UNIVERSITY OF NAIROBI
DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK

FACTORS DETERMINING THE UTILIZATION OF FREE MATERNAL HEALTH CARE IN KENYA; A CASE OF GARISSA PROVISIONAL GENERAL HOSPITAL

BY

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DECLARATION

This Research Project Report is my original work and has not been presented for a degree or any other award in any university.

Signature…….. Date …….……

Fatima Dahir Mohamed C50/75724/2014

This research project has been submitted for examination with my approval as the university supervisor.

Signature _____ **Date** _____

Supervisor: Professor Edward Mburugu

DEDICATION

This Research Project Report is dedicated to my loving parents; Amina Mohamed and Dahir Mohamed Burale, and my supportive husband Ahmed Mohamed Amin.

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LIST OF ABBREVIATIONS/ACROYMNS

MMR – Maternal Mortality Ratio

MOH – Ministry of Health

ANC – Antenatal Clinic

BEmOC – Basic Emergency Obstetric Care

CORPs – Community Own Resource Persons

DANIDA – Danish International Development Agent

DHMT – District Health Management Team

DMOH – District Medical Officer of Health

FANC – Focused Antenatal Care

FGD – Focus Group Discussion

FP – Family Planning

HIV – Human Immunodeficiency Virus

KDHS – Kenya Demographic Health Survey

MCH Mother – Child Health Clinic

MDG – Millennium Development Goals

MOP – Ministry of Planning

OBA – Output Based Approach

PGH – Provincial General Hospital

PHMT – Provincial Health Management Team

SMI – Safe motherhood initiative

SPSS – Statistical Package for Social Science

TBA – Traditional Birth Attendant

UNPF – United Nation Population Fund

UN – United Nation

UNICEF – United Nation Children Fund

WHO – World Health Organization

ABSTRACT

The purpose of this research is exploring the factors determining the use of free maternal healthcare in Garissa County. The study explored the views and characteristics of women in relation to factors that may affect their utilization, particularly those related to their own culture, religion/belief and the role of traditional birth attendant (TBA) whom the women trust more than the healthcare professionals. It also looked into perceived factors related to facilities like quality of services provided as well as those that are linked to health staff like their gender and attitude. The objectives were to determining the link amongst socio-bio traits of women and the use of free maternal healthcare facilities identify types of social support that impact on free maternal healthcare services, investigate how the gender and attitude of health workers affects the use of free maternal healthcare services and determining how the quality of services impacts on the use of free maternal healthcare. The study adopted a cross sectional descriptive survey design targeting women population of reproductive age between seeking antenatal, delivery or post – natal services in Provisional Garissa Hospital in Garissa County. A total of 120 pregnant women and mothers were sampled using stratified sampling technique and purposive sampling where key informants were interviewed. Data was collected using questionnaires and schedule interviews. Data collected was analyzed using both qualitative and quantitative methods. The quantitative techniques comprised tabulation, frequencies, percentages and means using Statistical Packages for Social Sciences software version 18.0.

The study established that mothers who utilized the free maternal care, a higher proportion of them earned higher income of more than 15000 shillings a month compared to those who utilized free maternal care with an income of lower than 6000 shillings. The findings also revealed that majority of mothers had no preference of gender to serve them when seeking maternal care services. The findings revealed that attitude of the staff during delivery process played a vital role as to whether an effective free maternal healthcare would be rendered to women or not.

The study recommended that the government needs to train more Staff, midwives as well as Community Health Workers who links the communities and health facilities locally thereby improve accessibility to free Maternal health care service. The study recommended that the county government needs increase health facilities per capita as well as health workers in the marginal areas for women to access free maternal healthcare services at their localities. Finally the study recommended that health workers need to be provided with incentives as motivational factor to ensure that they willingly serve individuals living in different regions.

CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

The project for costless maternal health care for expecting mothers provides for waived prices of health insurance with a wide range of insurance advantages this includes; an overall maternity care with privileges such as post-partum birth control counseling and ambulance services. This is funded by the NHIF (National Health Insurance Fund) that includes donations from oversees partners through a budget support in the health sector (Arhinful, 2010).

In 2008, the world maternal death estimate was 358,000with the developing countries having the highest percentage of 99% (355,000) deaths (UNICEF, WHO, the World Bank 2010 and UNFPA). High maternal death rates have a negative impact on a country. The developed countries have high living standards and also spend averagely 7.0% of their GDP on health funding while the developing nations spend only 4.2% on health (Holm, 2010).

Nakamara (2010) defines maternal health as the health status of women during childbirth, pregnancy and postpartum period. High rates of prenatal and maternal mortality and high morbidity is contributed by lateness in receiving health care in the case of pregnancy complications and poor health care services (Thaddeus and Maine, 1994). Most women risk having obstetric complications, therefore there need of universal availability to obstetric care (WHO 1998). According to WHO, approximately 500,000 women experience pregnancy and child birth complications yearly and millions of the women survive this complication but succumb to disabilities and illnesses from childbirth. The estimates from the Safe Motherhood Initiative (SMI) of 2003 state that 30 -50 morbidities are a result of maternal deaths. The aim of prenatal care is to identify early pregnancy complications, subdue them and give the required health care to the mother while postnatal care includes healing after childbirth, newborn care, breastfeeding nutrition and birth control services.

In India, the government has taken measures to increase hospital child births through institutionalization of maternal health care for child deliveries (Sonalde, 2006). In 2012 the institutional child deliveries were above 79% in Madhya Pradesh and 40% in Chhattisgarh as compared to 2011 that was 76.1% in Madhya Pradesh and 34.9% in Chhattisgarh. This was motivated by the initiative of government funding of delivery and prenatal care that lead to a

successful improvement on the rate of hospital deliveries and reduced maternal mortality. This made India be recognized for reduced incidences of maternal mortality globally (Denise, 2010)

The funding of maternal health care should be tied to maternal care investments like in other countries that have employed costless maternal care. The maternal health care program of Australia is recognized as the best in southern America, it has a universal maternal health care funded from tax in the insurance system that covers for hospital services, physician and drug prescription costs (Stephen, 2011).Before the commencement of this program, the Australian government heavily invested on the health sector in this includes: provision of adequate beds, at least ten midwives and nurses for each 500 women and approximately 9% of the GDP was used to fund health care(World bank 2003).

The total amount of funds invested in health care by USA is the greatest worldwide as stated by Centre for Disease Control (CDC). However, the level of deaths due to pregnancy complications in the USA is higher than in other countries. For instance, the probability of death of a woman during child birth in USA is three times higher in Spain, Four times higher in Germany and five times higher in Greece. Each day at least two women die due to pregnancy complications in USA and black American women are at even a greater risk than the white American women to succumb to this at a ratio of four back women to one white woman. The rate of maternal mortality in some developed countries is high and this rates have relatively not changed in over 20 years but have however increased to 13.3 deaths for every 100,00 child births from 6.6 deaths for every 100,000 child births in 1987(Becak, 2006). Japan successfully achieved a reduction of the maternal mortality rate in the 1960-1990 decade whereby the maternal mortality ratio reduced from 130 to 50. This motivated many developing countries to make efforts to reduce their mortality rates over the remaining years up to 2015 which was a millennium declaration target year.

In the year 2000, there were 251,000 maternal deaths in Africa with only 40% of deliveries being professionally done by nurses and midwives (WHO, 2005). Sub-Saharan Africa had above half (270,000) of the child birth deaths in 2005. According to WHO have been an increase of maternal death rate in Sub-Saharan Africa (WHO et al., 2010) with over the years with approximately 204,000 deaths in 2005 and only a small drop of this rate in 2005-2008.

Ghana adopted the free childbirth program for all in 2004, and funded by lower debt repayment methods and this led to an increase in institutional deliveries (Sophie Witter ,2009).The universal funding program stopped in 2007 after the establishment of the national health insurance scheme(NHIS) in 2004 however, the non-members of the NHIS had to pay for their deliveries so the government sought to introduce the free delivery program for all mothers in 2008, motivating more members to join to enjoy this benefits. Surveys conducted by the population council in 2006 and Ghana health services in 2007 revealed a reduction of the maternal mortality rate from 580 to 409 per 100, 000 births respectively.

Kenya has experienced high maternal mortality and morbidity rates over many years with the most recent as deaths of 488 per100, 000 births (KDHS, 2009) that is above the MDG limit of 147 in every 100,000 births. Approximately 20-30 women succumb to disability or injury in every one woman who dies due to pregnancy or deliver complications. This is contributed by inadequate access to good maternal health services during delivery, antenatal and postnatal services. Despite that growth in health infrastructures, accessibility and affordability of health facilities are a challenge and only 44% of births in Kenya are done in hospitals which are below the 90% target. The traditional midwives still assisting at 28% and births assisted by friends and relatives being 21% and 7% with no assistance (Calverton, 2010).

For the last 7 years, Ministry of Health in collaboration with other partners has put in place several mechanisms to improve maternal health in North Eastern province, and these are indeed attributed to improved utilization of maternal services (UNICEF, 2008). New maternity rooms have been constructed and existing ones renovated, the delivery kits and drug supply have been significantly streamlined. Though staff shortage is still an issue, many partners tried to employ staff, mostly nurses, specifically for the periphery health facilities in order to improve services. Additionally, much training were conducted on areas related to maternal health notably; Emergency Obstetric Care (EMCOR), Focused Antenatal Care (FANC), Malaria In Pregnancy (MIP) and Prevention of Maternal To Child Transmission (PMTCT) among other trainings (MOH, 2008).

1.2 Statement of the Problem

Scholars have explored extensively on the use of maternal services and factors that affect it. Mwaniki (2004) did an examination on socio-economic matters that affected the use of maternal

care in Mbere district in Kenya. It was disclosed that age, education and marital profile as well as economic status were key predictors involving maternal care. But, these studies ignored some of the factors that influenced access to the use of free maternity services introduced by Kenya government.

The proportion of women seeking free maternity care have increased at a higher rate, according to Owino (2013) who found out an increase in the number of women who sought for maternal services by a margin of 100%. Kenya Demographic and Health Survey (2008-2009) unraveled that amid thousand and one thousand two hundred women who succumbed to death during child delivery in every a hundred thousand births in North Eastern Kenya in comparison to the national rate of 488 deaths in every 100,000 births. In addition, sixty eight percent of women delivered without any form of assistance from a skilled medical practitioner.

Women who visited antenatal clinic at least once during their pregnancy stand more than 92% nationally, and nearly 70% in Northeastern province (KDHS, 2008) . Comparatively, the proportion of women who delivered at health facility is 43% in the country and 17% in NEP (KDHS, 2008). While globally there is some literature on this subject, there is little information regarding this set up and the community targeted in this study. What has been documented in NEP so far is mainly on rural settings within a pastoralist lifestyle that target general health care provision which apparently is different from this study that targeted urban population on specific health service (Free Maternal Healthcare). The circumstances and challenges under the previous studies and their target populations are quite different from this study's targeted population. Even then, many of the factors under study were not extensively covered in the previous studies in NEP. For example, an issue like the role of culture, religion and gender preferences of the community in the context of maternal services seems unclear.

The purpose of the study, therefore, was to investigate the factors that determine the utilization of free maternal healthcare in Garissa County. The study explored the views and characteristics of women in relation to factors that may affect their utilization, particularly those related to their own culture, religion/belief and the role of TBA whom the women trust more than the healthcare professionals. It also looked into perceived factors related to facilities like quality of services provided as well as those that are linked to health staff like their gender and attitude.

1.3 Research Questions

i. What is the relationship between social and demographic characteristics of women and utilization of free maternity healthcare services?
ii. How does the gender and attitude of health workers influence the utilization of free maternal healthcare services?
iii. To what extent does quality of service provided affect utilization of free maternal healthcare services?

1.4 Objectives of the Study

1.4.1 Main Objective

The main objective of this study was to investigate factors that determine the utilization of free maternal healthcare in Garissa County.

1.4.2 Specific Objectives

This study was guided by the following specific objectives:

i. To determine the relationship between socio-demographic characteristics of women and the utilization of free maternal healthcare services.
ii. To identify types of social support that influence utilization of free maternal healthcare services.
iii. To investigate how the gender and attitude of health workers affects utilization of free maternal healthcare services.
iv. To determine how quality of services provided influences utilization of free maternal healthcare services.

1.5 Justification of the Study

This research provides insight into various factors that are may determine the utilization of free maternal healthcare services in Garissa, Kenya. It may enable the Government of Kenya to assess whether the free maternal health care programme is worthwhile to Kenyans.

The finding of the study gives an insight to the health planners and implementers in various levels of the health ministry hierarchy. This was important because it helped to incorporate the feelings of the clients in their planning process and put the right measure to attract more mothers to utilize the free maternal services. These findings will provide a platform for further basis for research and students used this study to form basis of discussion of maternal healthcare services

in developing countries. A lot of research on maternal healthcare has been undertaken in the past and this study acted as an additional resource to update the studies done by previous scholars.

1.6 Scope and Limitations of the Study

Free Maternal Healthcare Services are available in the whole country and is aimed at reducing maternal mortality and morbidity rates. However this study focused on the utilization of free maternal healthcare services and factors that determine this utilization in PGH Garissa County and as such the outcomes of the study did not be generalizable to cover all the counties in Kenya. Data were be collected from women who were either pregnant or those who had delivered in PGH and from community health workers in the hospital (midwives and gynecologists). The study was conducted in an area inhabited by Somali speakers where some could not understand English, hence the limitation of language barrier. In order to overcome this, the researcher recruited research assistants who speak both English and Somali language.

1.7 Definitions of Key Terms used in the Study

Mortality – Incidences or new cases of deaths from maternal deliveries

Maternal care - Maternal health refers to refers to the health of women during pregnancy, childbirth and the postpartum period.

Utilization of free maternal health care- Use of free maternal care services by women during pregnancy at the public health facilities.

Postnatal care - Postnatal care is the assistance given to a mother for a period of six weeks from the time of delivery.

Postnatal services - Postnatal services comprise of physiotherapy, physical examination, immunizations, family planning, and healthcare education on childcare, breast-feeding, treatment and counselling services.

Skilled birth attendant- refers to people with midwifery skills including doctors, midwives, clinical officers or other trained health workers.

Pregnant women- Women who didn't have children but were pregnant and seeking ANC services.

Mothers- Women who had children and/or pregnant.

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

According to Cockerham (2012) a health habit is the exercise of an individual towards improving or maintaining their health status and body image, and preventing ill-health occurrences. The utilization of healthcare can be defined as the employment of health care provisions by individuals (Obayelu, Opaluwa and Awoyemi, 2011). The accessibility of healthcare services is a significant factor of the use of these services in low income countries (Mekonnen and Mekonnen, 2002). Therefore, for an individual to use these services there has to be: physical access of a healthcare institution and its capability to provide quality services; availability of affordable healthcare services paid through a health insurance or by cash (Shauri, 2010).

The use of healthcare services is a complicated behavioral event that relies on the quality, availability and price of services, health beliefs, social structure and users' individuality (Chowdhury, Akhete, 2003; Ebuehi et al., 2006). In this research the use of healthcare facilities by women is an important factor in relation to their welfare and survival, and that of the child during the expectation, delivery and postpartum period since it affects the rate of child and maternal mortalities in a community of people (Gazali et al., 2012; WHO, 2012).

2.2 Literature Review

2.2.1 Social-Demographic Characteristics of Women

The independent state of mind of a woman is instrumental in explaining the utilization of maternal services and facilities for child care. Metropolitan households and male-spouse's learning is found to impact positively to the use of antenatal services (Dairo & Owoyokun, 2010). A similar study in India, Madhya Pradesh on the inhibiting factor towards the use of maternal care services revealed that younger mothers have a high probability of using antenatal and postnatal care and seeking professional delivery services (Jat & San Sebastian, 2011). The tendency of women in metropolitan areas seeking maternal services is greater than those residing in rural regions (T.R. Jat et al., 2011). In a study in Ethiopia, religious beliefs were found to also determine the utilization of antennal care services, whereby the Muslim, Orthodox and Protestants were found to be affiliated with high utilization if maternal care than the followers of

traditional beliefs. The religion and marital status are a determining factor to utilization of antenatal care (Mekonnen & Mekonnen 2003 and 2002).

In Kenya the study done by Fosto in 2009, revealed that the overall women independent-mind set is important in seeking healthcare. Moreover, women, with secondary education have a high probability of delivering in health facilities unlike those who are uneducated. The probability of child delivery in a well-equipped facility decreases as the proportion increases. A study done in Nyanza, Kenya revealed that the higher the counterbalance, the greater the probability of home deliveries. Deliveries made in health facilities were more among low counterbalance women. The literacy levels of an individual affect the utilization of a health facility, those living in rural areas whereby at least sixty three percent of births take place.

Nevertheless, the population in urban areas has a high level of probability to deliver in health facilities with an estimated seventy eight percent of deliveries in healthcare facilities. . The economic status and age preference of the healthcare facility are factors that determine place of child birth with most women preferring their homes. This study showed that the location of childbirth is determined by education levels, parity, residence, age and economic status of a mother (Owino, n.d).

2.2.2 Quality of Services Provided

The concept of the quality of healthcare varies in its definition worldwide (Graham WJ, Varghese B.2012). The quality of care comprises of a facilities' safety, effectiveness and a reputable experience in dealing with patients (Graham and colleagues, 2013). Bruce's' definition of quality care comprises six factors; client information, methods employed, interpersonal relationships, continuity and follow-up mechanisms, technical competence and good consultation services. The quality of care with respect to maternal healthcare can be defined through; timeliness, effectiveness and the respect of fundamental reproductive rights (Bruce, 1990 Hulton et al. 2000). Moreover, it can be defined to have two units: the quality of care provided and the experience of users of the services and systems used. When poor services are provided it negatively affects a user's utilization of that service.

The Kenyan public health facilities staff have severally been reported to mistreat abuse and neglect patients, a problem elevated by understaffing and low supervision measures. According

to Center for Reproductive Rights and Federation of Women Lawyers of Kenya in 2007, most public health facilities are insensitive to cultures and fail to assimilate to local incidents for example cultures that mandate women to be served by a female staff. Moreover, the health staff is inadequately trained. In a recent report by World Bank, shows that only 58% of public health facilities can accurately diagnose 4 out of 5 most common diseases a patient has and only 44.6% of well-monitored neonatal or maternal conditions. Low quality of services in health institutions has contributed to reduced potential patients seeking treatment in the public health facilities. In North Eastern, most women alluded that there are poor quality services at 17.3%, low female staff at 9%, and high deliver costs at 4.9% are the greatest barriers to low deliveries in health facilities (Kenya Demographic and Health Survey, 2008-2009).

Some of the women interviewed by the Kenyan press revealed that they are uncertain that the existence of cost-less maternity healthcare will facilitate to the decline of the quality of services offered and diminish of their rights. This has resulted to individuals seeking traditional attendants over public facilities despite them even having free services (Inter press service, 9, 2013). Quality of care can be perceived from different stand point– provider, clients or even administrators/managers perspective. In the client point of view, quality of service can be seen in respect to time taken to offer the services, privacy, cleanliness as well as availability of medical supplies and equipments (Sheikh, 2010; Sarker et al, 2010). As stated, patients were not to use services unless they see their own needs are catered for and convinced that an effective remedy is available within the health facility (Witter et al, 2003). Quality service in relation to the client perception is to make services cost-effective by meeting women health needs in appropriate ways and this reflects in the future use of the services (Lawson et al, 2003).

Quality of the service provided is also said to improve staff ethics as properly trained staff with the right resources needed is more likely to facilitate positive attitude towards the clients (Lawson et al, 2003). Similarly, good quality of the service is associated with timely use of the maternal services by the community (Sarker et al, 2010). Quality of the service provided had a profound effect on acceptability and uptake of the service. Dissatisfaction of the health services offered in Northeastern is stated in some studies as contributory factor in low service utilization (Bousey et al, 2009; Ganga-Limando et al., 2006).

2.2.3 Gender and Attitude of Health workers

Attitude and behaviours involving maternal providers of healthcare act as key proponents or quality since they impact either negatively or positively in shaping women's perception and their partners regarding maternal healthcare. Unavailability of quality healthcare options such as doctors, midwives has led to dissatisfaction resulting into a reduced likelihood to seek antenatal and postnatal services (WHO, 2005). Behaviours and attitudes directly impact on the patients' well-being as well as clients and the association amongst health providers and patients. In addition, negative energy and behaviours can compromise and impact negatively on the quality of care delivered as well maternal effectiveness and efforts towards promoting infant health (Buttiens, Marchal, De Brouwere, 2004). Considering that behaviours and perception impact on maternal and infant health outcomes (Holmes & Goldstein, 2012) , this also allows women to enjoy their fundamental basic rights in a manner that protects them from violence and discrimination in achieving high standards of mental as well as physical health. In a recent survey by WHO (2012) and the humanity reproduction programme, there's a great need for advocacy against women mistreatment particularly during birth (WHO, 2014).

Though there seems to be little information that relates health service utilization and staff gender in the global arena, the issue is very important in North Eastern Province where there are strong religious influences on preferences of health provider especially on maternal services. While one study has not shown any relationship between gender and service utilization in North Eastern Province (Ganga-Limando et al 2006), another mentioned lack of female staff in health facilities as a contributing factor in dissatisfaction raised by the community in rural areas especially on maternity service (Bousery et al, 2009). These issues are important because the interaction between the service provider and the clientele is imperative for the success of any intervention. NEP is inhabited by a community who are culturally conservative more so among the women population. This is compounded by the fact that most of the facilities are manned by male staff of whom many of them are from outside the community. These therefore may increase, in a way cultural inaccessibility and exacerbate barriers related to staff factors.

2.2.4 Influence by Social Support and TBAs

Social support system from family members, life-partner, relatives as well as friends great impact on decisions made by women regarding prenatal care (Schaffer MA, Lia-Hoagberg, 1997). In most societies, women have conventionally relied on their fellow women for social

kind of support during childbirth and breastfeeding. Female friends and relatives give company to women during labour to their maternal unit; this is most attributed to improved outcomes from labour. House (1981), gave specifications on the several kinds of social support classified as emotional and instrumental during childbirth. He pointed out that social support was tangible, emotional and informative; he further explained the underlying relationships between these forms of relationships (Lazarus, 1981). Schaffer MA and Lia-Hoagberg, (1997) did an investigation involving a previous research and established that social support was linked to health behaviours including nonexistence of social support that was linked to an increase in maternal mortality (Mbizvo MT, Fawcus S, Lindmark G, Nyström L. 1993). To achieve a better understanding of the contribution of social support on use of maternal health care facilities, different sources and kinds of social support ought to be considered.

Many African countries previously encouraged the Traditional Birth Attendant (TBA) to conduct deliveries after undergoing training (WHO, 2005). However, though some success has been reported on reduction of neonatal tetanus through cord care, they have no major impact on reduction of maternal death and therefore cannot replace the midwives (Lawson et al, 2003). TBA is embedded in many African culture and cannot be easily wished away especially in the rural set-ups where the practices are popular (Mubyazi et al, 2010).

According to some studies in North Eastern Province, most mothers trust the traditional birth attendant over health facilities during deliveries (Bousey et al, 2009, Ganga-Limando et al, 2006). However, there are strong indications that most mothers understood and embraced the importance of antenatal and immunization services (Sheikh, 2010). Some argue that the design of existing lower facilities were not catering for the need of the mothers as maternal services were unavailable because of many factors including the basic in design of health facilities and lack of the necessary equipment (Ganga-Limando et al 2006). Currently, this seems changing as the ministry of health encourages all government health facilities to provide maternity services.

In summary, while globally there is some literature on this subject, there is little information regarding this set up and the community targeted in this study. What has been documented in NEP so far is mainly on rural settings within a pastoralist life style that target general health care provision which apparently is different from this study that targets urban population on the utilization of free maternal health care services. The circumstances and challenges under the

previous studies and their target populations are quite different from this study's targeted population. Even then, many of the factors under study are not extensively covered in the previous studies in NEP. For example, issues like the role of culture, religion and gender preferences of the community in the context of maternal services seem unclear.

2.3 Theoretical Framework

This section reviewed sociological theories that may explain factors determining utilization of maternal health care services.

2.3.1 Health Belief Model

This model is anchored on a few ideals and constructs that seem to make predictions on why individuals need to take action to protect and control infections or conditions (Glanz et al., 2008). HBM model posits that preventive measures put in place to avoid instances of diseases is as a result of fear of vulnerability of such a disease and the perception that its occurrence would impact negatively on individual implications (Cockerham, 2012). Hence, women can only go for maternal health care services in a situation where they perceive that the pregnancy they might be carrying might be affecting them in one way or the other.

HBM believes that taking counter actions reduces the levels of likelihood that a disease might affect an individual. Thus, the perception of this form of threat posed by an ailment could be affected by modifying factors such as bio data, socio-psychological as well as the structural constructs which impact the attitude as well as the corresponding that are necessary to prompt any action (Cockerham, 2012). Action prompts are essential elements especially because an individual might consider an action to be effective in mitigating the level of vulnerability, however, such an action might not be taken if it is considered expensive, very painful or traumatic in nature (Cockerham, 2012). Women might opt to go for healthcare services since by so doing, they believe that the have minimized the level of likelihood in experiencing difficulties during pregnancy.

The available chances of taking an action entail weighing the benefits of an action in relation to contrasted barriers. It is thus perceived that the motivation to prompt an action is needed as part of acceptable behaviour. Such stimuli might be internal or external, mass media communication or individual knowledge of an individual who might be affected by such health-related problems

(Cockerham, 2012). Women need to make a decision to either take action or not based on the benefits derived as opposed to the obstacles faced.

This model makes an assumption that if an individual deems himself or herself as vulnerable to a given condition and have a belief that that condition could possible affect them negatively, it would be advisable to take a protective action in advance in order to try and mitigate the impacts that could arise from such conditions. It is normally hoped that the implications of severity of such conditions might be mitigated if appropriate actions are taken in advance (Glanz et al., 2008).

It is essential to note that health seeking behaviour is anchored on the perceived value of the outcome. That minimizing personal vulnerability and the expectation that precautionary actions would be effective in reduction of anticipated risks (Cockerham, 2012). In line with this research, the theoretical basis is informed by five identified constructs that constitute the HBM. It advisable to conclude that women make use of maternal health care when they consider that the pregnancy they are carrying could impact on their wellbeing and mitigate the possibility of them being faced with challenges in the entire episode of pregnancy. Women might also decide to either take an action or do nothing based on the expected benefits that they might get.

2.3.2 Symbolic Interactionism

Symbolic interactionism was developed from the works of Erving Goffman; they proposed that people come together through different experiences that are exchanged on a day-to-day basis (Frisby & Featherstone, 1997). Looking at the analytic perspective, any information which is visual (that is facial, expression and gesture), as well as accurate to achieve a successful interaction. This theory holds that visual information is useful in making encounters with other people; it is also helpful in making judgments, forming opinions, and making decisions on how to speak and act. Gestures and images are also used for enhancing interaction with others, and to execute important functions as expected (1971).

This theory has tried to explain the interactionist approach in providing key findings regarding the interactions amongst patients and health-care Practioners. Deliberately or not, many physicians often manage situations through displaying their knowledge and medical competence. Patients wait for a long time for physicians to show-up in their white laboratory coats. In most

cases, they are dressed like doctors and the patients are referred to by their first-name. Complex terms are utilized in describing an ailment by a patient unlike using simple words mostly utilized by layman including patients.

Managing a situation is a critical exercise particularly when undertaking a gynecological exam. In situations when the physician is a male, this situation becomes tense with increased embarrassment and nervousness especially a man examines and touches a woman's genital parts. Under these situations, physicians need to act in a professional way. He should demonstrate no individual interests on a woman's body handle such an exam in the same manner he handles the rest of the exams (Cullum-Swan, 1992).

Interactionist perspective is important to this research in enabling the reader to have an understanding of relationships amongst an individual and the larger society. Whether a woman utilizes maternal health care services or not can be determined by the society's views on the utilization. For example, if significant others or other important relationships in a woman's life feel that it is unnecessary for her to utilize maternal health care services, then she is unlikely to use these services. Likewise, if TBAs are held in high regard and trusted more than health professionals, it will impact on the use of maternal health services. This theory will help guide this research in terms of interactions with health workers, TBAs and others that may influence the decision of utilizing maternal health care services.

2.4 Conceptual Framework

A conceptual framework is a concise description of the phenomena under study accompanied by a graphic or visual depiction of the major variables of the study (Mugenda, 2008).

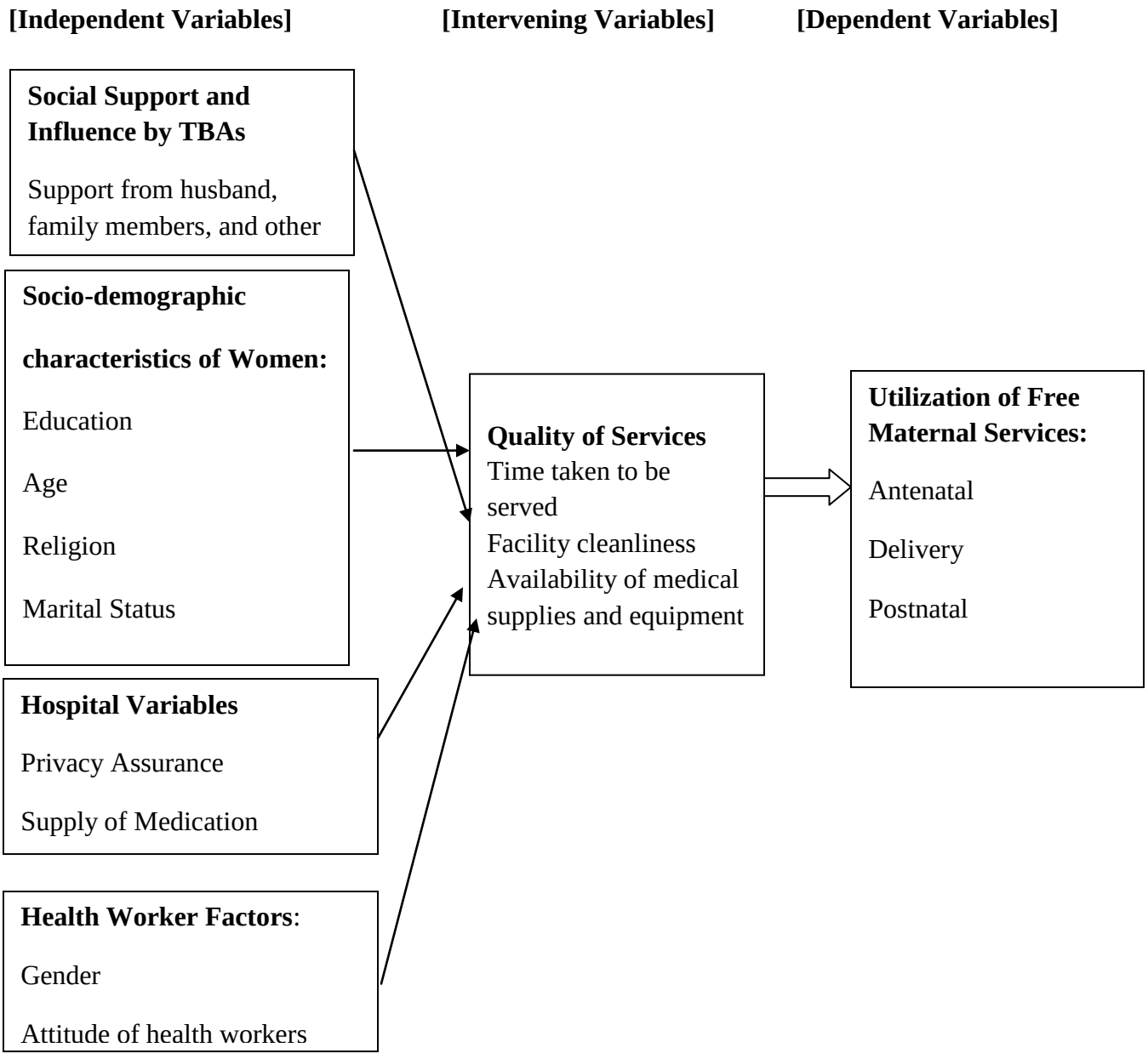
The conceptual framework outlines the dependent, independent and intervening variables as discussed in the literature review. Elaborations have been done in the Figure 1 below.

In the socio demographic factors, it is expected that education, age, religion, marital status and parity have an influence on the mothers' ability to access and utilize the maternal health care services.

Hospital variables and health worker attitude and gender will also influence whether or not the free maternal services will be utilized or not. Use of free maternal services will also be determined by the women's social support and if there is influence by TBAs. How the mother's

family and social support feel about free maternal health care services and/or in comparison to TBAs will determine the utilization of the services. The quality of services provided in the hospital will enhance or discourage mothers from access the free maternal care.

Figure 2.1: A Conceptual framework of Independent and Intervening Variables that influence utilization of maternal health services



CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter gives a detailed description of the methodology to be employed in conducting research. It constitutes the following sub-headings: design for this research, population of the research, size of the sample, procedures for sampling, instruments for collecting data, methods of analysis and research ethics.

3.2 Site Description

The study was conducted in PGH Garissa which is situated in Waberi Ward which is located in Garissa Township constituency, Garissa County, North Eastern region (Currently divided into 3 Counties – Garissa, Wajir and Mandera)**.** Garissa town was the provincial headquarter for NEP, nearly 400 KM north east of the capital Nairobi. It has a population projection of 141,889 (2009 census), but believed to be having much higher population because of people attracted by the surrounding refugee camps. There are 3 administrative divisions and one parliamentary constituency.

In 2008, Garissa Provincial General Hospital's ANC clinic attended to more than 6,250 pregnant women and conducted about 2600 deliveries, which translates to only 41% of those attending ANC utilizing maternity services (District Medical Officer of Health, DMOH, 2009).

Garissa Provincial General Hospital (PGH) is the only level five referral center for the Counties in North Eastern region as well as some neighboring Counties in Eastern and Coast regions and has since received much attention from various developmental partners in an effort to expand its capacity. The maternity ward was renovated and expanded about 7 years ago while a new maternity theatre was constructed and equipped through a DANIDA project. Staffing levels, particularly specialist in various disciplines have being improved.

3.3 Research Design

The research design that was adopted in the study was a cross sectional descriptive survey. Data was collected and analyzed using both qualitative and quantitative methods. The design was appropriate for the study since the data was collected at one point in time hence saved both time and money. The design enabled the researcher to describe variables and also explore the relationship between them.

3.4 Unit of Analysis and Units of Observation

The unit of analysis in the study was the utilization of free maternal health care services i.e. antenatal, delivery and post-natal services. The main unit of observation was based on women, either pregnant or recently delivered at the hospital. Other units of observation were nurses, doctors and other health care workers.

3.5 Target Population

The study targeted women population of reproductive age seeking antenatal, delivery or post-natal services in Provisional Garissa Hospital. Specifically, it targeted all pregnant women attending antenatal clinic in the hospital's MCH, newly delivered women who were in maternity unit during the study period and non-pregnant women who came for other services like immunization and post-natal services.

3.6 Sample size and Sampling Procedure

The sample size and sampling procedures for the study was determined by the following statistical procedures.

3.6.1 Sample Size

According to Mugenda and Mugenda (2003), a sample size of 10% of the sample size is considered adequate for descriptive study. The targeted sample size was 150 pregnant women and mothers which is 11.8% of the population in consideration of drop out cases. However, the interviewer managed to receive 120 completed questionnaires.

3.6.2 Sampling Procedure

Garissa Township constituency was selected conveniently because the researcher was familiar with the area and because it was where PGH was located hence aided ease transport arrangements.

To select the mothers, the study used stratified random sampling as a procedure to help minimize bias in the representation of the target population. In the method, women were put in the following different strata; those seeking antenatal care, delivery services and women seeking postnatal care. Hospital records of ANC, Delivery and Postnatal care visits in the month of May and June of 2016 were used as an average to get the sample size, as shown in the table below. In the month of May, ANC, PNC and delivery services recorded were 695, 205 and 375

respectively, whereas in June, ANC, PNC and delivery records were 610, 338 and 306 respectively. The women in the stratum were interviewed as they came to the hospital to seek the free maternal services hence there was no bias. These sampling methodologies were deemed appropriate to represent the target population and to provide the same results at the lowest possible cost and time.

Table 3.1: Distribution of the target population and sample

Free maternal services at PGH	**Target population Women of reproductive age**	**Distribution percentage**	**Sample**
ANC	652.5= 653	51.6	77
Delivery	340.5= 341	26.9	41
PNC	271.5= 272	21.5	32
Total	**1266**	**100.0**	**150**

3.7 Methods of Data Collection

The study used both qualitative and quantitative data collection methods.

3.7.1 Collection of Quantitative Data

Open and close ended semi-structured questionnaires were administered to the individual/ group of women attending maternal child health services including those in maternity unit.

Research assistants administered the questionnaires with the help of a supervisor who closely monitored their work. The principle investigator also did crosscheck the filled questionnaires regularly to ascertain correctness and completeness.

3.7.2 Collection of Qualitative Data

Some women were chosen for Key Informant interviews on selected days so as not to participate in the study twice. Health workers were also interviewed.

3.8 Ethical Considerations

The research did not involve invasive procedures and, therefore, did not expect to cause any direct harm to the participants. Study objectives were explained to the participants by the research assistants who also did provide them with a written consent form that was translated

into both English and the local language (Somali). The respondents were also be assured that their participation would be kept confidential and used solely for purpose of the research and they were to remain anonymous and they were allowed to withdraw at any stage in case they felt so. The respondents were clearly informed that their refusal/withdrawal would not have any punitive consequences in their health services seeking right.

3.9 Data Analysis

Data from the questionnaire was keyed in a database programmed by SPSS and analyzed. Key Informant discussion (notes) was typed on Microsoft word capturing main response of participants and was sorted based on the themes developed from the study objectives. Data from key informant interviews was qualitatively analyzed. All sets of data were analyzed in form of tables, charts, percentages, mean, mode etc.

CHAPTER FOUR: DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

This section presents the results of the data collected from PGH Garissa, which is situated in Waberi Ward, Garissa Township Constituency, Garissa County, North Eastern region. The region is currently divided into 3 Counties i.e. Garissa, Wajir and Mandera as mentioned earlier. The data is presented in tables and figures for analysis and interpretation. It, therefore, gives a vital analysis of the data in relation to the research objectives.

4.2 Response Rate

One hundred and fifty printed questionnaires were distributed in a timely manner to the respondents, and out of these, 120 questionnaires were filled and returned. The response rate was 80 percent of the total sample size picked for the study.

Table 4.1 Response Rate

Item	**Frequency**	**Response**
Total questionnaires distributed	150	100%
Questionnaires filled	120	80%

4.3 Socio-demographic Profile of Respondents

4.3.1 Age Distribution

The respondents' age distribution is as shown in Table 4.2.

Table 4.2: Distribution of the Respondent by their Ages

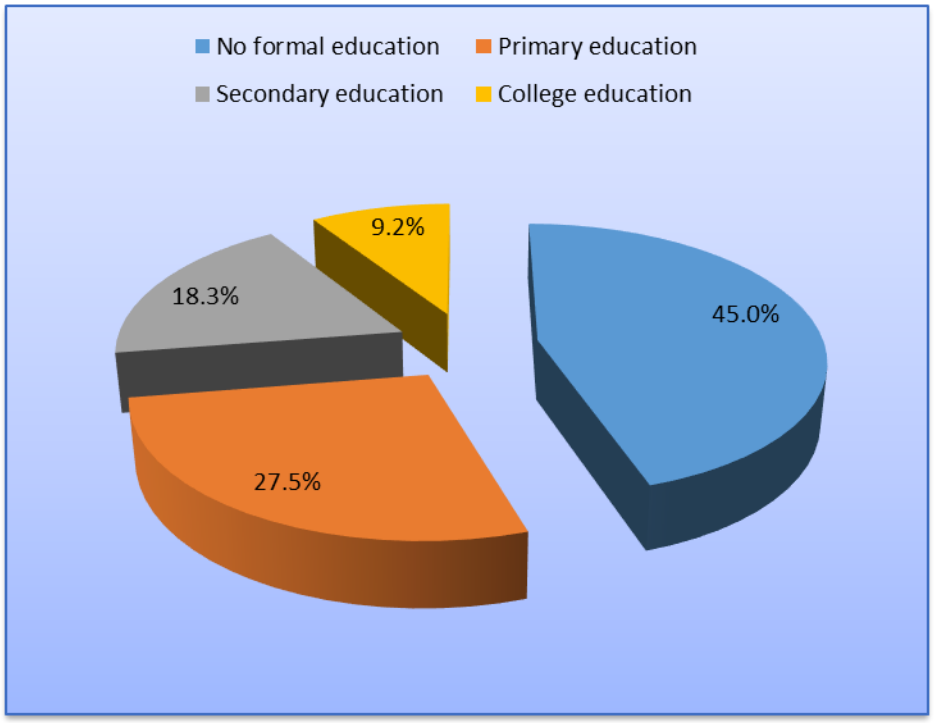
Age Distribution	Frequency	Percentage
15-19 years	18	15.0
20-24 years	49	40.9
25-29 years	33	27.5
30-34 years	16	13.3
>35 years	4	3.3
Total	**120**	**100.0**

Majority (41%) of the respondents who participated in the study belong to the age bracket of 20 and 24 years while a considerable number (28%) were between 25 and 29 years old as seen in Table 4.2. Then followed by 13% falling in the age bracket of 30 to 34 and 15% between age bracket of 15 to 19 respectively. However, a negligible number (3%) of the mothers with over 35 years were noted during the study.

4.3.2 Respondent Education Levels

Respondents were asked their level of education as shown on Figure 4.1.

Figure 4.1 Distribution of Respondent by their Education Levels(N=120)



During the study, it was established that majority of the women (45%) had no formal education, and this could raise a concern especially when it comes to being knowledgeable of health-related matters. Besides, 27.5% of the respondent only managed to get primary education while a small portion of the respondents, that is 18.3% of the respondent had secondary education. Only 9.2% of the women in the region managed to attain college education. In general, it is notable that a large number of the women (45%) in the region are illiterate.

4.3.3 Respondents by the number of their Children

The participants had different number of children as seen on Table 4.3

Table 4.3 Distribution of the Respondents by the number of their Children

Response	Frequency	Percentage
1-2 children	66	55
3-4 children	25	20.8
Five children and above	27	22.5
First pregnancy	2	1.7
Total	**120**	**100.0**

A good number of the women (55%) have one or two children. On the contrary, a good percentage (22.5%) of these women had five and more children. The rest had three to four children (20.8%) and only 1.7% were on their first pregnancy as shown in Table 4.3. This implies that there is high demand for free maternal healthcare services especially among those with two or three children. It is more common for women to seek health services the first or second time they deliver as compared to when deliver their fifth child.

4.3.4 Area of Residence

Different residential area of the respondents is presented on Table 4.4.

Table 4.4 Residence of the Respondents

Constituency	Frequency	Percentage
Fafi	29	29.0
Lagdera	23	23.0
Ijara	16	16.0
Garissa Township	14	14.0
Dadaab	9	9.0
Balambala	9	9.0
Total	**100**	**100.0**

From the information provided by the respondents, 29% are residents of Fafi constituency, 23% are from Lagdera constituency, 16% are members of Ijara constituency, 14% were residents of Garissa Township constituency, 9% were from Dadaab constituency, and 9% were members of Balambala constituency. This implies that there is high demand for maternal health care services in all the constituencies.

4.3.5 Duration of Stay

Respondents were asked how long they have been living in their current area of residence and the results were as shown on Table 4.5.

Table 4.5 Duration of Stay (N=120)

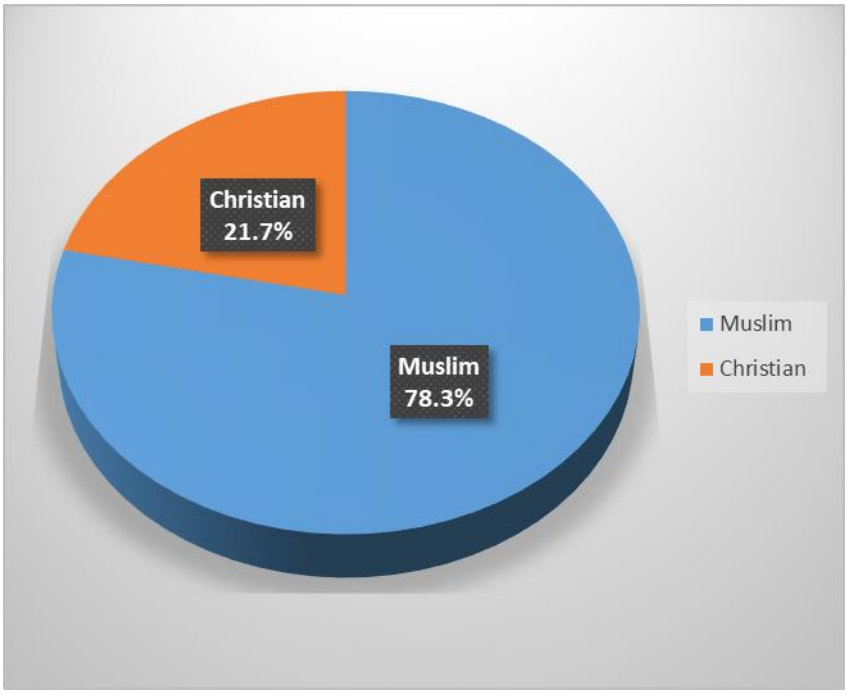
Duration of Stay(years)	Frequency	Percentage
One year or less	22	18.3
2 - 5 years	45	37.5
6 – 9 years	19	15.8
10 or more years	32	26.7
Unspecified	2	1.7
Total	**120**	**100.0**

The majority (37.5%) of the respondents indicated that they have stayed in the area for about 2 to 5 years, followed by 26.7% of the respondents stating that they have lived in the region for more than 10 years. Eighteen percent and 15.8% affirmed that they have lived in the regions for a period of not more than one year as well as between 6 – 9 years. However, 1.7% of the respondents were not willing to specify the duration of stay.

4.3.6. Religion of Respondents

The religious beliefs of the respondents is as presented on Figure 4.2.

Figure 4.2 Religion of the respondents (N=120)



It is evident from the research that Garissa region is a Muslim-dominated area. The highest number of women (78.3%) who participated in the study indicated that they were affiliated to Islam religion. As shown above, 21.7% of the respondents were Christians. This implies that religion did not hinder the respondents' utilization of free maternal health care services.

4.3.7 Marital Status

The respondents were also asked their marital status. The results are shown in Table 4. 6

Table 4.6 Marital status

Response	**Frequency**	**Percentage**
Married	115	95.8
Single	5	4.2
Total	**120**	**100.0**

It was evident that the majority of the selected respondents (95.8%) were married, while almost none of them showed a contrary marital status with an exception of 4.7% single women in the region. Based on the responses provided, there were cases of widows or divorced among the married women. This implies that unmarried pregnant women these services as much as their

married counterparts. This may be due to the fear of being stigmatized or disgraced in the community.

4.3.8 Occupation of Respondents

The study sought to find out the occupation of the respondents which were illustrated in Table 4.7.

Table 4.7 Occupation

Occupation	Frequency	Percentage
None	14	11.7
Housewife	64	53.3
Self-employed	30	25.0
Central government employee	4	3.3
Local government employee	8	6.7
Total	**120**	**100.0**

The study results show that the 53.3% of the women were homemakers/housewives. As well, 25% of the respondents were self-employed while 3.3% and 6.7% of them were employees of central and county governments respectively. Nevertheless, a good proportion of these women up to 11.7% lacked employment opportunities. Being that the unemployed or both the governments do not employ a good number of these women, they entirely depend on their husbands' income for a living.

4.3.9 Income Level in the Family

The respondents were also asked about the level of income in their family as indicated in Table 4.8 below

Table 4.8 Income Level

Income Level	Frequency	Percentage
Unemployed	32	26.7
Less than 6,000	7	5.8
6,000-10,999	26	21.7
11,000-15,000	16	13.3
Above 15,000	39	32.5

Total	**120**	**100.0**

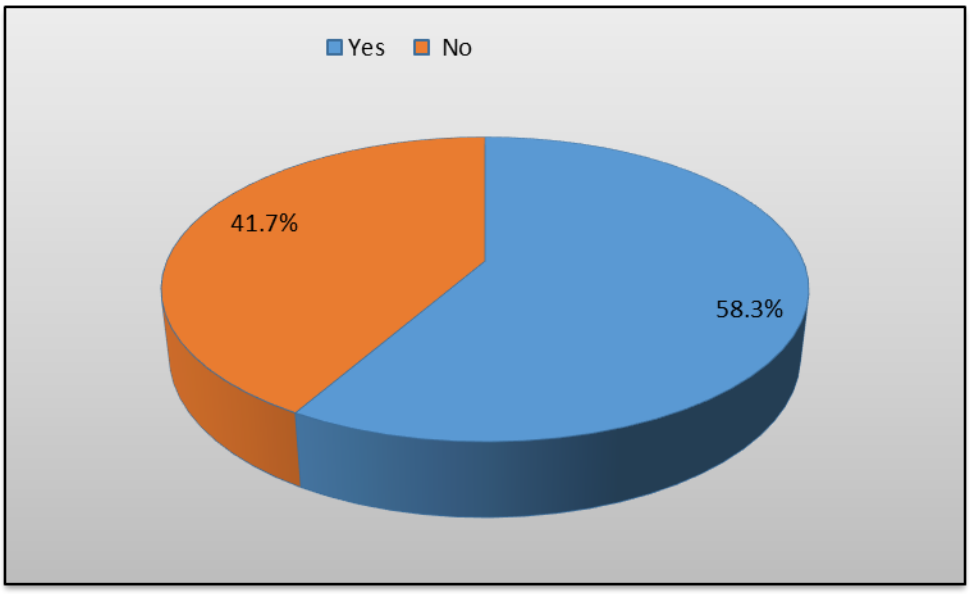
The average income level per month for most (32.5%) of the families was more than Ksh.15,000. On the other hand, a good portions (21.7%) of respondents have a salary range between Ksh.6,000 and Ksh.10,999 per month. Those that had the lowest pay of less than Ksh.6,000 a month were 5.8%. This implies that those with higher income level (e.g. Above 15,000) were more likely to utilize these health care services as compared to those low income level of Less than 6,000.

4.4 Characteristics of Women and Utilization of Free Maternal Health Care Services

4.4.1 Child Delivery Services

When asked whether they delivered at GPGH before, the response was as shown on Figure 4.3.

Figure 4.3 Child Delivery Services(N=120)



A larger percentage (58.3%) of women had benefited from the free maternal health care services provided at Garissa Provincial General Hospital. On the other hand, 41.7% of the women had not attended the hospital for child delivery services.

Table 4.9 represents how long ago these respondents delivered at GPGH.

Table 4.9 Number of Years Attended Garissa Provincial General Hospital (GPGH)

Timeline of Attendance	**Frequency**	**Percentage**
<1 Year	28	23.3
1-2 years ago	54	45.0
2-3 years ago	8	6.7
3-4 years ago	13	10.8
>5 years ago	17	14.2
Total	**120**	**100.0**

For the women who had delivered at the hospital, 45% respondents stipulated that they had done so in the last one to two years ago. A considerable number of people (23.3%) delivered at the hospital very recently (less than one ago), with 20 respondents affirming to have had attended Garissa Provincial General Hospital (GPGH) for 2 years and above.

While seeking to know the reasons why most of them preferred to deliver at the same hospital, they stated that superior service level at the hospital was great. For example, more than 50 percent commented positively on the services as very good, good, and excellent respectively. The result, therefore, proved that quality services in medical facilities should be given the first priority. This confirmed the Graham and Varghese (2012) who made an assertion that "clinical effectiveness, safety, and a good experience for the patient" all make up quality care that patients enjoy. Besides, the findings were also in agreement with argument made by Hulton et al. (2000) that in healthcare facilities that offer maternal health service, quality will always be determined by the timeliness, effectiveness, and standing up for basic reproductive rights. Finally, it can also be argued that due to the improved health care systems that the hospital is enjoying now, the facility has continued to experience an increasing number of women who want to deliver in health centers since the systems are efficient.

The respondents were also asked about their satisfaction with the services at the hospital and the response was show on Figure 4.4.

Figure 4.4 Service Satisfaction(N=90)

As one of the major healthcare centers in Garissa county, the improved service level has made it possible to challenge the common assertion that public health care facilities in Kenya is highly characterized by mistreatment, discrimination, negligence etc. It is, therefore, possible to conclude that the hospital is very sensitive to the demands of the patients especially the expectant mothers. However, this does not mean that poor quality services are absent. For example, inadequate number of healthcare providers especially in the North Eastern is contributing to poor quality care.

4.4.2 Referral to Garissa Provincial General Hospital

When the respondents were asked if they would refer others to the hospital, the response was as shown in Table 4.10 below.

Table 4.10 Response to Whether Others are referred to the Hospital (N=113)

Response	**Frequency**	**Percentage %**
Yes	105	92.9
No	8	7.1
Total	**113**	**100.0**

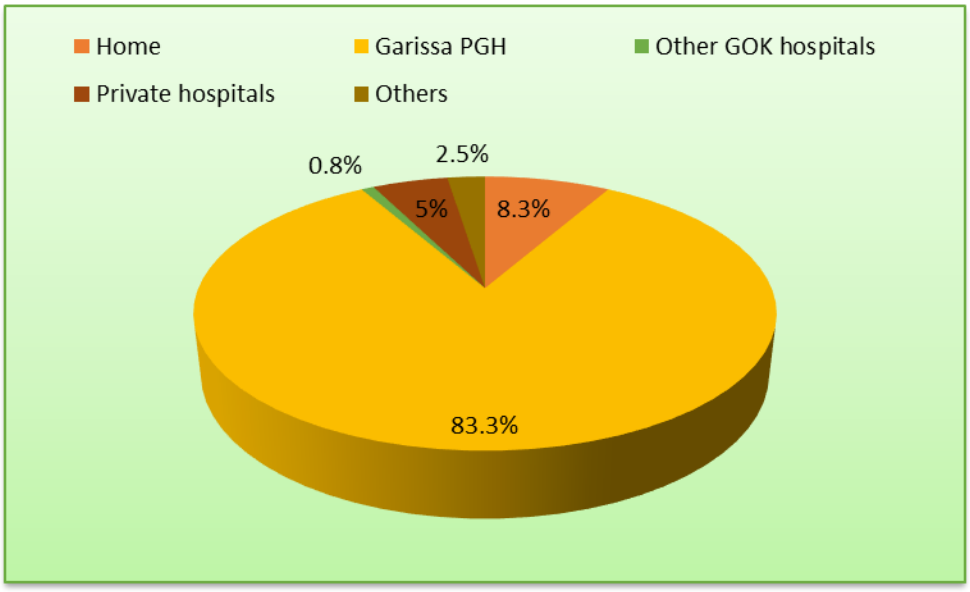
From the study, results indicated that 92.9% of the respondents would advise their fellows to consider delivering at the hospital, while a very small percentage of 7.1% would not recommend the hospital to other women who are seeking to deliver. In addition, 6% of the total respondents did not share thought on whether to refer others to deliver at Garissa Provincial General Hospital. The reasons why majority believed that they would recommend it to others include the following. First, the respondents believed that the hospital provide the privacy that most women need. This confirms the arguments of Sheikh (2010) and Sarker et al. (2010) who altogether agreed that maintaining privacy of the patients improve the reputation of healthcare facility. According to them, they will not use services unless they see their own needs are catered for and convinced that an effective remedy is available within the health facility.

Secondly, the staff had high level of ethics, and through this, they won the confidence of many women. In addition, the maternal services were offered free just like in any other public hospital, and the women needed not to travel for a long distance while looking for a hospital where they can deliver. The fact that the facility was closer to them meant that respondents' needs was well addressed in a timely manner.

4.4.3 Hospital of Preference

When asked the preference of place of delivery the response was as show on Figure 4.5.

Figure 4.5 Hospital Preference (N=120)



Most of the respondents (83.3%) declared Garissa Provincial General Hospital was the best hospital in the region they can deliver at. To them, the facility provided almost everything that they needed as far as delivery was concerned. Based on the experience that some of them had, the satisfaction achieved in the past made them to become confident with the health practitioners, a staunch reason as to why they did not want to change to other hospitals. However, 8.3%, 5% and 2.5% of the respondents chose not to deliver at the said hospital but rather to seek services at home, private hospitals or other health facility centers respectively as shown in Figure 4.8 below.

4.4.4 Respondents' Beliefs

When asked if there were beliefs that prevented them from utilization of health care services, the responses are summarized on the table 4.11.

Table 4.11 Whether Respondents' Beliefs prevent hospital based delivery (N=108)

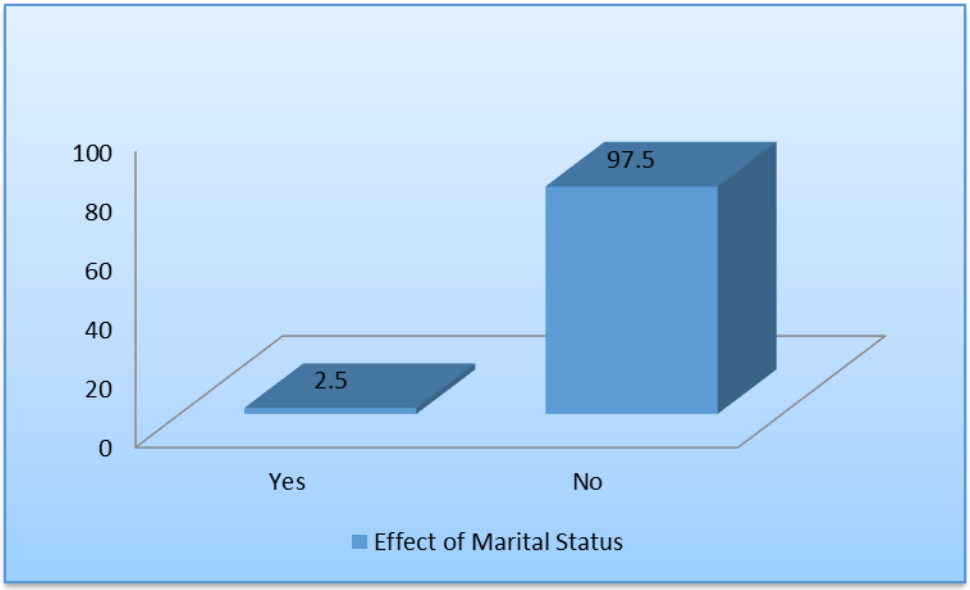
Response	Frequency	Percentage
Yes	2	1.9
No	106	98.1
Total	108	100.0

The satisfaction of health services and facilities got from Garissa Provincial General Hospital proved the respondent's satisfaction of health needs in the regions. In addition, 98.1% of the participants indicated that there is no belief that would in one way or the other prevent them from delivering in Garissa Provincial General Hospital as opposed to 1.9% of the respondents who had minor societal or religious beliefs that would prevent them delivering at the GPGH. However, 10% of the total respondents were uncertain as to whether there would be any belief that may prevent them from delivering at Garissa Provincial General Hospital.

4.4.4 Effect of Marital Status on the Utilization of Free Maternal Health Care Services

When asked whether their marital status would affect their utilization of free maternal health services, the response was as represented on Figure 4.6.

Figure 4.6 Effect of Marital Status (N=79)



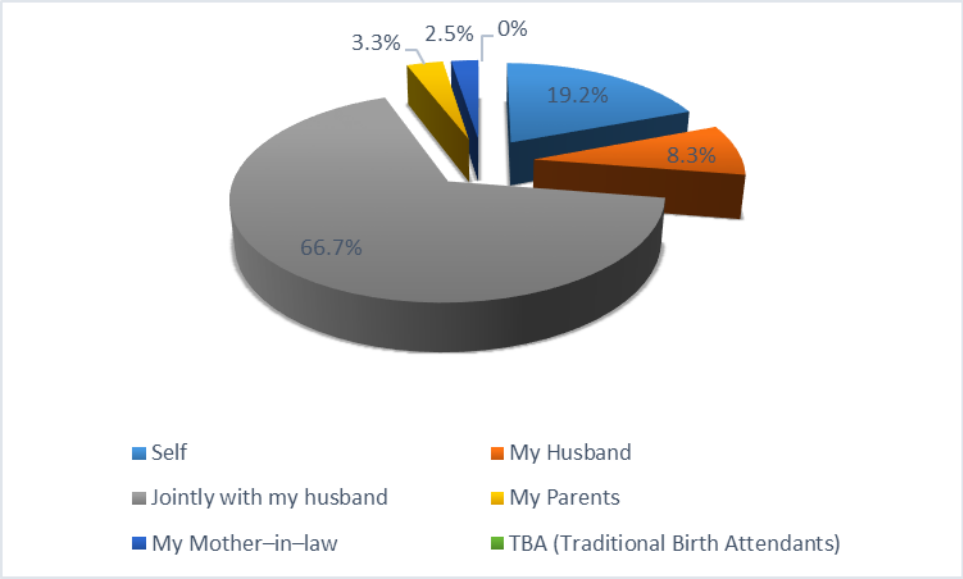
From the results, 97.5% respondents agreed that their marital status has no great affect to their utilization of free maternal health care services. However, sometimes it is believed that social support from a partner or spouse, family's social network, and friends have the potential to influence the decision of the women regarding their choice of the kind of prenatal care that they want to enjoy, which was agreed by 2.5% respondents.

4.5. Social Support and Influence by TBAs and Utilization of Free Maternal Health Care Services

4.5.1 Decision Making During Pregnancy

Respondents were also asked on decision making on place of delivery and the response is represented in Figure 4.7.

Figure 4.7 Decision Making During Pregnancy (N=120)



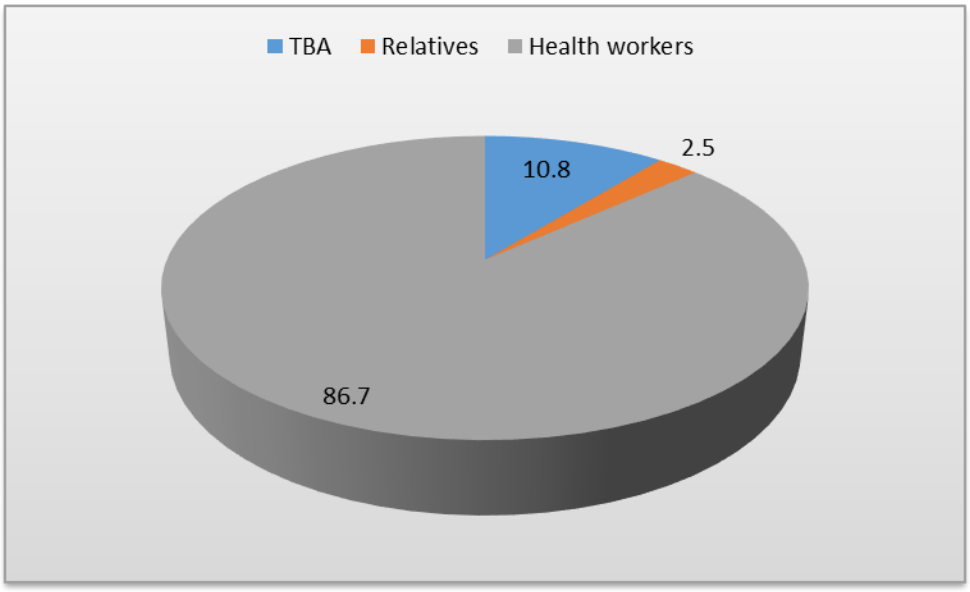
The study has shown that many women make joint decisions while determining which hospital they should visit when their time to deliver has reached. From the study, 66.7% of the women indicated that they do a joint decision making with their husbands while 19.2% make their own personal decisions regarding which health facility they should attend when their time to deliver reaches. Besides, 8.3% of the respondents agreed that their husbands play a big role in determining the hospital to attend during pregnancy. On the other hand, mothers-in-law and parents had 2.5% and 3.3% respectfully, indicating their role in decision-making during deliveries. In addition, none of the respondents did seek consent from the traditional birth attendants during delivery.

In some societies; women have relied so greatly on other women for prenatal care services as well as social support during pregnancy, childbirth, and breastfeeding. The women in the region were accompanied by their relatives and friends to maternity units. As the women being accompanied during pregnancy times, they got both emotional and informational support that was so crucial for them at that stage.

4.5.2 Delivery Assistants

Respondents were asked who they would like to assist them deliver and their response is represented in Figure 4.8.

Figure 4.8 Delivery Assistants (N=120)



From the response, 86.7% of the respondents had specific experts in mind, and in this case, they prefer health workers to others. About 10.8% still believed that traditional birth assistants (TBA) can come to their aid when their delivery period reaches. This was contrary to the 2.5% percent group who feel that they would rather be helped by relatives to deliver than any other parties. Having realized that the proportion of women seeking free maternity care have increased at a higher rate, having health workers to handle delivery operations is more beneficial than any other option.

The experience and expertise of health workers in this field is of great importance, and this is why majority of women would go for the professionals/experts who are knowledgeable in child delivery. Health and safety of the babies at birth is the main reason why they do prefer health practitioners.

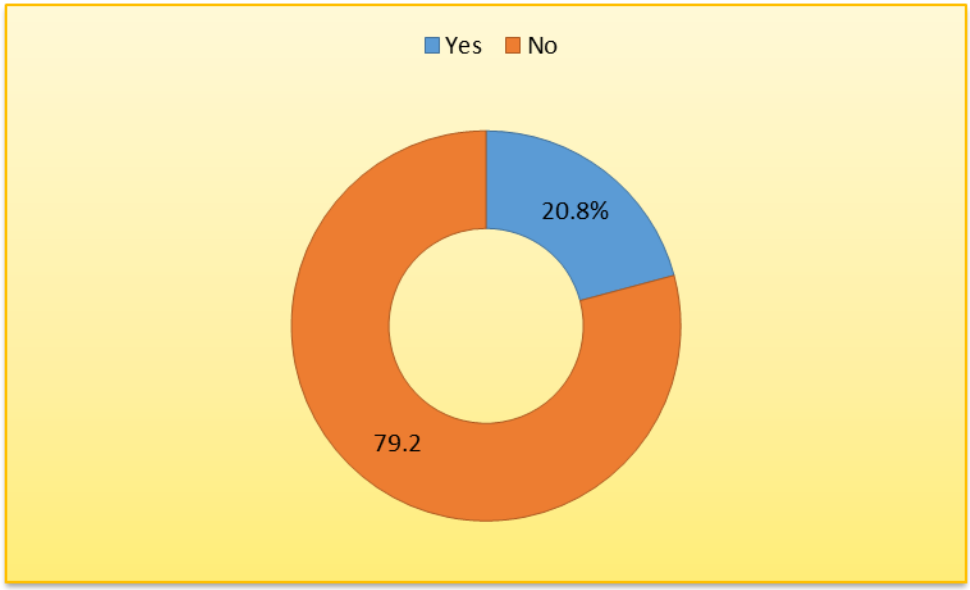
Secondly, they are experienced in handling birth complications should any arise. This comes as a result of the report released by the Kenya Demographic and Health Survey in 2009, which indicates that between 1000 and 1200 women die during delivery per 100,000 births in North Eastern Kenya compared to the national rate of 488 deaths per 100,000 births. It is, therefore, preempted that the decision to seek an expert will boost the proportion of women who deliver at

Garissa Provincial General Hospital, and consequently, the entire Garissa county as well as other counties within North Eastern region.

4.5.3 Traditional Birth Assistants

The respondents were also asked whether they had received services from TBAs and the response is as expressed on Figure 4.9.

Figure 4.9 Whether respondents benefit from Traditional Birth Assistants (N=120)



From the figure we can note that 79% of the respondents have not benefited from the services provided by the traditional birth assistants while 21% of the participants have sort help from TBAs. Obviously, there were reasons that lead to this decision, and it varied from one person to another. However, those who had been assisted by TBAs had mixed reactions. For example, while others would recommend it to others, some women made it clear that they should only be sought as the last option. Otherwise, due to serious complications that might arise during delivery, they strongly recommended that pregnant women should consider going to hospital than TBAs. However, those who recommended others to TBAs quoted different reasons relating to traditions.

While responding to how much they know individuals who use TBA services, 77.7% of the respondents indicated that they have no idea while 22.3% responded that they know people who use TBA services.

Table 4.12 Whether the respondents have knowledge on who use TBA services

Response	Frequency	Percentage
Yes	25	22.3
No	87	77.7
Total	**112**	**100.0**

While seeking their opinions on TBA, the participants majorly referred to the traditions of most of the African countries that widely encourage TBAs to carry out deliveries as long as they have undergone training.

TBAs are less effective when it comes to reducing the maternal death, and therefore, cannot replace the midwives. They are not good with emergencies and therefore high risk of bleeding and death.

Most TBAs are not trained as they acquired their skills from their parents or through apprenticeship. They are not well equipped to deal with most emergency cases. If they received some form of medical training, then they would be very effective.

This confirmed the argument raised by Mubyazi et al. (2010) who claimed that such practices are very much common and/or popular in rural setups. Finally, they also made it clear that many women in the North Eastern region have placed their trust on TBA as compared to deliveries with the help of health workers, and this explains why some of them still seek the effort of TBAs.

4.6 Gender and Attitude of Health Workers and Utilization of Free Maternal Health Care Services

4.6.1 Gender Preference during Delivery

Respondents were also asked their gender preference during delivery and the response is as shown on Table 4.13.

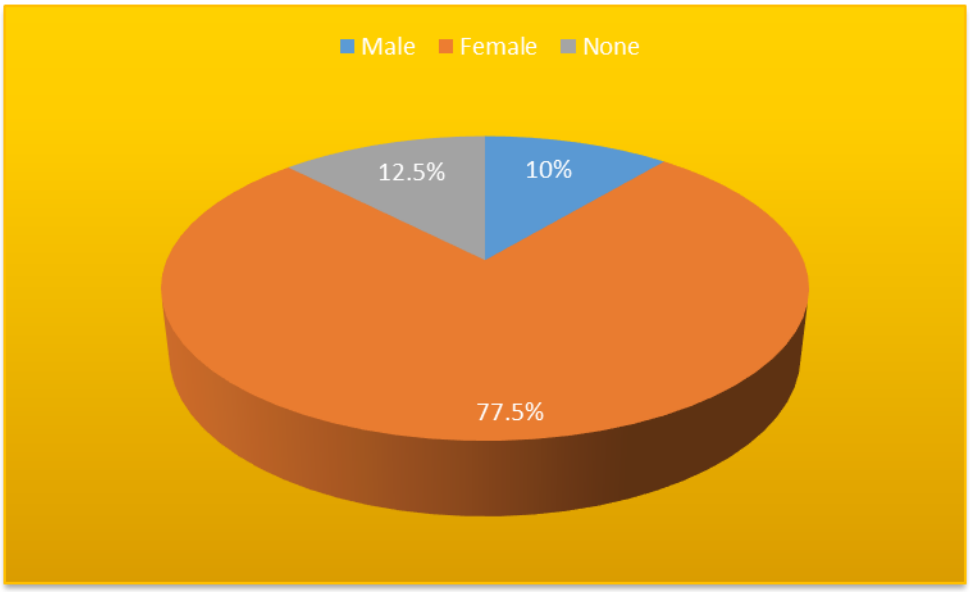
Table 4.13 Response to Whether a particular gender of service provider in preference during Delivery

Response	Frequency	Percentage (%)
Yes	49	40.8
No	71	59.2
Total	**120**	**100%**

From the table 4.13, it can be deduced that 59.2% of the total respondents had no preference to any gender while 40.8% stipulated that they would prefer to be served by a particular gender during delivery.

On the contrary, of the two options above, 10% of the respondents claimed that they do not care which staff come to their aid during delivery process. Contrary, for individuals with gender preference, 77.5% and 12.5% have expressed their willingness to be served by female and male respectively as shown in figure 4.10.

Figure 4.10 Gender Preferences during Delivery (Male, Female or None) (N=81)



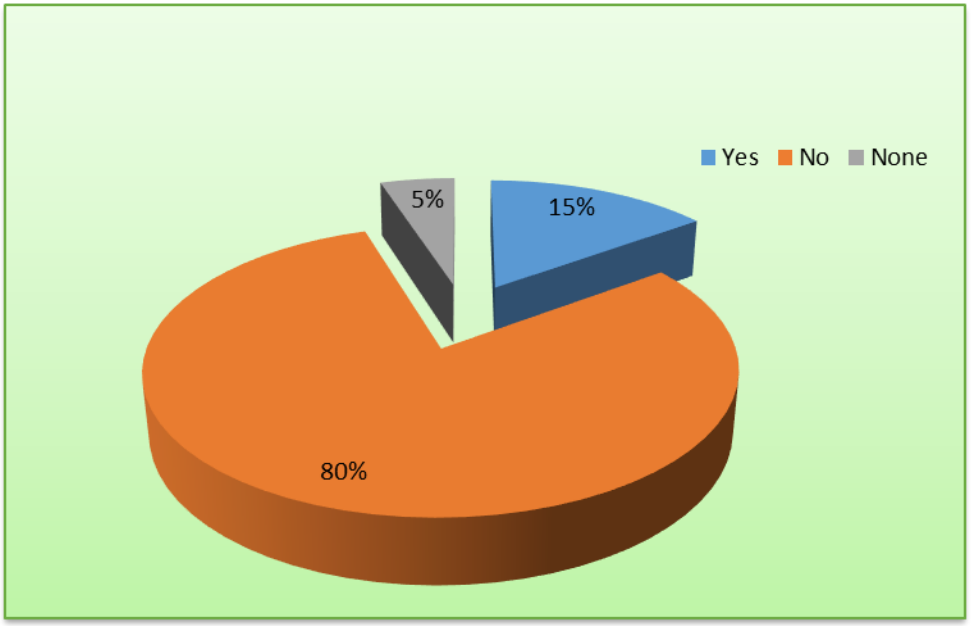
The respondents articulated that women are kind in their service and they will do exceedingly better than men will. Besides, they also mentioned that female health workers are full of respectful care, and therefore, can contribute much to their satisfaction. Nevertheless, the

respondents claimed that strong religious influence in the region dictates that they better to be attended by a female health practitioner on matters to do with maternal services. This confirms the study by Bousery et al. (2009) who claimed that lack of female staff in health facilities is a contributing factor in dissatisfaction raised by the community in rural areas especially on maternity service.

4.6.2 Impact of Lack of Preferred Gender

The respondents also had different views on whether they would stop to deliver at the hospital in case their preferred gender is not in the facility as shown in Figure 4.11.

Figure 4.11 Impact of Lack of Preferred Gender (N=120)



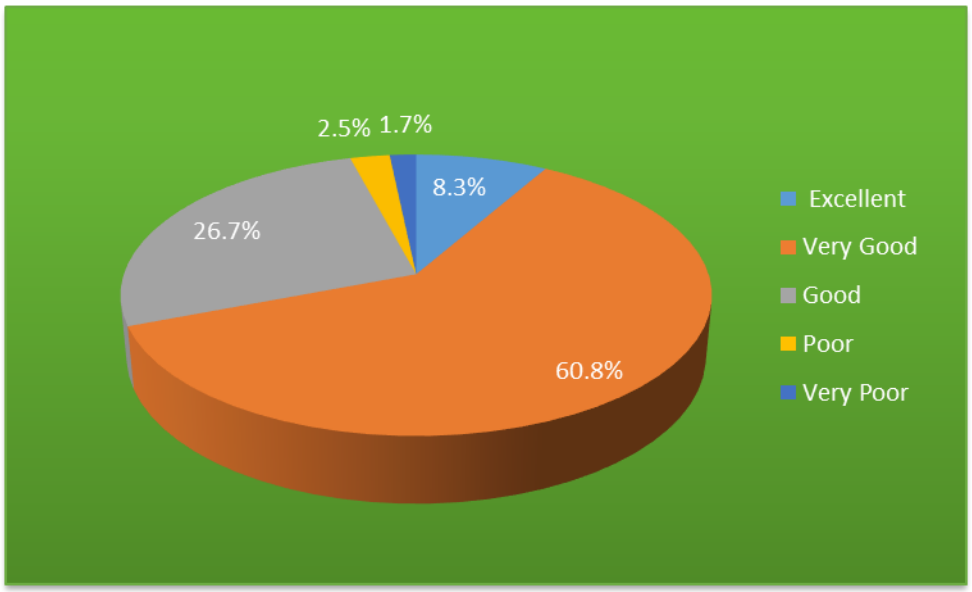
Most of the respondents (80%) claim that lack of their preferred gender cannot bar them from seeking maternal services at the hospital while 15% of the total participants do agree that it can be a reason for them not seeking maternal services at Garissa PGH. On the contrary, 5% of the respondents seemed not to care much about the gender as long as quality maternal services are assured.

This implies that there is need to train more female health workers so as to meet the high demand for female health care providers.

4.6.3 Staff Attitude

The respondents rated the general staff attitude as represented in the Figure 4.12.

Figure 4.12 Staff Attitude (N=120)



From the figure above, a conclusion can be made that generally, the attitudes of the staff during delivery process at Garissa PGH maternity was very good as it was represented by 60.8% while 26.7% of the respondents collectively agree that staff attitude during delivery is good. In addition, 8% also claim that staff attitude is excellent. However, almost a negligible number represented by 2.5% and 1.7% rated the staff attitude as poor and very poor respectively. Even though the sum of respondents (4.2%) attached staff attitude with the case (as poor 2.5% and very poor 1.7%), the health workers at the hospital are clearly demonstrating their professionalism while at work, and this is massive gain by the hospital because its reputation in the region has gone high.

Table 4.14 represents response on whether staff attitude could affect future utilization free maternity services.

Table 4.14: Whether Staff Attitude could affect the future utilization of the maternity service

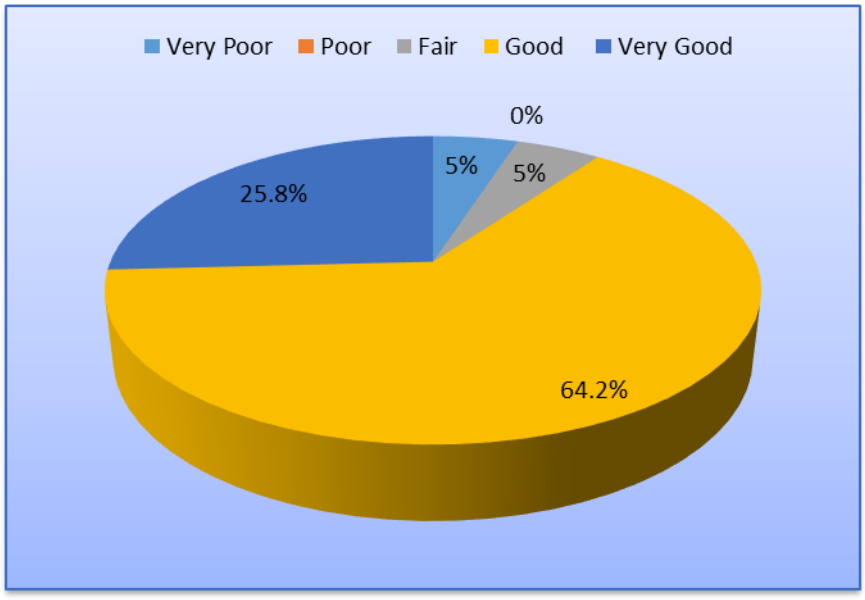
Response	Frequency	Percentage
Yes	12	10.4
No	103	89.6
Total	**115**	**100.0**

In this regard, only 89.6% of the respondents agreed that attitude during delivery especially at Garissa PGH maternity could affect their future utilization of the maternity service at the same hospital, while 10.4% did believe the attitude of the staffs during delivery process has nothing to do with their future utilization of the facility.

4.6.4 General Service Delivery in PGH Maternity

Generally, the service delivery at the hospital is good. As shown in the figure 4.13, 64.2% do agree the services being provided is good while 25.8% claim that the general service delivery in the PGH maternity is very good. On average, the service level at the facility is superb. Notwithstanding, 5% of the total respondents claim that the overall service delivery is fair and 5% claim it is very poor respectively, and probably, this could be as a result of the bad experience they had with the hospital.

Figure 4.13 General Service Delivery in PGH Maternity



4.6.5 General Comment to Improve Maternity Service in Garissa PGH

To improve maternity service at Garissa PGH, the hospital needs to increase the number of staff so as to cope with the increase of the number of women seeking free maternal health care services.

There is need for the hospital to expand the maternity ward and increase the number of beds since there are cases in which the women are forced to share beds due to the shortage of extra beds.

Improve the communication between the clients and the staff. Most of the women seeking utilization of the free service in the area mainly speak Somali. Nurses that are well versed with the local language should be prioritized.

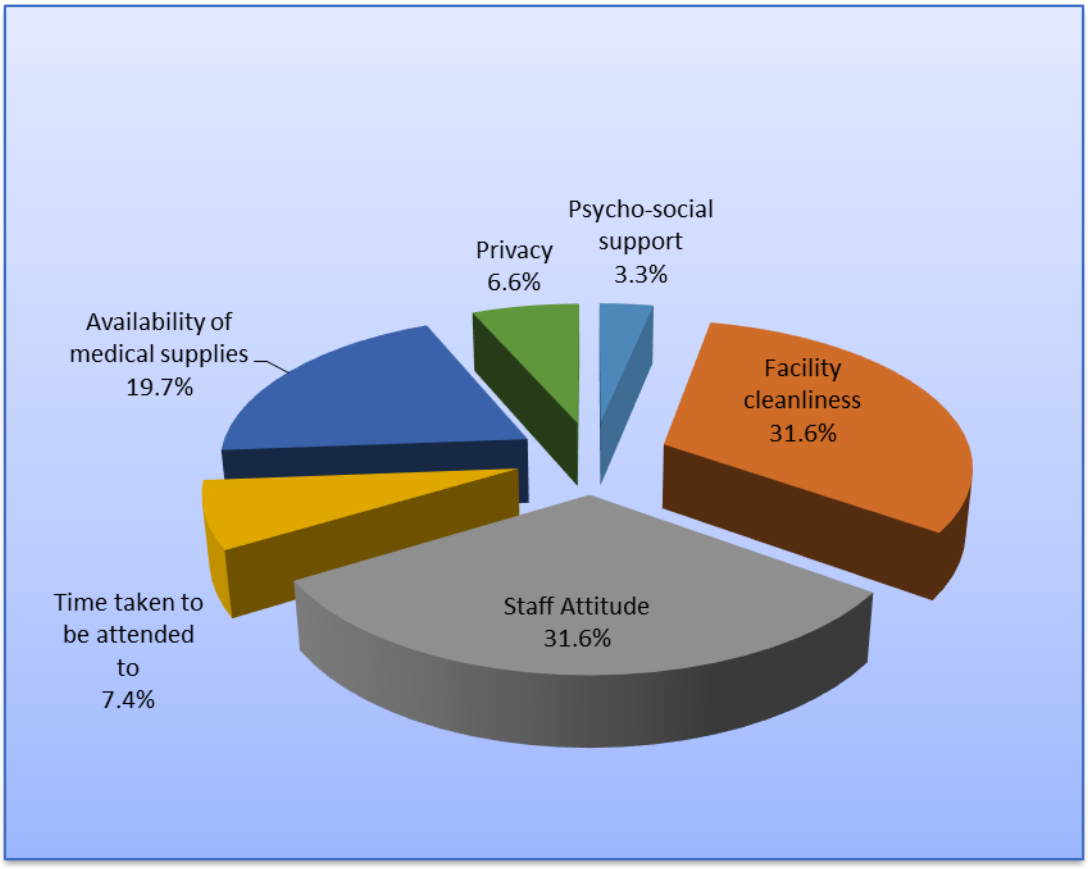
4.7 Quality of Services and Utilization of Free Maternal Health Care Services

4.7.1 Aspects of the Garissa PGH Maternity Service

Figure 4.14 gives a representation of a number of aspects that the respondents liked most at the hospital. From the figure, 31% of the women who participated in the study indicated that they pleased with the staff attitude and the same percentage were pleased with facility cleanliness. Besides, 19.7% were delighted with the availability of medical supplies, whereas 7.4% were persuaded by the prompt service they receive at the hospital. Further, 6.6% also indicated that high level of privacy was a critical aspect that they liked most in the hospital. However, 3.3% were pleased with the psycho-social support that they receive at the hospital.

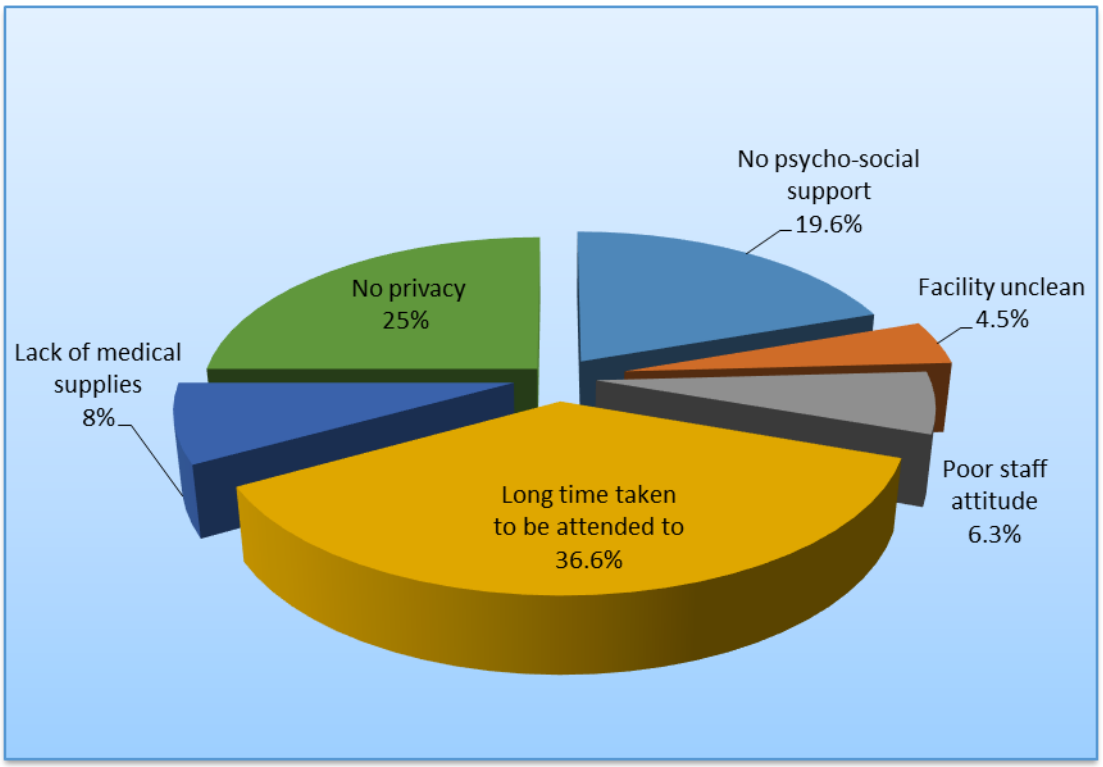
On the contrary, 37% of the respondents noted that they were displeased with the long time that is taken before they are attended to 25% of the women disliked lack of privacy while 20% expressed their dissatisfaction following lack of psycho-social support that they receive.

Figure 4.14 Aspects of the Garissa PGH Maternity Service Respondents liked (N=224)



However, 8%, 6%, and 4% of the participants noted that lack of medication supplies, poor staff attitude, and unclean facility as some of the key aspects that they disliked most at the hospital maternity. The percentages do not add up to hundred percent due to rounding off. See figure 4.15 for further illustration.

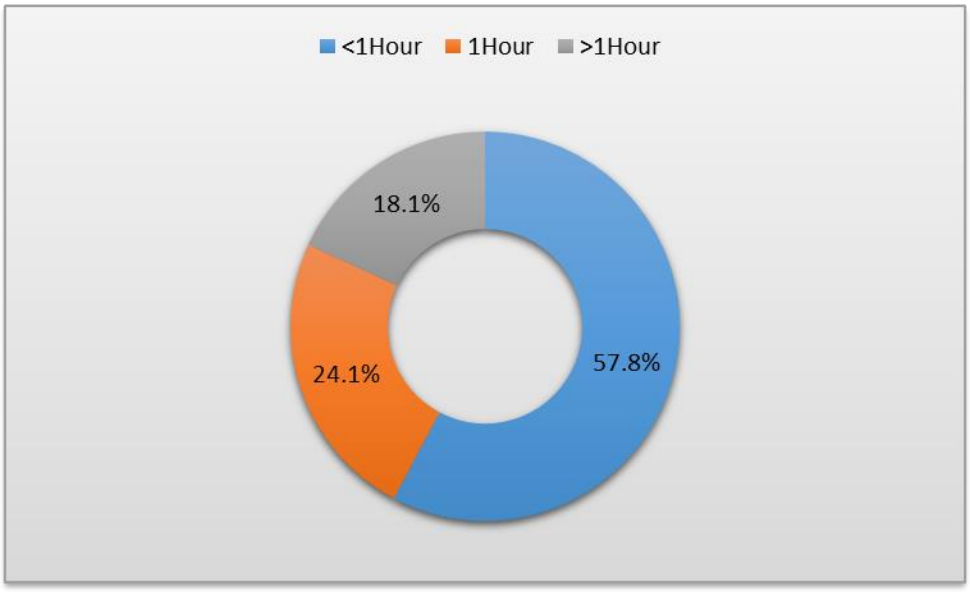
Figure 4.15 The Aspects of PGH Maternity Service Respondents Dislike (N=112)



4.7.2 Time taken to be seen/responded to

From the figure 4.16, it can be noted that 57.8% of the participants claimed that they had wait barely for less than an hour for them to be attended to by the medical/health practitioner. On the other hand, 24.1% indicated they had to wait for approximately one hour to be served. Nevertheless, only 18.1% of the respondents mentioned that the average wait time was more than an hour. Based on these figures, it is can be deduced that the doctors and nurses at the hospital are very sensitive on time because the latter is very critical for pregnant women who are about to deliver. Taking too long for them to be attended to can cause unnecessary suffering by the patients, and therefore, taint the reputation of the organization.

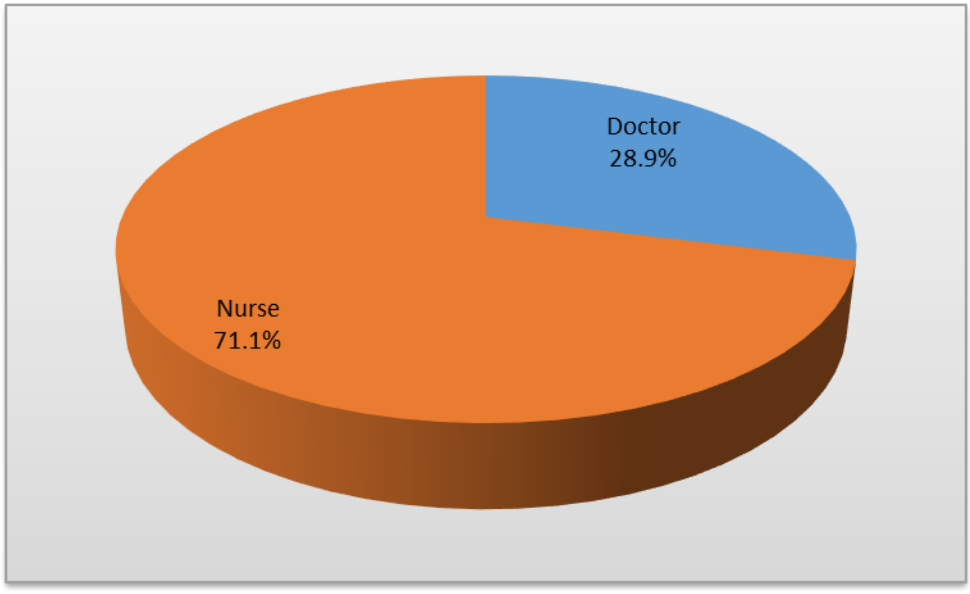
Figure 4.16 Time taken to be seen/responded to (N=116)



4.7.3 Delivery Attendant

From the figure 4.17, it is clear that nurses are of great help to pregnant women who are about to deliver. For example, 71.1% of the respondents indicated that the nurses attended to them while 28.9% mentioned that the doctors served them.

Figure 4.17 Delivery Attendant (N=114)



It is, therefore, necessary to underscore the input or major role that nurses play in the hospital as far as maternity services are concerned in health centers.

4.7.4 Client Satisfaction

Based on Table 4.15, the following can be deduced. First, majority of the participants (95%) were satisfied with the medical examination and checkup that were done unto them as opposed to the 5% participants who were unsatisfied. Secondly, 96% of the respondents mentioned that they were satisfied with the services provided at the facility although a negligible number of represented by 4% of the total respondents were dissatisfied with the available services. Third, 92% of women were convinced that the location of the facility makes it very easy for them to access it with an ease. In addition, the condition and adequate privacy that the facility has add up to their satisfaction. Only 8% of the respondents disagree with this statement. Finally, 94% of respondents noted their satisfaction with the regular water supply at the hospital, functional toilets, regular electricity, and availability of all necessary equipment for maternal services unlike 6% of the respondents who disagreed. These factors are quite important, and their unavailability can paralyze the delivery services.

Table 4.15 Staff Attitude in relation to the future utilization of the maternity service

Staff Attitude in relation to the future utilization of the maternity service	**Yes(F)**	**Percentage (Yes)**	**No(F)**	**Percentage (No)**	**Total (F)**	**Total %**
Satisfied with the medical examination	112	100	0	0	**112**	**100**
Satisfied with the services at the health facility	107	95.5	5	4.5	**112**	**100**
The condition of health facility and adequacy of privacy	104	92	9	8	**113**	**100**
Availability of social amenities	105	93.8	7	6.2	**112**	**100.0**

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

In this section the sub topics were discussed as: Summary of findings, conclusions of the study and recommendations for future research for policy and contribution to the body of knowledge.

5.2 Summary

The study had four major themes: determine the relationship between socio-demographic characteristics of women and the utilization of free maternal healthcare services, identify types of social support that influence utilization of free maternal healthcare services, investigate how the gender and attitude of health workers affects utilization of free maternal healthcare services, determine how quality of services provided influences utilization of free maternal healthcare services.

The findings show that mothers who utilized the free maternal care, there was a higher proportion of mothers who earned higher income of more than 15000 shillings a month compared to those who utilized free maternal care with an income of lower than 6000 shillings, i.e. 32.5% compared to 5.83%. The findings also indicate that more housewives were adopting the utilization of free maternity care. Mothers who were self-employed had adopted the utilization of free maternal care to a higher extent compared to those employed by the local and central government i.e. 25% compared to 6.67% and 3.33% of local and central government employees respectively.

Age bracket plays a big role in determining the utilization of free maternal healthcare services as the study targeted women of the age, whereby the majority of the respondents were of the age bracket of 20 and 24 years who move from different regions in search of free maternal healthcare in Garissa Provincial General Hospital. Individuals from the lower or above age group have limited knowledge on the benefits of seeking free maternal healthcare services at the public hospitals. However, this relates to large population of the women with no formal education that equips them with the required knowledge on health-related matters.

In addition, the gender preference would determine whether one would access free maternal in the public hospitals. As mentioned in the study, it is evident that the majority of the respondents had no preference of any gender to serve them while others stipulated that they would prefer to be served by a particular gender during delivery where some clings to religious doctrines. Some women choose to be attended by a female health practitioner in specific on matters to do with maternal services in hospitals where free delivery are rendered to expectant women. Others do claim that lack of female staff in health facilities is a contributing factor in dissatisfaction raised by the community in rural areas especially on maternity service hence triggers effective free utilization of the free maternal healthcare in the Garissa PGH. Consequently, the attitudes of the staffs during delivery process at Garissa PGH maternity plays a vital role as to whether an effective free maternal healthcare would be rendered to women living the selected area of study.

5.3 Conclusions

This chapter has provided the possible recommendations that could be used by the Ministry of Health, the hospitals' management committees and the service providers to improve the free maternal health care in Garissa County. It is important however for the health professionals to understand the barriers that hinder women from utilizing the free maternal health care as this provides evidence to address women's problems using the community strategy model rather than the medical model that only looks at the current disease map as the only problem of the client.

5.4 Recommendations

1. In order to improve access to the free maternal health care, government should locate health services as close as possible to the community where the people live. This could be done by training more midwives as well as Community Health Workers who serve as the critical link between communities and health facilities in Kenya, and assign them to manageable households at community level by doing so more women will be reached with information on the importance of the maternal health boosting the levels of uptake.
2. Training more staff and equipping them with appropriate tools and responsibilities to teach the women about the importance of free maternal health care services can also improve accessibility.

3. The marginal regions do require social support in order to influence an effective utilization of free maternal healthcare services especially to expectant women who seek delivery services when they are due, and when death rates of maternal mortality would rise. As highlighted above, the county government, therefore, should focus on increasing more of health facilities per capita as well as health workers and construction of new facilities in the marginal areas for women to access free maternal healthcare services at their localities.

4. Health workers need to be provided with incentives as motivational factor to ensure that health workers provide free maternal services with willingness to serve individuals living in different regions at their nearest hospitals. The existing infrastructure should also be improved to provide improved delivery services, effective referral systems from the TBAs from the local health facilities to Garissa County Referral Hospital among other institutions to be set across the county.

5.5 Areas Suggested for further Studies

A similar study should be done in other counties especially those that are pastoralists.

A study to establish the level of utilization in rural community settings should be carried out.

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APPENDICES

Appendix I: Questionnaire
QUESTIONNAIRE FOR THE MOTHERS

Socio-demographic Profile of Respondents

1. How old are you?

15-19yrs [ ] 20-24 [ ] 25- 29 [ ] 30-34 [ ] > 35 [ ]

2. What is your level of education?

No formal education [ ] Primary education [ ]

Secondary education [ ] College education [ ]

3. How many children do you have?

One Child [ ] Two children [ ] Three Children [ ]

Four Children [ ] Five Children [ ] Six or above [ ]

4. Where are you currently residing? (*Specify*)

Constituency_____ Ward_____

5. How long have you lived in this area?

One year or less [ ] 2 - 5 Years [ ] 6 – 9 years [ ] 10 or more years [ ]

6. What is your religious affiliation?

Muslim [ ] Christian [ ] Other [ ] *(Specify)* _____

7. What is your marital status?

Single [ ] Married [ ] Divorced/Separated [ ] Widow [ ]

Other *(Specify)* _____

8. What is your present occupation?

None [ ] Housewife [ ] Self-employed [ ]

Central government employee [ ] Local government employee [ ]

Others (specify) _____

9. What is the level of income per month in your family?

Less than 6,000 [ ] 6,000-10,999 [ ] 11,000-15,000 [ ] Above 15,000 [ ]

Characteristics of women and utilization of free maternal health care services

10. Have you delivered at Garissa Provincial General Hospital (GPGH) before?

Yes [ ] No [ ]

11. If yes, when was it?

Less than a year ago [ ] 1 – 2 years ago [ ] 2-3 years ago [ ]

3-4 years ago [ ] More than 5 years ago [ ]

12. How were the services?

Excellent [ ] Very good [ ] Good [ ] Poor [ ] Very poor [ ]

13. If answer is poor or very poor, why_____

14. Will you advice someone to deliver at PGH Garissa?

Yes [ ] No [ ]

15. Why

_____

16. Where would you prefer to deliver this pregnancy or if you could be pregnant?

Home [ ] Garissa PGH [ ] Other GOK hospitals [ ]

Private hospitals [ ] Others (specify) _____

17. Is there any belief (s) that refrain you to deliver in a hospital?

Yes [ ] No [ ]

18. If yes which ones?

Religion [ ] Cultural [ ] Others (specify) _____

19. Will your marital status affect your utilization of free maternal health care services?

Yes [ ] No [ ]

If yes, how? _____

Social support and influence by TBAs and utilization of free maternal health care services

20. Who decides where you will deliver when pregnant

Self [ ] My Husband [ ] Jointly with my husband [ ]

My Parents [ ] My Mother–in–law [ ] TBA [ ]

Others (specify) _____

21. Whom do you prefer to deliver you?

TBA [ ] Relatives [ ] Health workers [ ]

Others (specify) _____

22. Why do you prefer that person(s)? _____

23. Have you received services from TBAs?

Yes [ ] No [ ]

24. If yes, would you recommend it to others and why? _____

25. Do you know someone who uses TBA services?

Yes [ ] No [ ]

26. What is your opinion on deliveries through TBAs?

_____

Gender and attitude of health workers and utilization of free maternal health care services

27. Do you have any preferences on staff gender to deliver you at the hospital?

Yes [ ] No [ ]

28. If yes, would you prefer a male or female staff?

Male [ ] Female [ ]

29. Why do you prefer that gender?

30. Can the lack of your preferred gender stop you to deliver in the hospital?

Yes [ ] No [ ]

31. How do you rate general staff attitude during delivery at Garissa PGH maternity?

Excellent [ ] Very Good [ ] Good [ ] Poor [ ] Very Poor [ ]

32. Will this affect your future utilization of the maternity service in the hospital?

Yes [ ] No [ ]

33. If Yes, why? _____

34. In a scale of 1-5 where 1=Very Poor, 2=Poor, 3=Fair, 4=Good, 5=Very Good, how do you rate the general service delivery in PGH maternity?

1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ]

35. Any general comments on how to improve maternity service in Garissa PGH?

_____

Quality of Services and utilization of free maternal health care services

36. What aspect of the PGH maternity service did you like? ***Allow multiple answers***

Psycho-social support	[ ]	Facility cleanliness	[ ]
Staff Attitude	[ ]	Time taken to be attended to	[ ]
Availability of medical supplies	[ ]	Privacy	[ ]

0thers (specify) _____

37. What aspects of PGH maternity service do you dislike? ***Allow multiple answers***

No psycho-social support	[ ]	Facility unclean	[ ]
Poor staff attitude	[ ]	Long time taken to be attended to	[ ]
Lack of medical supplies	[ ]	No privacy	[ ]

0thers (specify) _____

38. How long did you have to wait for the doctor/nurse to see you?

Took less than 1hr	[ ]	Took 1hr	[ ]	Took more than 1hr	[ ]

39. Who attended to you at the health facility?

Doctor	[ ]	Nurse	[ ]	CHW	[ ]

Others_____

40. a)Are you satisfied with the examination and check-up done by the health provider?

Yes	[ ]	No	[ ]

b) If No, why?

_____

41. a) Are you satisfied with the services available at the health facility?

Yes [ ] No [ ]

b) If No, why?

_____

42. The health facility is located in its own premises and building, is in good repair/condition and has adequate privacy. Do you agree with this statement?

Yes [ ] No [ ]

43. a) Health facility has regular water supply, functional toilet, regular electricity power and all necessary equipment for maternal services. Do you agree with this statement?

Yes [ ] No [ ]

b) If No, explain.

_____

Appendix II: Key Informant Interview Guide

1. How would you describe the economic status of the women seeking the free maternal care services? (Probe on whether educated, high earning women prefer the service)
2. What are the maternal services being provided in the health facility under the free maternal health care?
3. Has the number of women seeking maternal care increased? (Probe on the approximate percentage in increase)
4. What challenges are faced in the free maternal care and how can it be improved?
5. What are your experiences/opinions in relation to maternity services provided by PGH Garissa maternity during delivery?
6. What aspect in terms of services provided by PGH Garissa maternity **did you like** during delivery?
7. What aspect in terms of services provided by PGH Garissa maternity **did you dislike** during delivery?
8. Does lack of the preferred gender stop women to deliver in a hospital?
9. In your experience, what are the altitudes of health workers in handling women during delivery at PGH?
10. Will women's' previous negative experience affect their future utilization of the maternity service at PGH? Why?
11. According to you, will you advice someone else to deliver at Garissa Provincial General Hospital (PGH) and why?
12. What are your suggestions in improving maternity services at Garissa PGH?

Appendix III: Informed Consent Form

a) English Version

I am a student of Master of Arts in Rural Sociology and Community Development from university of Nairobi, college of health science, and school of public health. I'm conducting a research on **Factors determining utilization of free maternal care in Kenya; A Case of Garissa County Referral Hospital.**

To conduct this research, I require information from women who are attending this clinic in this hospital and also women who recently delivered at Garissa County Referral Hospital. As one of these women, I would like to carry out an interview with you. I will record your answers in a questionnaire which will allow me to analyze the answers later on.

I assure you that the information you provide will remain confidential and will not be used for any other purpose other than to address the objective of my study which is to assess the factors determining utilization of maternal services at Garissa County Referral Hospital. Though it may not have a direct benefit to you, the findings of this research may enable the Ministry of Health and other health stakeholders to provide better health care services for the population of NEP and others in the country and therefore improve service delivery.

1 would appreciate if you could spare approximately 10 minutes of your time for an interview.

No samples or other tests will be done and there is no any risk anticipated in participating. If you agree to participate in the interview, you have the right to withdraw from it at any time. There will be no negative consequences and you will not be denied any services if you choose not to participate in study.

If you are willing to participate in this interview, confirm that you have received this information and that you understood by signing below. If you want further clarification/information please contact the principal research: Fatima Dahir Mohamed, Tel 0710693816, email dahirhayat@gmail.com. If you agree that we proceed with the interview please sign here

_____

b) Somali Version

Foomka ogolaanshada wareeysiga cilmi barista

Waxaan ahay arday waax kabarda jaamacada Nairobi kunaa taqsuusayo hormarka bulshaada. Waaxan sameeynaya cilmi baaris kusaabsan ***ariimahaa sababo isticmaalka serviceka bilaashka eh ee cisbitaalka Garissa County Referral*.**

Si aan u sameeyo cilmi baarsitani haddaba waxaan ubaahnayahay in macluumaad aan ka helno haweeynka istiicmaalo clinika iyo kuwaa waqti dhow kuudhaley cisbitaalka guud ee Garissa. waxaana jeclaan lahaa in aan wareeysi idin layeelano. Suaalo qoraal ah ayaa la idin ka qori doona, kaadibna jawaabahaasi oo aan lafo guri doono. Waxaana idiin balan qaadeeynaa in aan ilaalin doono kasloonida macluumaadka aad na siisaan oo aanan u siticmaali doonin wax kale oo aan aheeyn ujoodhaadhi kusaabsan cilmi baaristayta. Maxsuulka ama natiijada cilmi baaristani waxa lagaa yabaa inn eey u suurtagalin doontaa wasaarada caafimaadka iyo haayadaha kale ee kushaqo leh caafimadka sidii ay adeeg daryeel caafimad oo wanagsan ay u siin lahayeen dadka gobalka waqooyi bari iyo inta kunool wadanka Kenya.

Waan kuugu mahadcelin lahaa haddii aad 10 daqiiqo oo waqtigaada kamid ah aad iigu hurto si aan wareeysigasi kuula yeelano. Ma jiri doonta wax saambalo ama tijaaba ka qaadis ah. Haadii aad aqbasho in aad ka qeeybgasho wareeysiga, waqtigaad rabta ayaad isaga bixi kartaa . Ma lahan wax xumaan mise ciqaab ah oo ka soo gaari doonta ama adeeg laguu diidi hadii aaad wareeysiga ka qeeybqaadan weeyso.

Fadlan hadii aad dooneeysa in aad ka qeeybqaadato wareeysigan ee xaqiiji in aaad heshay macluumaadkaan ood fahantsantahay diyaarna u tahay in aad wareeysiga ka qeybqaadato. Hadad dooneyso faafahin deeri ah ama suala kale, laxariir cilmi baraha sarre: **Fatima Dahir Mohamed, telefoonka: 0710693816 iyo emailka** dahirhayat@gmail.com**.** Hadad aqbashay iin aad ka qeeyb qaadato wareeysigaan, fadlan saxiix halkaan _____