE OF KOPANGA-AREA WOMEN

Talking with women in the community, almost all respondents expressed the importance of coming to the clinic as a first step to ensure a healthy pregnancy. When asked why this was important, many of the same reasons the clinic staff highlighted the women addressed—the top responses were to check the health of the baby (learn the position), to get HIV status checked, and to gain general knowledge (what to eat, how to prevent complications).

“[It is good to go to the clinic] to see how baby is lying, to take a woman’s temperature, to test for HIV. It is important to go to the clinic because people are sick with HIV; [if you go to the clinic] you can keep the baby healthy. Also, it is good to go to the clinic because if a woman is too short, or too tall for how the baby is laying, you can know this [to avoid complications during delivery].”

Most women expressed confidence in a health facility’s ability to assist with care during pregnancy, based on the knowledge and supplies available at the clinic.

“[The] facility helps in many ways. The clinic can tell you if the child is alive, and can tell you how to be healthy, and, they have medicine. They know things in advance. You can feel good, but maybe you have problems you don’t know about. The clinic can tell you about these things.”

Only one woman mentioned the need to determine a due date, and very few mentioned checking the general health of the mother beyond the HIV test, or to acquire supplements.

The women's perspective on the health of women during pregnancy was somewhat less positive than the clinic staff's—most women mentioned hearing of complications during pregnancy (such as miscarriage or bleeding) and that women either sought care for these issues from the clinic, or took medicinal herbs from TBAs or that they had foraged. The general sentiment regarding the use of herbs was that women didn't have much faith in herbs, but they are often the only choice available. When asked why women used herbs, one woman responded:

"They cleanse the womb. But, [the TBAs] often don't know the measurement and they can take a long time to cure the problem—sometimes one month. Meanwhile, the woman is suffering...but you do not have a choice. Also, a TBA can give you any herb, even if they don't know what the woman is really suffering from."

The most common source cited for complications during pregnancy was overwork:

"There is much work to do in the area. Too much work leads to complications and can cause miscarriages."

Almost all of the women emphasized the need for a balanced diet during pregnancy, and cited the necessity for proteins, fruits and vegetables. A balanced diet was cited as important to give "energy" to the mother and baby. If women can't afford to purchase healthy foods, women said they could forage in the bushes to find good foods (bananas, mangos, cassava, guavas) or can plant crops to sell for income to purchase "good" foods. A few women mentioned the importance of not eating too much food, for fear the baby would grow too large and lead to a complicated delivery:

"[You] must be very careful with the kind of food you eat when expecting. Sometimes you can eat too much, and this will make the baby too big to come out."

Across all of the interviews, only one woman expressed concern for the ability of the clinic to address health issues during pregnancy. When asked where a woman should go when she experiences problems during pregnancy, she replied:

"To the hospital. When [I] first had troubles, [I] went to the clinic and they gave medicine. The problems continued, so [I] went to a TBA for medicine and the problems got better after that."

PERSPECTIVE OF THE TBAS

The group interview with the TBAs confirmed that women do come to them for care during pregnancy, primarily though, when experiencing problems or complications, rather than for routine care. The TBAs said that sometimes they give the women herbs to address these issues, but said they often send them to the clinic if they perceive the problem is serious. The common uses for herbs are to relieve pain, "cleanse the womb" and to change the position of a baby. The TBAs also said there are many complications during pregnancy in the area, such as bleeding, pain or cramping and that herbs are commonly used to address these issues. Aside from seeking care for complications, the TBAs said women can also come to a TBA to learn the position of the baby. Herbs were only mentioned as useful as a response to a problem—it wasn't clearly expressed that herbs were taken as a preventative measure, or a part of routine prenatal care. However, it was clear that the TBAs did look towards herbs as a helpful response to problems. When asked if women in the area could receive help quickly when they needed it for problems during pregnancy, a TBA responded (with agreement of others), "yes, with traditional herbs."

Like clinic staff and women in the area, the TBAs also emphasized the need for a balanced diet and less work during pregnancy. Again, complications were largely viewed as a result of overwork while pregnant.

"[I] always advise women not to do hard jobs."

"When doing hard jobs, [like] washing too many clothes, [or] if they are bending and their clothes are too tight, it can cause a miscarriage."

DELIVERY CARE AND PRACTICES

The latest data available from the 2008-2009 Kenya Demographic Health Survey shows that 43% of births in Kenya are delivered in a health facility, with 56% of births taking place at home. The data shows that births to older women and births of higher order are more likely to be home deliveries, and that mothers in rural areas are more than twice as likely to deliver at home than those in urban areas. Furthermore, as the education and wealth of a mother increases, the proportion of babies delivered at home decreases. For example, 84% of children whose mothers have no education are delivered at home, compared to 27% of mothers who have at least some secondary-level education. Mothers who receive more antenatal care visits during pregnancy are less likely to deliver at home. National statistics show that 44% of all births are attended by a skilled care provider, (doctor, nurse, trained midwife or health worker) 28% delivered by a TBA, 21% of births are attended by relatives or friends, and 7% of births take place with no help, aside from the mother herself. Again, as the education or wealth of a mother increases, so does the likelihood of delivering with a skilled care provider. Women of older age at delivery and babies of higher birth order are more likely to deliver with no assistance. Women who live in urban areas are more likely to deliver with skilled care providers compared to those who live in rural areas.

Estimates available for the Nyanza Province shows that 44.2% of births occur at health facilities, while 54.9% of deliveries occur at home. Information on delivery attendance estimate that 45.5% of births in the Nyanza Province are attended by a skilled-care provider while 26.2% are delivered by a TBA, 20.5% by a relative/other, and 6.3% are delivered by only the woman herself. District and sub-division level data on health facility use and birth attendance estimates are limited. Information from Family Care International estimated that only 23% of Migori District births occur at health facilities.^{xiii} By considering the national trends described above and information from additional demographic data (provided at the beginning of the **Results** section), broad conclusions can be drawn about patterns of accessing care and birth attendance in the Kopanga area. As mentioned, the majority of women in Kopanga are likely to have low levels of education, experience high rates of poverty, and reside in a rural area, therefore rates of delivery at non-clinic settings and rates of delivery attended by non-skilled providers are both likely to be higher than district estimates.

PERSPECTIVE OF CLINIC STAFF

Talking with the clinic staff about maternal and child health issues in the area, the resounding sentiment expressed was that women are attending the clinic during pregnancy and after delivery, but not to birth their babies at the clinic. The staff was quite adamant about the

increased risks to mothers and children when delivering at home, or with TBAs, and that delivering at the clinic is the best place for women to birth their babies to improve maternal and child health outcomes.

“During pregnancy, attendance is not bad. But deliveries are happening at home. The women trust the TBAs. After delivery, the women are bringing their babies to the clinic. The problem is women aren’t coming for delivery.”

When asked why women should deliver at a health facility, the responses all included that with clinic deliveries, the health and safety of both mother and child could be better guaranteed. The clinic staff mentioned the skills and knowledge of staff, ability to prevent transmission of HIV to the baby, available technology, medicines and supplies and the sanitary conditions as reasons for the improved safety of women and children at health facility deliveries: “Many problems happen at home births like stillbirths, bleeding. Women die in labor.” The resounding sentiment was that the majority of women who come to the clinic for delivery do so because of a complication, or in an emergency situation, but if their pregnancy seems “normal” they won’t come to the clinic: “Women leave their house if she has problems but if she is healthy, will talk with no one.”

All of the clinic staff believed most women in Kopanga deliver at home with the assistance of a TBA, or other women (co-wives, mothers etc.) The staff identified several reasons for why women would deliver with a TBA, but the most common reason cited was that women trusted TBAs, or they preferred traditional herbs.

“TBAs give herbal medicines that the clinic doesn’t. [Women deliver with TBAs] to get the herbal medicines.”

“Women want the herbs—they believe they will be healed.”

Although the clinic staff discussed that TBAs play a major role in birthing babies in the Kopanga area, the staff expressed concerns with the knowledge base, skill level and general preparation of TBAs to assist with healthy and safe deliveries. Furthermore, almost all of the clinic staff said that TBAs are very expensive; while the clinic charges 300KSH (around \$3US) TBAs can charge 500-800KSH for delivery. In a few cases, some distrust of TBAs was expressed:

“TBAs sometimes cheat [women]. They say: ‘if you go to the clinic, [because of the medicine the clinic will give her] the baby won’t come out. I will give you these herbs and the baby will be OK.’ Many problems happen at home births like stillbirths, bleeding. Women die in labor.”

Aside from the belief that women may prefer to deliver with TBAs, or have a preference for traditional herbal medicines, the top reason cited as a barrier to clinic delivery was cost. The staff thought that in general, women in the area are very poor. They may not know the price of a clinic delivery, and assume it’s higher than it is, or choose to deliver at home as delivery there can be free unlike a clinic delivery. Although the clinic staff identified cost as a major barrier to clinic deliveries, they emphasized that the clinic cost was affordable; and perhaps the perceived cost was a more real barrier than the actual cost for women: “It should cost more for women to deliver, but [we] keep the prices cheap and affordable.”

The second most common barrier to clinic deliveries cited by clinic staff was the “ignorance” of women, that women don’t know the importance of delivering at the clinic, or don’t know their choices. The staff thought this “ignorance” stems from the lack of education of women in the area:

“Women here don’t know Kiswahili, they cannot read and write. They are not educated. Statistics show that this area is very uneducated.”

“80% of women are illiterate – it is a matter of awareness. If they lack awareness they will not come.”

Distance and lack of transportation were also cited as barriers to clinic delivery, as well as if the clinic staff was harsh, cruel or unqualified.

“When the staff is too harsh, they won’t come. ‘They abuse us!’ [the women say]. If you are too harsh with your patients, they fear us, and they won’t come. If staff is unqualified, patients know this. Then, they won’t come.”

Lastly, a final reason cited by two clinic staff members was fear of HIV testing. Studies show that fear and stigma associated with HIV testing is a critical contributor to low rates of accessing prenatal care services at health facilities across Africa.^{xiii} Current research from the Migori District shows that not only do HIV-related fears and stigma play a role in low rates of antenatal care, but in accessing delivery services as well.^{xiv} A clinic staff member expressed concerns with HIV/AIDS testing acting as a significant barrier to delivering at the clinic:

“Government requires when pregnant women come to the clinic, they must be tested for HIV. There’s a real fear women have in getting tested and knowing their HIV status. They think life is over if they have HIV. Also fear that men are having outside affairs [positive status would confirm this]. Women are faithful and men are not that faithful in marriage. So, women are not coming to the clinic because of the requirement to test for HIV.”

PERSPECTIVE OF KOPANGA-AREA WOMEN

Among the women who participated in interviews, the majority of women had delivered at least one of their babies at a health facility outside of the Kopanga area, but for many women, if they had delivered one or two of their babies at a health facility, their other children were delivered at home, or at the home of a TBA. The women confirmed that Kopanga-area women often deliver with TBAs, with family or friends, or deliver alone, or “with God.” However, when the women were asked where was the best place for a woman to deliver her baby, all of the women interviewed responded at a health facility: “At the hospital. It is better than home or with a TBA. [The] hospital is very good, it can help a lot.” Furthermore, when asked where women preferred to deliver their babies, each woman responded at a clinic or health facility. When asked where she wanted to have her next baby, a woman responded: “In the hospital, anywhere, as long as it’s a hospital.” Not one woman interviewed said she preferred to deliver at home, or with a TBA, but rather, when they did so, it was out of necessity (barriers to clinic delivery are discussed below). When asked what was good about delivering at home, a typical woman’s response was: “it is better than nothing, but not good.” The most common response for why the clinic was the best place to deliver was that delivering at the clinic was safer for the baby and the mother, as clinic staff had the training and knowledge to help avoid or treat complications:

“You can have a problem; the baby can come out badly. Doctors can stop bleeding, and turn the baby to the right position.”

“In the hospital, they make the placenta come out, they know how to cut and tie it. Then the child is vaccinated.”

“It is very bad to deliver at home because you can have many accidents, can bleed very much. If you deliver at home, it is not good.”

“A TBA can’t do anything that the hospital can. Hospital is good for stopping bleeding—TBAs can’t do things a hospital can.”

Although the general sentiment among women was that the hospital was the safest place to deliver, several women also expressed that clinic deliveries were only a necessity if a woman is experiencing complications, or in an emergency situation during her delivery:

“If you have problems during pregnancy or labor, you should go to the hospital. If pregnancy is going smoothly, then you can stay at home.”

Other facilitators for clinic deliveries included receiving goods from the hospital like towels, mosquito nets, or blankets: “[with the delivery cost] you get blankets and a net. Getting things is good for a woman!” A few women responded that it was cheaper to deliver at the clinic than with a TBA, or that the cost of delivery at a clinic was affordable for them, yet recognized this wasn’t true for all women: “It is not expensive, but Africans are poor and it is hard to get money.”

IDENTIFIED BARRIERS TO CLINIC DELIVERY

As stated, one of the major aims of this phase of the assessment was to identify barriers to clinic deliveries, especially from the women’s perspective. The Kenyan DHS report identified common barriers to clinic deliveries by asking women whose most recent birth (in the last five years before the 2008 survey) did not occur in a health facility, why this was the case. Nationally, the most common reasons cited were distance or lack of transport to the facility, or both (42%), and that clinic deliveries were not necessary (21%). Other frequent responses included delivery came too quickly to get to a facility (18%) or that it was too expensive (17%). On a national scale, very few women responded they did not deliver in a health facility because there were no female providers, it was not customary, their husbands or family did not allow it, quality of service was poor, or the facility was not open. Data at the Nyanza Province level reflects similar responses, as shown in Table 2 below.

Table 2: Nyanza Province Data, Barriers to Clinic Delivery

	Cost too much	Facility not open	Too far/no transport	Poor quality service	No female provider	Husband/family did not allow	Not necessary	Not customary	Abrupt delivery
Nyanza Province (%)	17.2	7.1	45.7	0.7	0.3	1.3	8.2	0.8	24.2

Again however, as the Kopanga area is estimated to have high rates of poverty, low rates of educational attainment and is in a rural location, according to the national data, some of the Nyanza Province data may underestimate the significance of some of these barriers. For example, according to national data, women with less education and lower socio-economic status (those in the middle, second and lowest quintile of wealth) are more likely to say a health facility birth is not necessary, or the cost is too high. Furthermore, women who live in rural areas are most likely to

say the distance or lack of transportation impeded their ability to reach a health facility. With these indicators and outcomes in mind, it was no surprise that the most common barrier to clinic deliveries cited by women interviewed was cost, followed by distance and transport, and the perception that women did not have the knowledge to understand the importance of a clinic delivery.

When asked why women were delivering at home or with a TBA, or were not coming to the clinic to deliver, the overwhelming response was a lack of money. The majority of women said that clinic deliveries were just too expensive—they may be able to pay the prenatal care costs (20-30KSH) but that 300KSH was too much (one woman said it can take a year to save 300KSH).

“The payment amount is different for delivery. When [we] go to the clinic before [delivery], it is a different amount than the price for delivery. The price [we] must pay for delivery is just too expensive.”

“In Nairobi, [I] didn’t deliver with a TBA because there are no TBAs in Nairobi. TBAs are in rural areas and [I] had to deliver with them because [I] had no money to pay.”

“Our problem is financial. If [we] go to hospital, the hospital will not help [us] because we have no money. If [we] do have money, [we] will be helped.”

“We have much, much problems with money. [We] are very poor.”

When discussing cost as a barrier to facility deliveries, it became clear that TBAs were much more accessible to women than health facilities if they had no money to pay—contrary to the clinic staff’s belief. Although TBAs may charge 500KSH, women reported they also accept in-kind payment such as a goat, chicken or even soap. A woman can also accept a TBA’s services and pay “when she can.”

“If they are related, [to you] they don’t charge money, they may charge soap. If not a relative, they charge money. It is not expensive, midwives are affordable. If women don’t have money, that’s what keeps them having their babies at home.”

“[We] go to a TBA because you can go to them without money. You can give them a chicken, a little money when you have it, like 20KSH.”

In-kind payment, or ability to pay later, was a very significant facilitator to delivering with a TBA, and even though generally women agreed that TBAs did not have knowledge or ability that the clinic did, and in some cases caused harm to women, they had no other choice based on cost. When asked how TBAs can help with problems during delivery, a woman responded:

“She doesn’t. It’s just that they go to her because they have no money. Some TBAs have gloves. It is because they are cheaper [we] go to TBAs. You can have pain, and a TBA is near. Hospital is too far.”

The interview also attempted to gauge if the perceived expenses associated with delivery at Kopanga Clinic acted as a barrier to delivery rather than the actual cost of delivery. In order to do so, the women were asked if they knew the price of delivery at the clinic, if a government clinic or a private clinic was more expensive to attend, and lastly, what type of clinic Kopanga was. Few women knew the actual price of delivery, and of those women who could identify the correct price of delivery, the majority still responded that 300KSH was prohibitive. For the women who did not

know the price, the translator told them the price, and what things a woman received when she left the clinic: blankets, towels and a treated mosquito net. When women were told the price and the supplies they received, many had a positive response, especially about the supplies received after delivery. However, again, for many women 300KSH was still a significant and perhaps prohibitive cost. All women responded that government clinics were less expensive than private ones, and among the women who were asked, all responded that Kopanga was a private clinic. Although the women responded private clinics were more expensive, often women commented that the care received at private clinics was better, or more accessible in terms of wait times, and several mentioned care at Kopanga was less expensive than delivering at Migori hospital, a government facility.

“Government hospital is cheaper, but treatment is better at Kopanga.”

“Private is much more expensive, but care comes faster.”

[Is delivery at Migori expensive?] “Yes. 300KSH coming and going for travel, 400KSH for admission, 1,500KSH for delivery. I got nothing when I left Migori Hospital.”

“It can be very expensive sometimes; prices are just according to clinic. [My] friend stayed in Migori for three days and it cost 7,000KSH.”

Overall, it appeared general knowledge about the services and costs of the clinic were limited in the community.

As mentioned in a previous quote, distance was the second most common barrier to clinic deliveries mentioned, as well as a facilitator to using a TBA for delivery: TBAs are close to the women, and the clinic is quite far, especially to walk. Motobike is the main source of transport in the area if a woman can't walk, and of course, rather cumbersome to use if in labor. Transportation costs can also be prohibitive. The third most common barrier to clinic deliveries mentioned was a lack of knowledge. Again, in discussing their own beliefs about delivery, none of the women expressed that they thought clinic delivery was unimportant, and often recognized the dangers associated with home delivery. However, they often said that many women in the area did not understand the importance of delivering at the clinic, which served as a reason for women delivering in non-health facility settings.

“Some women don't know the goodness of the clinic, so they stay home”

“Some are ignorant; they don't know the benefits of the clinic. But if you tell them the benefits, they will come. They are ignorant. They don't understand why they should come to the clinic.”

Lastly, the interview attempted to gauge if the permission of family members served as a significant barrier to clinic deliveries, or if the clinic was lacking basic comforts or traditional practices women preferred, and thus kept them at home. Based on the responses to these questions, it did not seem that needing permission was a common prohibitive factor—only one woman highlighted male influence as a barrier to clinic deliveries:

“Must tell [my] husband I am going [to the clinic]. Those husbands that know about the hospital and the importance of going will let the women go. If they don't know, they will not let the women go. It is difficult to teach husbands, it is very complicated.”

As far as identifying the women's preferences during a delivery at the clinic, the most important aspect of a clinic delivery reported was to have a nurse attending deliveries. A few women mentioned the importance of having other women (co-wives, relatives) with them in the room, and a few wanted their husbands to accompany them to the clinic. Most however, responded they did not want their husbands in the delivery room as "he does not know what to do." Only one woman mentioned a fear of a male attendant at delivery, but many said they preferred only women in the room as they "felt free" with women. A few women (and clinic staff also) mentioned that it was a Luo belief that if your husband accompanies you to a clinic delivery, the baby would take a long time to deliver.

PERSPECTIVE OF THE TBAS

The discussion with the TBAs reaffirmed their significant role in birthing babies in the Kopanga area. Out of the 15 TBAs present, they claimed that on average, each assisted with 5-15 deliveries a month. It was also confirmed by the TBAs that delivery with a TBA should cost 500KSH, but they accept in-kind payments: "Some are free, some take soap, or trade. Women can give anything they can afford, sometimes money." However, when asked where the best place for a women to deliver, they all responded at the clinic. When asked why a health facility was the best place to deliver, they expressed that they don't have the knowledge or supplies to always effectively handle emergencies—like excess bleeding, changing the position of the baby, or getting the placenta to come out in a timely way. One TBA responded that "most women" suffer from excess bleeding during deliveries, and they only have herbs to stop it, which sometimes work, and sometimes do not. The TBAs continually emphasized that although they are delivering many babies, they lack clean supplies, and often must reuse gloves, razorblades, and have limited protective gear like coverings for clothes:

"[We] lack uniforms, gloves, and materials to use when mother is delivering their babies. If [we] don't have materials, [we] can't help very well. [A] Problem [we] are facing when delivering children: [we] only have herbs and there are things inside the women, and [we] can't get them out without medicines. In this area there is HIV here and TBAs financial statuses are very low. [We] also need foot coverings to protect from blood."

In spite of this reality, the TBAs expressed they are often the only choice for women to deliver with, due to their proximity to women and the fact that they do have enough knowledge and experience to help during delivery—this is better than delivering alone, or with others who have less experience.

The interview also included a few questions about the TBAs perceptions on the threat of HIV in the area, how they determined if a woman had HIV (if at all), and how they protected themselves from it. When asked if HIV was a problem in Kopanga, a TBA responded:

"The cases of HIV here are still rare. There are cases, so [the TBAs] separate the placenta from mother and baby immediately so the baby won't get blood from the mother and get HIV."

Other methods of protection included, using gloves (if available), being careful to avoid cutting themselves when using razor blades, and throwing away supplies after using them. However, many TBAs mentioned needing to reuse supplies as they lacked resources to buy clean ones for each delivery.

When asked if TBAs consulted a woman's "passport" for her HIV status, it was said they used the passport to determine if a woman had visited a clinic for prenatal care, and thus if she was eligible to deliver at the clinic rather than to determine their HIV status. In general, it seemed TBAs were aware of HIV as an issue, but perhaps did not have knowledge around the specifics of HIV transmission, and certainly did not have the supplies to adequately protect themselves and women from transmission.

One of the most surprising results of the discussion with the TBAs was their adamant insistence that the cost of the Kopanga Clinic was not only reasonable, but that it was beyond fair. The TBAs recognized that the necessary inputs for a safe delivery were very expensive, and that women do not understand the costs associated with delivery for those who are assisting. When asked if the delivery price of 300KSH was too expensive, the TBAs responded:

"No! If a woman delivers at home with a TBA it should cost 500KSH. So, 300KSH is not expensive because it is a lot of work to deliver a baby...The price is fair, fair, fair!"

"Those who say it is expensive, they don't know what they are saying. Even if you buy soap it is 100KSH! [If the price was] 150KSH, you can't buy enough things, like food for the woman. This is a very fair price!"

POSTNATAL CARE AND PRACTICES

A large proportion of maternal and neonatal deaths occur during the first 48 hours after delivery, thus postnatal care is considered important for both mother and child to both treat complications arising from delivery, and to provide the mother with important information on how to care for herself and her child.^{xv} It is recommended that all women receive a check on their health within two days of delivery.^{xvi} National statistics show that 53% of women do not receive postnatal care, and the majority of these women receive care within four hours of delivery. Nyanza Province data show that 65.8% of women do not receive post natal care. Again, the likelihood of receiving postnatal care increases as a woman's socio-economic status and level of educational attainment increases, and women residing in rural areas are less likely to receive postnatal care than their urban counterparts. So, rates of postnatal care utilization are likely lower for the Kopanga area than provincial data show based on the likelihood of a Kopanga-area woman to have low levels of educational attainment and socio-economic status, and their location in a rural area.

PERSPECTIVE OF CLINIC STAFF

The clinic staff largely believed that women were coming to the clinic for postnatal care after delivering, regardless of delivery location. Again, they responded that in their opinion, the larger problem in the area in regards to maternal and child health had to do with non-health facility delivery rates. The staff emphasized the importance for both women and children to come to the clinic for care after delivery, and especially emphasized the need for immunizations for children. Furthermore, staff members reflected their own feelings of responsibility for education of women on health issues, "we have to impart knowledge on these women!" and emphasized the need for education through pregnancy and postnatal care such as nutrition and hygiene. From the interviews it appears that largely though, women are coming for care of their children post-delivery

(for immunizations and to weigh the baby) rather than for check-ups for themselves. There was little discussion about TBAs playing a significant role in postnatal care or services for women in the area. Furthermore, the clinic staff expressed concern about the high level of malnourishment of children in the area.

PERSPECTIVE OF WOMEN

When asked what was most important for a woman to do for the health of her child once it was born, almost every woman responded to take it to the clinic. For the majority of women, the reason a clinic visit was important was to receive immunizations for their children, or to check the general health status of their child. Getting the baby weighed was viewed as an important practice in order to determine the baby's health status: "get the weight of the baby and if the weight is high, the baby is healthy." A few women mentioned the clinic as a place to receive knowledge, "at the clinic women can learn more about how to feed the baby right" and one said "a woman should also go to the clinic because HIV and other viruses exist. The clinic will advise on how to prevent these viruses." Aside from this response, few women mentioned the importance of going to the clinic to receive a check-up for themselves and most responses referred to the importance of postnatal clinic visits for only their babies.

Other routine care mentioned as important after the birth of their child included making sure their baby was fed well, kept clean and provided for:

"A [woman should] take care of the baby, dress them not to get pneumonia, feed the baby well."

"[You] need to know how to eat, and how to clothe children throughout the day. Provide the baby with toys to make the baby happy."

"Wash baby all the time, breastfeed, give food to baby. Eat foods to make breast milk come, like fruits and porridge."

When asked about the importance of breastfeeding, many women agreed it was a part of postnatal care, but if breast milk couldn't be produced, they would substitute cow's milk, or "a kind available from the supermarket."

According to the interviews with the women, it did not seem as though TBAs played a significant role in postnatal care. If a woman delivered with a TBA, she may visit to see how the baby is doing, but not often. One response about a TBA's role post-delivery was: "[A] TBA will come only to get more money, if you birth at a TBA's home, the TBA does not need to come." Only one woman said she sought care from a TBA that she couldn't get from the clinic:

"First, you should take the child to a health facility [after birth]. But sometimes, for things like yellow fever, she can go to a TBA to get help for yellow fever. But, mostly she should go to the clinic."

The interview questions on postnatal care also revealed some common beliefs of women regarding when a woman can leave her home, return to normal activity, and if visitors were allowed to come to her home after birth. When asked how long a woman should stay at home, almost all the women responded it was important to stay close to home and limit activity after birth:

“Only short calls away from the home. You cannot leave for 1-2 weeks at a time. With many difficulties and no people to help, even carrying a bucket of water is too much, she starts bleeding and can fall down.”

Most women responded that after birth a woman should stay near to home and limit activity as much as possible for one to two months after birth as she is “very weak” and needs to “build energy.” During the interviews it was also learned that Luo tradition has strict customs for how long a baby needs to stay inside the home:

“If a boy, the baby must stay inside for four days, if a girl, three days. The woman can go outside, though.” [Why must the baby stay inside?] “Waiting for the placenta to break, so they can’t go outside.”

The exact reason for this belief is unclear, but several women mentioned concerns about the placenta, and the sun. It was unclear to the interviewers if the interpreters had another meaning for “placenta” such as the umbilical cord, for example. Another reason cited was the sun, or just because it was “tradition.” It was also unclear if this tradition had any impact on a woman’s choice for delivery location.

Lastly, all the women emphasized that they welcomed visitors after their babies were born. Most often, wanted visitors were family and friends:

“My parents come, people from home to see [me] and the baby. Yes! It is good for visitors to come.”

Mostly, women mentioned other women as common visitors, but no one mentioned health workers, or nurses as “good” visitors to come, but it was not expressed by any women that they would not be allowed to visit a woman’s home after birth.

PERSPECTIVE OF TBAS

Talking with the TBAs about postnatal care and practices, they said that they do not typically play a large role in postnatal care. Yet, they did mention it was important to visit their clients after delivery to check on their welfare.

“It is important for TBAs to see the woman after delivery because woman or child may have a problem. So if they see these problems, they help them, or send them to the clinic.”

The general impression provided by the TBAs was that they may visit their clients, but women did not often seek care from them after delivery. The TBAs did emphasize the importance of the clinic post delivery for children to get immunizations, and a few also mentioned to get malaria nets.

DISCUSSION

The results from the first phase of this two-part community health assessment reported here represent the initial attempt to characterize the prenatal, delivery and postnatal care and practices of women in the Kopanga area. Considered together, the information gathered from the respondent groups in this study tells a similar story about the care and practices through pregnancy to birth. However, there are a few key differences between the responses of the clinic staff and community members that should be highlighted to provide further insight on barriers to delivery at the clinic.

- **Actual delivery costs, not just perceived delivery costs are prohibitive for many women.** Although the delivery costs at the Kopanga Clinic are considered reasonable from the perspective of both the clinic and even TBAs in the area, it is clear that for many women, 300KSH is unaffordable. The clinic staff thought that perhaps women weren't aware of the actual price of delivery, and their assumptions that the price was high kept them from coming to clinic for delivery. The findings did show that among the women interviewed, they identified the Kopanga Clinic as a private clinic and also reported their belief that costs at a private clinic are higher than at government clinics. Thus, women in the area may in fact believe the prices are higher than actual costs. However, as reported, in the majority of cases where women didn't know the price and were told the costs and supplies received, 300KSH was still too high for many to afford.
- **Women choose to deliver with TBAs based on accessibility, not preference.** It was clear from the responses received from women in this study, that although a clinic delivery was considered the best and preferred location for delivery, women choose to deliver with TBAs because they are frequently more accessible to women due to the ability to provide in-kind payment, and their relative proximity to women. The clinic staff's assumption that perhaps women prefer to deliver with TBAs over having a clinic delivery does not appear to be a predominate barrier to clinic deliveries—that in reality, price and distance to the clinic are the most significant barriers.
- **Women do not necessarily prefer traditional herbs over facility-based care or interventions.** Similar to the misperception that women prefer delivering with TBAs, the reports from women show they take traditional herbs as they are readily accessible by foraging or for purchase at a small price from TBAs. Although women and TBAs do report herbs as effective in some cases, the resounding sentiment was that the herbs were often the best option available if women could not afford, or access the clinic for care. Among the women and TBAs interviewed, in only one instance was it reported that herbs could provide results or treatment that care at the clinic may not be able to provide.
- **Stigma associated with HIV tests may be a significant barrier to clinic deliveries.** Although many women reported the importance of going to the clinic to receive HIV testing, evidence from the literature and perspectives of the clinic staff suggest that in fact, the fear associated with HIV testing may keep women from attending the clinic during pregnancy and delivery more so than reported in this limited study. The quantitative survey should more adequately measure the significance of this barrier to clinic attendance.

NEXT STEPS

The preliminary findings reported here can be considered as P4P and the Kopanga Clinic determine future directions for supporting the health and wellbeing of mothers and children in the Kopanga area. However, by completing the second phase of this assessment, the clinic and partners will have a more comprehensive picture of the prenatal, delivery and postnatal care practices and preferences of women in the area. With more complete information provided by a larger, more representative sample of women throughout the Kopanga Clinic's catchment area, the results from the survey will give essential insights for improving, adapting or even expanding maternity services while making them more accessible and acceptable to the Kopanga community. Based on the results from this initial phase, the quantitative survey should expand upon the areas explored in this first phase, and will aim to reveal factors at the individual, family, community and health facility level that may motivate or discourage use of skilled care during pregnancy, childbirth and the postpartum period.

Although the initial findings from this first phase of the assessment need to be supplemented by more comprehensive data, the information gathered thus far provides some important insight into next steps that the clinic and P4P may want to consider taking to further support the health and wellbeing of mothers and children.

- **Expand community education efforts on available services, associated costs and supplies received with care at the Kopanga Clinic.** From these initial interviews, it was clear that in general, knowledge in the community about the services and costs of service available at the Kopanga Clinic was quite limited, and perhaps because of this, are underutilized. Many women interviewed reported using care or services at other area clinics (such as the Grike Clinic or Migori Hospital). As all women responded government care was less expensive than private care, and the Kopanga Clinic was a private clinic, this finding suggests that women with limited ability to pay for services may avoid the Kopanga Clinic based on this perception. Again, as mentioned, this perception may not be the most significant factor contributing to low delivery rates, but is very likely an important factor. By increasing efforts to publicize information about available services and associated costs, the clinic may very well see an increase in those attending the clinic throughout pregnancy and delivery. In fact, this type of information sharing may have a more significant impact on utilization rates than general health education suggested below.
- **Expand community education efforts on maternal child health issues.** As reported, a resounding concern among clinic staff and community members was the “ignorance” or lack of knowledge among women and men about the harms associated with deliveries by unskilled or under-supplied providers. In addition to expanding efforts to provide knowledge in this area, both clinic staff and community members felt women could benefit from increased education on general health and wellbeing of women and their babies through pregnancy and after delivery. For example, it was suggested that women and their children would benefit from increased understanding of the importance of nutrition or supplements during pregnancy, hygiene during breastfeeding, or the importance of determining a due date to increase preparations for facility-based deliveries. Such education may indeed improve general awareness and understanding of pertinent health issues and risks associated with childbearing.

- **Look to Kopanga-area women as allies to the clinic, and to lead community-based education efforts.** When asked how the clinic could help support the health and wellbeing of women and their babies, and to address the aforementioned “ignorance” of women, many women reported they would participate in educating their peers:

“I, myself can go around [to talk to women], but not too far. [I] can talk to people near, or when [I] talk with people [I] know, when women are together, [I] can tell them what happens at the clinic and that it is good. Us women, we share knowledge together. Sometimes women sit together so if someone like [me] knows about the clinic, we can start talking together and [I] can see what these women think individually. [I] will keep coming to the clinic when I have problems, will also tell other women to come to the clinic when they are expecting.”

Although the clinic could improve their own outreach and education efforts conducted by clinic staff, partnering with women in the community, and tapping into existing social and information-sharing networks may prove to be a very successful approach in spreading information. Furthermore, as women may be more likely to trust and internalize information coming from their peers over clinic staff that are potentially unknown to them.

- **Support an equal partnership between the clinic and Kopanga-area TBAs.** One of the results of the group conversation with TBAs at the clinic during this first phase of the assessment was the creation of a partnership between the clinic and TBAs in the area. This partnership, called LIMO (Linking Mothers) was spearheaded by the Clinic Nurse Manager Alice, and encourages TBAs to bring women to the clinic for delivery. Under this arrangement, if indeed a TBA does bring a woman to the clinic for delivery, the clinic will split the delivery fee in half with the TBA, and the TBA is encouraged to stay with the woman to observe the birth and support the mother during labor. Already since this partnership was formed, the clinic has seen a marked increase in clinic deliveries since late December.

However, as TBAs will continue to remain more accessible to women with an inability to pay in cash, and due to their proximity to women who may be unable to reach the clinic because of distance, the clinic may want to further support TBAs. Further support could include advanced training for safe delivery practices, and by the provision of clean and sanitary supplies.

“TBAs have basic knowledge [on birthing babies]. But they need to learn sanitary practices. So when women go to the TBAs, they know how to do it well. TBAs can come to the clinic for training and how to address problems. We could train TBAs—for example, ask the TBA: ‘if there’s bleeding, what will you do?’ [We could] teach them the problems so that when TBAs see them, they can come to the clinic right away.” –Clinic staff person, Kopanga Clinic

- **Expand the ability of the Kopanga Clinic to offer mobile clinics in the surrounding area.** Based on information provided by clinic staff, it appears that the Kopanga Clinic does indeed offer limited clinic services in the community through mobile clinics. However, the ability for the clinic to offer these mobile clinics more frequently and in more remote areas is quite limited at this time. As distance to the clinic is a significant concern of the clinic

staff, and a real barrier for women in accessing clinic services, “bringing the clinic to the women” would be a valid approach to improving access to the clinic. Furthermore, by offering mobile clinics, the overall presence of the clinic in the community would be strengthened. This increased presence may offer better opportunities for outreach and education, as well as gaining trust and overall recognition within the community.

Although much significant learning took place in this first phase of the assessment, by completing the second phase of the assessment, P4P, the Comprehensive Rural Health Project and the Kopanga Clinic will have taken a significant step towards better understanding the needs, existing resources and preferences for care during pregnancy through delivery and after birth. With more complete information, all partners should continue to work together to evaluate current services available at the clinic and to explore future options for how the clinic can best support the health of women and children in the area.

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APPENDIX A: INTERVIEW GUIDE¹

Prenatal Questions

1. When a woman learns she is pregnant, what kind of things does she do to take of herself and her baby?
 - a. Why is it good to do these things (eg go to the clinic)?
 - b. What types of foods does she eat?
2. If a woman doesn't have money to buy good food when she is pregnant, what does she do?
3. What bad things can happen during pregnancy?
 - a. Have you heard of these things happening to women in Kopanga?
4. When these things happen what can she do? Where can she go?
 - a. Why is a hospital good during pregnancy?
 - b. How can a TBA help during pregnancy?

Delivery Questions

5. Where do you give birth to your babies?
 - a. What does the hospital do for you?
 - i. What does the hospital give you when you leave?
6. What is good about giving birth at home? Why does a woman deliver at home?
 - a. When you are delivering at home, what makes you feel comfortable?
7. Why is it difficult for women to come to the clinic?
8. Is the clinic expensive?
 - a. How much does the clinic cost to deliver a baby?
9. Is a TBA expensive?

¹This interview guide was used to speak with women in the community, and was not identical for all respondent groups. However, it does provide a good example of the types of questions asked to both clinic staff and traditional birth attendants. Final interview guides for these groups available from the author upon request

- a. How much does a TBA cost?
- 10. Who do you want to help you when you have a baby? Who should be in the room?
- 11. What is most expensive, a government hospital or a private clinic?
 - a. What kind of clinic is Kopanga?
- 12. Do you have ideas of how the clinic can help women when they have a baby?

Postnatal Questions

- 13. What does a woman do to take care of her baby after it is born?
 - a. What does the clinic do for your baby?
- 14. Should a woman go to a clinic after she has a baby to take care of herself?
 - a. Why?
- 15. Who can visit you after you have a baby?
 - a. Can a nurse visit you at your home?
 - b. Does a TBA visit you at your home?
 - i. What is good about having a TBA visit?
- 16. Can a woman leave her house after having a baby?
 - a. How long must she stay at home?
 - i. Why?
 - b. When can she bring the baby outside?
- 17. It seems some women have questions about the clinic and health, how is it best to get them this information?
- 18. If you have to go to the clinic, who do you decide with?
 - a. Do you need permission from your husband or co-wife before you go to the hospital?
- 19. Do you have any thoughts/needs you want to share with us?
- 20. Do you have any questions for us?

APPENDIX C: QUALITATIVE ANALYSIS CODEBOOK

CODEBOOK USED FOR THEME IDENTIFICATION

Pre-natal practices

PREGDIET—Eat “balanced diet” (proteins, veggies, fruits, carbs)

Facilitators to balanced diet

DIETCROPS—Plant a garden

DIETSELL—Sell crops planted to buy food

DIETFORAGE—Forage to find good foods

DIETBORROW—Get food or money to buy food from friends/neighbors

DIETHUSBAND—Husband plays role in securing good food

PREGCLINIC—Go to clinic

Importance of clinic

CLINICHIV—Check HIV Status

CLINICBABYHEALTH—To check health of baby (position, size)

CLINICMOMHEALTH—To check health of mother

CLINICDUE DATE—To get a due date

CLINICSUPPLIES—For supplements, immunizations

CLINICKNOWLEDGE—To learn about pregnancy, delivery, care for baby, etc

PREGHYGIENE—maintain good hygiene

PREGTBA—Go to TBA for herbs, prenatal care

PREGNOTHING—No change in practices

Prenatal Problems

PREGMISCARRY—miscarriages ID'ed as a problem

PREGBLEEDING—Bleeding during pregnancy ID'ed as a problem

PREGSELFPROB—Woman reports having problems

PREGPAIN—Pain or fever

Source of problems

PREGHERBSBAD—Don't take herbs b/c they cause harm

PREGWORK—Work less to avoid complications

PREGBELIEFS—Text about traditional beliefs/broken customs etc

PREGCLOTHES—Tight clothes

PREGNOCLINIC—Problems stem from not going to clinic

Solution to problems

PROBCLINIC—Go to clinic to get help

PROBTBA—Go to TBA to get help

PROBHERBS—Take herbs to help problem

PROBNOTHING—Do nothing/out of your control

Perceptions of pregnancy or practices during pregnancy

PREGPROBPRECEPTIONS—Perception there are lots of problems during pregnancy in area

PREGHEALTHYPERCEPTIONS—Perception women have healthy pregnancies

PREGTBAPERCEPTIONS—Perception that TBA can't help during pregnancy

PREGCLINICPERCEPTIONS—Perception clinic can't help during pregnancy

PREGOTHER—Other text about prenatal practices

Delivery Practices

Location

DELIVERHOME—Woman delivers at home

DELIVERCLINIC—Woman delivers at any clinic/hospital/health facility

DELIVERTBA—Woman deliver's at TBA's home

Location Preference

PREFDELIVERHOME—Woman prefers home delivery, no assistance

PREFDELIVERCLINIC—Woman prefers to deliver at clinic/health setting (but may not be able to)

PREFDELIVERTBA—Woman prefers to deliver @ TBA's home or with a TBA

Preference for who's at clinic delivery

PREFCLINICSTAFF—Nurse, doctor

PREFCLINICTBA—TBA in attendance

PREFCLINICHUSBAND—Husband in attendance

PREFCLINICWOMEN—Other women (sister, co-wife, neighbor)

Don't want at clinic delivery

ANTICLINICHUSBAND—Don't want husband there

ANTICLINICTBA—Don't want TBA there

ANTICLINICMALE—Don't want male doctor

ANTICLINICNURSE—Don't want nurse (stated preference for doctor)

ANTICLINICGUESTS—Don't want anyone else but health professional in room

Preference for who's at non-clinic delivery

PREFWITHTBA—Deliver with TBA

PREFWITHWOMEN—Other women (sister, co-wife, neighbor)

PREFALONE—No one but woman

PREFGOD—Mention of god, or faith

Don't want at non-clinic delivery

ANTIUSBAND—Don't want husband

Permission needed to go to clinic

CLINICPERMISSION—text about needing/not needing permission to come to the clinic

Barriers to clinic delivery (WHY NOT COME?)

BCOST—Too expensive

BKNOWCOST—Women know cost but it's still too expensive

BPERCIEVEDCOST—Women don't know cost, but THINK it's higher than it is

BTRANSPORT—No transportation

BROADS—Bad roads

BIGNORANCE—Women are ignorant of importance to come to clinic

BDISTANCE—Clinic is too far

BTRADHEALER—Prefer a traditional healer/TBA

BTRADMEDS—Prefer traditional medicines/herbs

BLITERACY—Women are illiterate

BSTAFF—Clinic staff are feared/cruel/unskilled

BHUSBAND—Husband won't allow or don't know importance of clinic delivery

BWAITTIME—Takes too long to receive service

BEMERGENCY—Delivery happens quickly, can't reach clinic in time

Facilitators to coming to clinic for delivery (WHY COME?)

FCLINICCOST—they have money to pay

FKNOWCOST—Women know cost and say it's affordable

FSAFETY—It is safer for the woman to delivery at clinic

FSAFEBABY—It is safer for baby to be delivered at clinic

FBABYHEALTH—Can ensure health of baby at clinic (weighed, shots)

FINCENTIVE—Receive nets, towels, blankets, napkins

FSTAFF—Clinic staff are knowledgeable/skilled (more so than TBA or woman)

FEMERGENCY—In emergency situations go to clinic

FTBAEXPENSIVE—TBA's are expensive, or not cheaper than clinic

Facilitators to delivering with TBA (WHY TBA DELIVERY?)

FTBACOST—Monetary cost is less

FTRADE—Can trade in-kind

FACCESS—TBA is closer

FHERBS—TBA's have herbs that clinic doesn't

FTBAKNOWLEDGE—TBA's have knowledge to help delivery

FTBABESTOPTION—TBA's are the best option available, better than delivering alone

Perceptions of delivery or practices during delivery

DELIVERYPROBS—Perception there are a lot of problems during delivery

DELIVERYTBAPERCEPTIONS—Perception that TBA can't help during delivery/will cause harm

DELIVERYCLINICPERCEPTIONS—Perception clinic can't help during delivery

DELIVERYTBAWOMEN—Perception that women prefer to deliver with TBA

DELIVERYCLINICBEST—Perception that clinic is best place to deliver

DELIVERYTBABEST—Perception that TBA is best to deliver with

Post-natal Practices

POSTDIET— text on feeding baby well

POSTCLINIC—Go to clinic

Importance of clinic

POSTIMMUNIZE—Immunize babies

POSTBABYHEALTH—Check baby's health, weigh, examine

POSTWOMAN—Go to clinic for woman's health check-up

POSTKNOWLEDGE—For knowledge from clinic (how to breastfeed, etc)

POSTTBA—See TBA for woman or baby's health

Importance of TBA

POSTTBAKNOWLEDGE—For TBA's knowledge (can't get at clinic)

POSTTBAHERBS—For herbal treatment

POSTNOTHING—No mention of need for healthcare (either from clinic or TBA)

POSTHYGIENE—Text on maintaining hygiene of self or baby

POSTBREASTFEED—Text on breastfeeding

POSTNOBREASTFEED—Text on breastfeeding alternative (cow's milk)

POSTSTAYHOME—length of time woman stays home

POSTBABYHOME—length of time baby stays inside

POSTVISITORS—who can come visit the woman after baby is born

How get Kopanga women come to clinic for delivery?

CLINICPRICE—lower the price

INCENTIVES—Provide more incentives (towels, nets)

EDUCATECLINICSTAFF—Staff circulate in community educate on importance of clinic delivery

EDUCATEPEERS—Women circulate and educate each other on importance of clinic delivery

EDUCATETBA—TBA's will educate women on price

EDUCATEMEN—Target education to men on importance of clinic delivery

QUALITYSERVICE—Provide quality services/staff

CHANGESERVICE—Text about changing services, ambulance, change clinic staff

How can clinic help women birth healthier babies?

MORECLINIC—Have more women deliver at clinic

MORETBA—Train TBAs

MORESUPPLIESTBA—More supplies for TBA

Perception about Kopanga Clinic

CLINICGOV—Think Kopanga is government clinic

CLINICGOVEXP—think government clinic is more expensive than private clinic

CLINICPRIV—Think Kopanga is private clinic

CLINICPRIVEXP—Think private clinic is more expensive than gov clinic

OTHER COMMENTS

OTHER—For other interesting comments