URBAN POOR KENYAN WOMEN AND HOSPITAL-BASED DELIVERY

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The increasing availability of formal obstetric care in Kenya notwithstanding, the majority of births in urban areas of the country still occur at home assisted by unskilled traditional birth attendants (TBAs).[1–3] To add to current knowledge on this topic, we probed the views of poor women—who form the bulk of mothers who deliver at home in urban Kenya—on the attractions of and deterrents to hospital-based deliveries. In investigating lay views surrounding the hospital as a delivery site, our aim was to illuminate the lives and plights of urban poor Kenyan women who, even in the 21st century, continue to experience difficulties in accessing quality obstetric care.

METHODS

We collected cross-sectional data from 12 focus group discussions involving 74 purposefully selected women from two slums in Nairobi: Viwandani and Korogocho. Respondents ranged in age from 16 to 54 and had sundry reproductive experiences. We implemented the study in 2006 to extend the scientific understanding of the impediments and barriers to using emergency obstetric care in the two slums. We collected data using an open-ended interview guide that sought information on a range of issues, including attitudes, perceptions, and experiences related to hospital and home deliveries.

The Ethical Committee of the Kenyan Medical Research Institute approved the research procedures, and we obtained informed consent from participants before we conducted the interviews. We adopted an ethnographic, inductive approach involving thematic examination of the narratives to analyze the data.[4] In many instances, we used verbatim quotes to illustrate responses on relevant issues and themes. However, as with most qualitative research, the generation of in-depth and new scientific insights and information can be claimed, but statistical significance cannot be proved.[5]

Respondents

The respondents were at least 16 years of age, and the mean age was about 30. The majority of them had a primary-level education. Married and single mothers constituted the majority of the sample, and at the time of the study, only four of the women did not have a child. Judging by their narratives, the bulk of births by the women had occurred at home, assisted by a TBA. Respondents mainly self-identified as Luo, Kikuyu, and Kamba by ethnicity. Other ethnicities included Somali, Luyha, Gare, Olakaye, Borana, and Kuria. They also largely self-identified as Christians. The majority were full-time housewives without personal income sources. We distributed the respondents nearly uniformly between the two study sites.

RESULTS

Views on motivations to seek hospital-based delivery

The participants indicated availability of providers and equipment that could make birthing safer as the major appeal of hospital-based deliveries. They generally admitted to the capacity of hospital-based providers to make childbearing safer, frequently noting that hospital-based delivery put women under the care of skilled providers and ensured the ready availability of equipment for managing emergencies and difficult deliveries. Informal providers (e.g., TBAs) reportedly lacked these skills and tools. While delivery could occur safely in any birth site, the respondents only characterized hospitals as capable of effectively managing life-threatening complications and difficult deliveries.

One respondent said: "We know that hospitals handle births better, especially difficult births. . . . If you are able to reach there and find good people . . . they will help." In one instance, a woman admitted that hospital-based providers saved her life. She sought delivery services from a TBA and stayed two nights in the TBA's house writhing in labor pains. The baby finally came out feet first. She was scared and asked to be transferred to a hospital, but the TBA refused, promising that she could handle the situation successfully. However, the woman knew she was in grave danger and crawled out of the TBA's house. She was lucky to find a taxi to take her to a hospital in the city. She passed out upon reaching the hospital and remembered waking up with a baby girl by her side. She is convinced that she would have died had she remained at the TBA's home.

Aside from personal stories of how hospital-based deliveries had saved their own lives, participants also reported knowledge of women who had experienced near-misses or died during homebirth. One respondent's friend had died during a homebirth attended by a TBA. The baby did not turn after many hours of labor. When it eventually did, the exhausted woman was too weak to push, and the TBA did not know what to do next. The woman died before she reached the hospital. Another respondent reported that her neighbor, who was pregnant with twins, died during a home delivery assisted by the victim's mother, who was also a TBA. The first baby was successfully delivered, but the second baby was breech. After a long, unsuccessful struggle by the woman's mother, both the second baby and the woman died. Frequently, participants suggested that hospital-based delivery could have saved these women's lives.

An important issue that dominated the narratives, however, was that it was unreasonable for women to seek hospital birth unless they anticipated a difficult delivery. So, although respondents frequently admitted to the superiority of the hospital as a delivery site, they tended to view it primarily as a delivery site for women anticipating or at risk of obstetric emergencies and difficult deliveries. The women considered the management of uncomplicated deliveries to be the traditional turf of TBAs, who were depicted as naturally and divinely gifted to assist during deliveries. Respondents frequently viewed TBAs' innate expertise and skills as more effectual and dependable than the learned practice of hospital-based providers. One woman's view that God gifted TBAs with their abilities so that they could help women received enormous support among the participants. A few comments indicated that some TBAs were charlatans; however, these comments were often tempered with claims that charlatanism was not restricted to TBA work.

Able and talented TBAs reportedly existed and were viewed as fantastic in their jobs. In some instances, participants even portrayed TBAs as better quality than and superior to hospital-based obstetric providers, as was the case with a middle-aged respondent who noted, "Many of them are better than the hospital providers when it comes to handling deliveries. It is their work and many of them are really good at it." Also noteworthy was that while narratives depicted TBAs as often less safe to use, they also clearly pointed to the popularity of homebirths among the women, with TBAs receiving staunch mention as the first-line providers of obstetric care to women in the study communities. One woman's apt observation was thus: "They (TBAs) may not be as good as the doctors and nurses, but they help us a lot . . . we will keep on using them. Many mothers here would die without them."

Responding women considered it a much greater risk to not seek formal antenatal care than to deliver at home, and also regularly admitted that a woman would deliver anywhere safely if she attended antenatal care religiously. Several self-reports supported the belief that the key to successful delivery was ardent formal antenatal care attendance, rather than the delivery site. Further in line with this belief, while only a few responding women admitted to ever using the hospital for delivery, formal antenatal care attendance was nearly universal among them.

One interlocutor's experience with her first pregnancy changed her opinion about the usefulness of hospital-based deliveries. Because it was her first pregnancy, she was scared that something bad would happen and so resorted to hospital-based delivery. "It was the best place to go as they will be helpful if an emergency struck. But nothing happened." Because nothing happened, she saw no need to seek hospital-based deliveries again, and her other children were subsequently delivered at home. She went on to say: "Seeking hospital-based delivery is fine, but my experience is that hospitals are only good when you anticipate a difficult delivery. If you take normal deliveries there, you end up spending your money for nothing." Another respondent admitted that with adequate antenatal care, "Any woman could deliver safely anywhere." Yet another pointed out:

> Unless a woman has been told during antenatal care to expect a difficult delivery, it would be irrational for her to still seek hospital-based birthing after faithfully attending antenatal care. You will just go there and waste time and money. We take antenatal seriously because most of us will not go back to deliver in the hospital. . . .

Formal antenatal care attendance reportedly diminished the likelihood of complications during delivery. The women said that antenatal check-ups furnished them with knowledge about the development of their pregnancies, making them more confident during delivery. A key motivation for seeking formal antenatal care was, therefore, to prepare for home delivery. Respondents did not recognize informal providers such as TBAs as quality providers of antenatal care. TBAs could manipulate pregnancies, balance fetuses, and even treat common ailments related with pregnancy, but they reportedly lacked the skills to identify conditions that cause obstetric risks and difficult deliveries.

Perspectives on de-motivations for hospital-based delivery

The women we studied reported cost and poor provider attitudes as the primary deterrents to using hospitals for delivery. They considered hospital-based deliveries to be very exorbitant and often out of their reach, and they also perceived hospital-based providers as harsh and uncaring toward them. Participating women noted that their poverty prevented them from affording hospital-based delivery and gave hospital-based providers undue reason to mistreat them. One woman's view was that most slum dwellers could not afford hospital-based care. She said:

> Even those facilities belonging to government or churches and offer[ing] free or discounted services, it is not easy for us to utilize them. They may not even ask for anything from you, but . . . the whole thing is not easy for us. . . . You still have to convey yourself there, pay for tests, and buy drugs . . . sometimes we just can't pay for all these because of poverty . . . so we go to the TBAs.

Martha (aged 34) also noted, "It costs a lot to deliver in the hospital and when poor people like us go there, [we] are treated shoddily." The respondents considered homebirths as a natural response to their socioeconomic sensitivities. In homebirths, women did not have to pay for transportation, registration, laboratory, and other costs, including bribes reportedly offered to formal providers to facilitate services, and payments for supplies such as transfusion blood, syringes, needles, drugs, and sanitary materials, which would be incurred during a hospital stay.

Josephina, a mother of four, offered important insights on how these expenses hindered women from seeking hospital-based delivery. She gave birth to her first baby in a public health facility in Nairobi at a time when she was unemployed and her husband did not have a stable job. Josephina recalled going to the hospital numerous times for consultations and says that she spent a lot of money during the period. There were days she would trek to the hospital due to lack of transport fare. In addition to paying various amounts for minor services, she also regularly bribed hospital staff to ensure that she would receive swift attention in the hospital. Josephina also paid in advance for blood that she would be transfused with, although she never received any at delivery and was never refunded her money. She also brought her own supplies (e.g., sanitary towels, cotton wool, and syringes), which she deposited with the hospital. Her labor began at night and her husband had to pay about 600 shillings ($10 U.S.) to hire a taxi to transport her to the hospital. Josephina acknowledges the risks involved in homebirths, but says, "Unlike homebirths, hospital-based deliveries make people poorer. It is safer to deliver at home than to start going to the hospital at decisive moments."

The women also reported that they were demotivated to seek hospital-based deliveries by what they suggested was an epidemic of needless maternal and child deaths in Kenyan hospitals. The women often blamed this trend on "quacks" and impostors who they said have successfully infiltrated formal health facilities in the country, as well as on the uncaring attitudes of qualified hospital-based providers. While some of the providers lacked the requisite training and skills to protect care seekers when preventable deaths struck, qualified providers were reported as uncharitable toward poor health seekers, often abandoning them to their fate when they presented at facilities. And as their narratives stoutly implied, the women were persuaded that formal care providers mistreated them because of their poor economic conditions. Among other confirmatory narratives, a 27-year-old Korogocho mother observed that once poor women walked into hospitals with their inexpensive dresses, they were easily identified by nurses and doctors, some of whom even acted as if they smelled. She said, "Some of them are so wicked that they will not pay you any attention until you are dying." The insensitivity of hospital-based providers to the respondents' cultural beliefs also emerged in the narratives as a key hindrance to the women's use of hospitals for birthing.

Baby theft was also reportedly rampant in Kenyan hospitals and received frequent mention among the women as a major motivation to deliver outside the hospital. The women maintained that baby stealing was very common, occurring often with support from hospital-based providers. The stories we elicited included that of a woman whose baby boy was substituted with a girl and of a couple given a dead child while their living child was sold to another rich couple. Respondents believed that hospital staff often colluded with rich people to steal or exchange these babies, and that poor people's babies were common targets of these unscrupulous providers.

Participants also admitted to avoiding hospital-based birthing because they would be forced to undergo human immunodeficiency virus (HIV) testing in the hospital. Njeri, a mother of two, said, "If you go to the hospital to deliver, they will insist that you undergo HIV testing and many of us are not ready for that. If you go there and find out that you are positive, what will you do?" The incidence of HIV in their communities was reported to be very high, and it was often noted that

many slum women learn about their HIV status during hospital-based delivery. To avoid undergoing HIV testing in hospitals, women tended to seek homebirths. Participating women stressed that it was the awareness of being HIV positive, rather than the disease itself, that killed people. The cureless nature of the disease, they added, made people lose hope and give up on life. People with HIV were also stigmatized in their communities and associated with depravity. To them, testing HIV positive would be an unbearable tragedy.

DISCUSSION

Judging from the study, poor urban Kenyan women are not unaware of the capacity of the hospital to make child delivery safer, and there is little evidence that they reject outright the utilization of modern obstetric services, as has been suggested by some writers.[6–8] Also, contrary to mainstream arguments that women deliver at home because they are unaware of the risks of doing so,[9] there was substantial awareness that using the hospital for birthing put women under the care of people with specialized training managing obstetric complications. The women were also very apt in acknowledging the superiority of the hospital as a delivery site, especially during obstetric emergencies or when anticipating difficult childbirths.

Despite glowing tributes paid to the hospital as a desirable delivery site, urban poor Kenyan women in the current study did not consider safe delivery to be a function of the place of delivery. For them, the greater danger was not in delivering outside the hospital, but in not dutifully seeking formal antenatal care. Consequently, the women reported that they devotedly sought hospital-based antenatal care during pregnancy, but hardly ever used the hospital for delivery. To a large extent, this inclination demonstrates the limited choices available to poor women in Kenya. Liamputtong noted that despite poor women's knowledge of the efficacy of Western medicine and its potential to make their deliveries safer, it is often outside their sociocultural reach and means.[10] In Kenya, poor slum women who seek hospital-based delivery risk exhausting their limited resources and being mistreated by providers at the hospitals. Long distances to formal services and high levels of insecurity in the slums also create difficulties in reaching formal services, especially if labor begins at odd hours.[11]

The safety-first strategy of urban poor Kenyan women is to dutifully attend antenatal care and plan to deliver at home. Judging by the available data, Kenyan women do not implement this choice out of ignorance. Rather, it is the result of their rational doubts—nurtured in contexts of intense marginality, inequality, and poverty—about the expediency of hospital-based delivery, especially when risky births are not anticipated. For many of the women, there is very little justification in seeking hospital-based delivery if one could safely deliver at home.

In the literature, it is suggested that southern women only attend antenatal care because grandmothers tell them to do so, because they want drugs such as ferrous sulphate, and when they are not well.[12,13] Results of the present study challenge this view. The respondents acknowledged the uptake of hospital-based antenatal care as key to the prevention of complications during delivery, and women noted that antenatal care enrollment enabled them to have regular check-ups and learn about the progress of their pregnancies. The women did not also support seeking antenatal care from TBAs, citing their poverty of skills and expertise in preventive obstetric care.

Also striking is the regular framing of the hospital as a delivery site for women anticipating or already facing obstetric emergencies and difficult deliveries, rather than as a site for normal deliveries. While in many respects, this reveals poor Kenyan women's acknowledgement of the hospital as potentially able to make delivery safer, it also clearly mirrors their relegation of the hospital to a delivery site of last resort. Gilson[14] and Liamputtong[10] have noted that in situations of severe poverty, hospital-based birthing tends to matter more to women who perceive themselves to be at very high risk of suffering complications during delivery.

Women's reported motivations to deliver outside the hospital included the physical proximity of the nonformal birth settings; the affordable, caring, and respectful character of their services; and the perceived safety and security of babies born at home. Homebirths were also sought because the women considered delivery services to be the traditional turf of TBAs, and because they would not be compelled to undergo HIV testing. The respondents reported that normal health providers in Kenya were very inhospitable and dismissive, especially to poor women. Besides ignoring them and regularly failing to respond to their questions, the health-care providers tended also to be very discourteous toward health seekers. Poor patient-provider relationships and provider inattention to health seekers' views and worries are foremost barriers to the uptake of formal care services in developing countries.[15]

Limitations

There were some limitations to the current study. We relied only on information gathered from a small number of women, who were not representative of a

national or local sample of poor Kenyan slum women. It also relied only on data from focus group discussions, which may have also undercut more critical contemplations among the respondents. Yet, there is room for believing the accounts of interlocutors in the study, as efforts were made to ensure that they spoke frankly and liberally during the study.

CONCLUSION

The findings reported in this article have complex implications for work related to maternal heath-care delivery in Kenya. On the one hand, they show women's considerable recognition and awareness of the hospital's superiority in managing obstetric emergencies, which offers a key entry point for work aiming to facilitate their use of formal obstetric care services. On the other hand, they also show that due to a host of reasons, including poverty, uncharitable providers, and the physical inaccessibility of facilities, poor Kenyan women do not consider hospitals as appropriate sites for delivery except when they anticipate difficult deliveries. Socioeconomic transformations beyond the scope of conventional public health campaigns and further research are essential to address the structural underpinnings of poor women's doubts and beliefs regarding hospital-based deliveries.

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