DETERMINANTS AND FETOMATERNAL OUTCOMES FOR HOME BIRTHS AMONG CHILD BEARING AGE WOMEN IN MARAKWET EAST IN ELGEYO MARAKWET COUNTY -KENYA

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DECLARATION

DECLARATION BY STUDENT

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To my lovely family, my husband Jonathan Kipkosgei Koech, my son Kenneth Kibichii, daughters Grace Jebiwott, Joy Jemeli, Abigael Jelagat and Kipchumba Kipkosgei for their inspiration, support and encouragement throughout the study not forgetting my parents Mr and Mrs. Stephen Kwambai and my brother James Kwambai for their financial support and prayers during the time of writing this thesis.

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ANC	Antenatal Care
CBR	Community Based Rehabilitation
DHIS	District Health Information Systems
FGDS	Focused Group Discussions
FGM	Female Genital Mutilation
HBM	Health Belief Model
HIV/AIDS	Human Imunno Deficiency Virus/Acquired Immune Disease
IDHIS	Iten District Health Information Systems
IREC	Institutional Research Ethics Committee
KDHS	Kenya Demographic Health Survey
MCH	Maternal Child Health
MMR	Maternal Mortality Ratio
NCI	National Cancer Institute
PPH	Postpartum Hemorrhage
SDGs	Sustainable Development Goals
STATA	Statistical Software package
TB	Tuberculosis

TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UNDP	United Nations Development Programme
UNFPA	United Nations Funds for Population Activities
UNICEF	United Nations International Children Emergency Fund
WHO	World Health Organization

ABSTRACT

Introduction: Health status of mothers and children is an important indicator of the overall economic health and well-being of a country. Maternal deaths commonly occur in fragile and humanitarian settings outside the hospital. In Elgeyo Marakwet county 35% of births took place at home. These home births are associated with high risk of morbidity and mortality which is preventable if attended by skilled birth attendants.
Objectives: To establish the reasons for home births, to determine fetomaternal outcomes and to assess perceptions of mothers towards free maternity care policy.
Methodology: The study was conducted in Marakwet East; Elgeyo Marakwet County.A Cross-sectional descriptive study that used mixed method design. Purposive and consecutive sampling procedures were used. Sample size of 236 mothers aged (15-49) years were interviewed using questionnaires. Thirty eight mothers participated in four focused group discussions. Mixed methods of data collection were used. Percentages, frequencies and logistic regression models were derived using STATA version 13. Data was presented in tables and prose. A p-value of 0.05 was considered statistically significant at 95% confidence interval.
Results: Most women (83%) had home deliveries. Some of the reasons found were; poor birth preparedness 150 (65.2%) coupled with mothers not involving their partners on decision on place of delivery 153 (66.52%), trust for TBAs 102 (44.35%) and 103 (44.78%) distance to health facility. Fetomaternal outcomes included sustained perineal tears 141 (61.3%), blood loss after delivery 53 (23.04%) and birth asphyxia 49 (21.30%). Logistic regression findings showed that single women were 8.9 times more likely to give birth at home (COR1.60 95%CI 0.62-3.78 p ≥value >0.05).Women who made self-decisions on place of delivery were 0.51 times highly likely to deliver at home (COR 0.51 95% CI 0.11-2.33 p-value ≥0.05) .Women perceived free maternity policy as the major cause of congestion in the few health facilities, thus affecting their privacy and confidentiality.
Conclusion: Most women in Marakwet East had home births. Main reasons for home births were; poor birth preparedness coupled with women not involving of their partners on place of delivery and trust for traditional birth attendants. Most women walked to the health facilities due to lack of means of transport. Coupled with poor topography, this made it hard for the women to get to the health facilities on time. Fetomaternal outcomes associated with home delivery included; perineal tears, bleeding after delivery and birth Asphyxia. Introduction of free maternity policy was perceived as the main source of congestion due to increased number of mothers and inadequate infrastructure in the health facilities.
Recommendations: County government to invest more on health education of the mothers on birth preparedness, dangers associated with pregnancy, child birth, postpartum period and importance of hospital delivery. To deploy trained midwives in the community to act as agents of evidence based practice. To improve road networks for availability of means of transport for easy access to health facilities. Improve beyond zero campaign initiative to reach hard to reach areas of the county. Traditional birth attendants be educated to act as ambassadors in referring patients in labor to deliver in a hospital setting.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

.As part of the Sustainable Development Agenda between 2016 and 2030 United Nation targets to reduce the global mortality ratio to less than 70 per 100,000 live births and end preventable newborn deaths aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births through interventions such as increasing maternal health care services in remote areas, and reducing home births which are mostly associated with increased maternal deaths (United Nations, 2015).

The persistent rise of maternal mortality ratio (MMR) is mostly affecting the developing countries and it is estimated that, 47% of global maternal mortalities occur in Africa with highest levels in Sub-Saharan countries. In much of sub-Saharan Africa, fewer than half of women deliver their infants in health facilities (Cheryl, Moyer & Aesha, 2013). The reasons are myriad, and understanding these factors is critical to identifying gaps in the existing research, planning interventions, and developing effective policies for addressing low facility-based delivery rates. Most of these maternal mortalities are a direct result of complications arising during pregnancy, delivery and during puerperium (Simfukwe, 2011)

Maternal health is intricately linked with the survival of newborns, approximately 2.7 million newborn babies die every year and an additional 2.6 million are still born especially those women who deliver at home under care of unskilled attendants (Kenya National Bureau of Statistics et al., 2015).(Mwaliko et al., 2014b) observed that pregnancy and childbirth related complications contribute to a significant number of

pregnancy and childbirth related deaths and disabilities in the world especially in developing countries. They mentioned some of the major causes of deaths as prolonged/obstructed labor, complications from unsafe abortion, hemorrhage, malaria during pregnancy, anemia, and sepsis. Amy (2016) noted that childbirth is inherently dangerous, and if an emergency occurs, the baby or even the mother may die and that hospital birth minimizes neonatal mortality and maternal mortality(Amy, 2016).

In rural Kenya, factors such as distance to hospital, lack of educations among others were some of the factors for home births(Carol Wanjira Kagia, 2010).(Yego et al., 2013) argued that to travel to health facilities, families have to hire a local vehicle, which may or may not be available when needed and during the rainy season some roads become impassable. The cost of hiring a local car or motorbike ranged from 10 dollars up to 20 dollars depending on the distance between the home and the facility. Cheryl, Moyer and Mustafa (2013) opined that safe motherhood initiatives such as the provision of free maternity services are still being underutilized by many women in Kenya especially those in poor, rural, and remote settings of the country which has led to extremely high rates of maternal mortality Rates.(Moyer & Mustafa, 2013)

In sub-Sahara Africa, a number of countries have halved their levels of maternal mortality since 1990 while other regions, including Asia and North Africa have even made greater progress in reducing maternal mortality(WHO, 2016).The interventions which most mothers delivering at home miss include injection of oxytocin immediately after birth to reduce risk of bleeding, good hygiene practices, timely recognition of infection and early treatment and good monitoring of a mother during childbirth to manage complications early(WHO, 2016).

Regardless of increased levels of antenatal care in many parts of the world in the past decade, only 51% of women in low-income countries benefit from skilled care during childbirth with 40% of these women said to receive the recommended antenatal care visits. And this quantifies that millions of births around the world are not assisted by a midwife, doctor, or a trained nurse (WHO, 2016).World Health Organization's key priorities include improving maternal health by contributing towards the reduction of maternal mortality. This will be achieved through increasing research evidence, providing evidence-based clinical and programmatic guidance, setting global standards, and providing technical support to Member States(WHO,2016).In addition, WHO advocates for more affordable and effective treatments, designs training materials and guidelines for health workers as well as monitor progress (WHO, 2016).

KDHS revealed that Sixty-two percent (62%) of births were assisted at delivery by a skilled birth attendant (doctor, nurse, or midwife), thirteen percent (13%) were assisted by relatives or friends, and nineteen percent (19%) were assisted by a traditional birth attendant and five percent (5%) of births were unassisted. The role of community health workers in delivery assistance was very limited (less than 1 percent) adding to 38% home birth (KDHS,2014).Almost all health facility births ninety nine percent (99%) were assisted by a skilled provider, as compared with just three percent (3%) of births delivered outside health facilities. Its therefore very important to note that obstetric care from a health professional during child birth is recognized as critical in reducing maternal and neonatal mortality (KDHS, 2014).

The global strategy for women, children's and adolescents health, 2016-2030 which was

launched by Baan KI-moon, UN Secretary during the United Nations General Assembly 2015,in New York, was a road map for the post-2015 agenda as described by the sustainable development goals and seeks to end all preventable deaths of women, children and adolescents and create an environment in which these groups not only survive, but thrive and see their environments, health and wellbeing transformed (United Nations, 2015).Through this global strategy and goal of ending preventable maternal mortality, WHO is working with partners by strengthening health systems to respond to the needs and priorities of maternal mortality and morbidities which are usually encountered during home births under the care of unskilled birth attendants (WHO, 2016).Moreover this Strategy ensures universal health coverage for comprehensive reproductive, maternal and newborn health care, therefore addressing inequalities to access and quality of reproductive health(WHO, 2016).

1.2 Statement of the Problem

According to World Health Organization, about 830 women die every day from preventable causes related to pregnancy and child birth,99% of all maternal deaths experienced in developing countries shows a higher maternal mortality rate in women living in rural areas and among poorer communities as well as young adolescents who face the risk of complications. However, skilled care given before, during and after child birth can save the lives of women and newborn babies (WHO, 2016)

High number of maternal deaths in some areas of the world reflects inequities in access to health services, and highlights the gap between rich and poor. Almost all maternal deaths (99%) occur in developing countries, with slightly more than half of the deaths

experienced in sub-Saharan Africa and almost one third in South Asia. To add to this, the maternal deaths occur in fragile and humanitarian settings outside the hospital. Women in developing countries have on average many more pregnancies than women in developed countries and their lifetime risk of death due to pregnancy is higher. A woman's lifetime risk of maternal death is the probability that a 15 year old woman will eventually die from a maternal cause that is, 1 in 4900 women die in developed countries, versus 1 in 180 in developing countries. In countries designated as fragile states, the risk is 1 in 54; showing the consequences from breakdowns in health systems and disparities between women with high and low income and those women living in rural versus urban areas (WHO, 2016).

According to (WHO, 2016) the maternal mortality ratio in developed countries in 2015 was 12 per 100 000 live births while in developing countries it was 239 per 100 000 live birth leaving a very wide gap. The situation in Kenya is even worse in that the current MMR stands at 362 maternal deaths per 100,000 live births (KDHS, 2014)

Moreover most of the home births are conducted by the (TBAs) who by the safe-motherhood initiatives whether trained or untrained were excluded from the definition of a skilled birth attendant because they lack clinical skills on use of drugs, equipment and competency to manage complications such as hemorrhage, eclampsia and severe infection (Starss et al., 2005).

In Elgeyo Marakwet County(Kenya National Bureau of Statistics & ICF Macro, 2014) findings show that 65% percent of mothers had hospital delivery while35% percent had home deliveries However, 18% of home deliveries were from Marakwet East Sub-County as per Iten referral hospital, 2015 health records. This therefore confirmed that

women still give birth under the care of unskilled birth attendants despite the strategies that have currently been put in place by the government to reduce maternal, infant mortalities and morbidities towards achieving SDG 3 in the country at large.

The health status of mothers and children is an important indicator of the overall economic health and well-being of a country (United Nations, 2010). For every woman who dies, another 30 suffer long-lasting injuries and illnesses such as obstetric fistula (WHO, 2016).

It is therefore necessary to undertake this study to identify the reasons for home births among child bearing women, determine fetomaternal outcomes and explore perceptions of women towards free maternity policy in Marakwet East, Elgeyo Marakwet County.

1.3 Justification of the Study

Women die as a result of complications that develop during pregnancy, child birth and after child birth which in most cases can be prevented or treated. The complications may be varied in that 75% of these are caused by severe bleeding and infection usually after birth, high blood pressure during pregnancy (pre-eclampsia and eclampsia) from childbirth and unsafe abortion, the remaining 25% are caused by or associated with diseases such as malaria and HIV/AIDS during pregnancy. These therefore contribute to adverse maternal and neonatal mortality and morbidity (WHO, 2016).

Free maternity services policy and beyond zero campaigns are some of the strategies that are geared towards reducing maternal and infant mortalities and morbidities in the country that are mostly witnessed when mothers give birth at home under care of unskilled birth

attendants, but still home births are witnessed in the country(Initiative et al., 2018)

Increasing the percentage of births delivered in health facilities is important indicator for reducing deaths arising from complications due to pregnancy, child birth and postpartum period. The expectation is that if complications arise during delivery in a health facility, a skilled birth attendant can manage them or refer the mother to the next level of care. Kenya is promoting skilled care during pregnancy and childbirth for both mothers and newborns(MOPHS, 2008).

Therefore this study will be of great importance because it will help to find out the mysteries surrounding home births and outcomes associated with home birth which affect women, the infants and the neonates. In one single act of delivery, a mother gives birth to a new life, hence a new generation and it's also through this single act in which continuity of a nation lies. However delivering a neonate may be full of complications posing danger to the mother, and the neonate. This requires that the delivery is done under the supervision of a skilled birth attendant who will provide an environment that ensures that the mothers and neonates are safe (WHO, 2016).

However women continue to deliver under the care of unskilled birth attendants, an environment that does not guarantee their security and that of their neonates (KDHS, 2014). Therefore, understanding the reasons that contribute to the risk of mothers giving birth at home and its outcomes will ensure that effective intervention mechanisms are put in place to encourage the mothers to seek hospital delivery hence reducing maternal and neonatal mortality and morbidity towards achieving the SDG 3(United Nations, 2015).

First and foremost this study sought to establish the reasons that make women deliver at

home, the outcomes that follow home births and the perceptions of women towards the free maternity care. This will benefit policy makers as a base statistics in development of new programs and improving existing ones for the betterment of reproductive health intervention programs hence improving the health status of both the mother and the baby in the county and the nation at large. Secondly, the results of this study will also help women understand the adverse outcomes of giving birth at home that can negatively affect their health physically, psychologically and economically if they encounter complications during child birth. Thirdly this is a community based research which will gather useful data and information straight from the community. This information will then be shared to county headquarters level and to the National Reproductive Health Programme division of health so as to help in mobilizing the needed resources to improve maternal and neonatal health, hence attaining the sustainable development goal three (3) that aims in Ensuring healthy lives and promote well-being for all at all ages hence meeting the target of SDG.3.

1.4 Research Questions

1. What are the reasons for home births among the women in Marakwet East in Elgeyo Marakwet County?
2. What are fetomaternal outcomes following a home birth among women in Elgeyo Marakwet East in Elgeyo Marakwet County?
3. What are the perceptions of women who have had home births towards free maternity care policy in Marakwet East in Elgeyo Marakwet County?

1.5 Specific Objectives

1. To establish the reasons for home births among the women in Marakwet East in Elgeyo Marakwet County.
2. To determine the fetomaternal outcomes following a home birth among women in Marakwet East in Elgeyo Marakwet County
3. To assess perceptions' of women who have had home births towards free maternity care policy in Marakwet East in Elgeyo Marakwet County.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of related literature to the study. The chapter first presents the review of the related literature of the study covering the following, the reasons for home births, and the outcomes of births and lastly the perceptions of women towards free maternity care policy.

2.2 Reasons for Home Births

In developed countries, virtually all women with a high income have at least four antenatal visits, are attended by a skilled birth attendant during childbirth and they receive postpartum care. Vice versa 40% of all pregnant women do not have the recommended antenatal care visits in low-income countries, this is attributed to factors such as cultural practices, poverty, inadequate services ,long distance to health centers, and lack of information, which prevent women from receiving or seeking care during pregnancy and childbirth and therefore to improve maternal health, barriers that limit access to quality maternal health services must be identified and addressed at all levels of the health system (WHO, 2016).

In Bangladesh and India which has a MMR of 176 and 174 respectively per 100,000 live births, deliveries do still take place at home (62%) and more than (56%) deliveries are assisted by traditional birth attendants (TBAs) or relatives while medical personnel conducting only (42%) of all births this figures are attributed to identified wide range of factors, including; traditional views, poverty, strong faith in TBAs and their experience, illiteracy, lack of knowledge regarding maternal health services, prevailing religious

beliefs like women are not allowed to expose their sexual organs to men, poor road conditions and lack of available transport, and the fear of undergoing a caesarean delivery at health facilities due to cost implication (Sarker et al., 2016).

Interesting findings in developed countries reveal that some women plan to give birth at home because of motivating factors such as active learning about home birth routines and safety procedures involved, comfort and involvement of the family members ,including siblings were highlighted, unmediated labors, adequate time for bonding and skin to skin care ,autonomy of choice and control in decision making, communication, concerns about hospital acquired infections and availability of a midwife of your choice at your own home(Murray-davis et al, 2012).

In South and Southeast Asia, more than 70 % of all births in the lowest two wealth quintiles occurred at home. Women consider the Traditional Birth Attendant (TBA) as a culturally acceptable and competent health worker. Living in the same community, she offers respectful, prompt care and personalized attention to the woman during delivery. Poor accessibility of the institution and other factors like low maternal education, being a rural resident and multi- parity increase the likelihood of home delivery. On the other hand, evidence from developed countries shows that convenience, privacy, and respect are also very important determinants of a woman's preference for home deliveries (Bhattacharyya et al., 2016).

The MMR in Ethiopia stands at 353 per 100,000 live births. In Western Ethiopia, 60.3% women still deliver at home compared to hospital delivery due to their believe that labor is a natural process and it will go on well, being close to their relatives and family members hence close attention during child birth, low awareness on the risks associated

with home deliveries ,elderly Primigravida, lack of formal education backgrounds, lack of autonomy in utilizing maternal health services and lack of attendance for ANC services hence no room for contact and information sharing by health care worker(Tekelab et al., 2015).

Shiferaw et al, (2013) found out that (78 %) deliveries were at home and (16 %) were only assisted by skilled health workers. Various factors were elucidated which include cultural acceptance for TBAs , previous negative experiences at the health facilities, few health facilities, aversion of caesarean section, poor awareness on dangers associated with home birth, lack of decision making and distance with lack of transportation.(Shiferaw et al., 2013)

(Gan-yadam et al., 2013) observed that factors predicting the place of delivery include cultural, socioeconomic status, demographics and service accessibility factors. Low maternal or paternal educational attainment, low socioeconomic status, rural residence, young maternal age and high-order birth have been also observed to be associated with high probabilities of deliveries outside a health facility. It was supported by (Adjiwanou & LeGrand, 2014) who noted that a range of factors prevent women in sub-Saharan Africa from obtaining quality health care from the formal sector including living a long distance from health facilities, poor roads, lack of transport, poverty, cultural practices, lack of information, and poor quality health services.

Findings in Zambia shows that most women give birth at home due to several individual, family and health system-related factors including women's low risk perception regarding their personal susceptibility to labor complications, negative attitude towards facility- based delivery services, lack of decision- making autonomy regarding child

birth. Moreover, various physical and socio-economic barriers including long distances, lack of money for transport and the requirement to bring baby clothes and food while staying at the clinic prevented women from giving birth at the clinic and this is reflected by the country's MMR which is 591 maternal deaths per 100 000 live births since more than half (53 %) of the women in Zambia, do not receive skilled birth attendance which is even worse in the rural areas which shows that more than 70% still deliver at home, outside the health facility and assisted by TBAs(Sialubanje et al., 2015).

The maternal mortality ratio in Kenya shows that 362 maternal deaths per 100,000 live births and this approximately shows that four(4) women die during pregnancy, during child birth or within two months after childbirth. The lifetime risk for maternal death (0.015) indicates that approximately 2 % of women or about 1 in every 67,will have a maternal death or they will during pregnancy, childbirth, or within two months of childbirth. Most of these maternal deaths are caused by serious complication such as severe bleeding and infections after childbirth, pre-eclampsia and eclampsia during pregnancy and unsafe abortions(Kenya National Bureau of Statistics et al., 2015).

An analysis of the Kenya demographic and health survey was studied for factors influencing place of delivery for women, about 53% of deliveries took place outside health facilities despite more than 88% of mothers living less than five kilometers from a health facility and 93% of pregnant women having at least one ANC visit during pregnancy. 60 % gave difficulty in physically accessing health facilities i.e. long distance and/or lack of transport was the most reported reason for not giving birth in a health facility and 20.5% of mothers who reasoned that giving birth in a health facility was not necessary. This pattern was regardless of wealth, parity, education or rural/ urban

residence. Women living near a health facility reported delivering at home due to abrupt child birth and high costs being the main barriers to health facility delivery(Kitui et al., 2013).

In Mandera, eastern part of Kenya; the problems are driven, at least in part, by lack of access to quality maternal health services, including ante-natal, delivery, and post-natal services; long spans of marginalization, insecurity, weak health systems, lack of accountability and negative cultural and religious practices. Many women still live at a considerable distance from health facilities and cannot afford to pay (hidden) fees for maternal services(Harvey, 2015)

Home birth is still a major challenge in most remote areas of Kenya, in West Pokot most women still give birth at home (66.7%) , accounting for higher outcomes of maternal deaths among women who gave birth at home. Factors such as illiteracy, harsh climatic conditions, poor transport systems, and long distances to the health facility, inadequate public utilities and poverty are some of the contributing factors. In addition, findings revealed that most women in West Pokot are purely housewives and have limited or no access to resources, lack self-decision making process leaving relatives to hold on strong cultural believes that do not favour women therefore deciding for women. Likewise, distance to the health facility was a major contributory factor especially to mothers who had attended ANC(Ogolla, 2015).

A cross sectional community based study done by (Mwaliko et al., 2014a) in Western Kenya found that distance to a health facility was not a factor affecting the decision of place of delivery. This is contrary to the findings of many studies that showed distance to be a major factor.

2.3 Outcomes of Giving Birth at Home

In areas where essential care and skilled health attendants are limited, PPH is the leading cause of MMR globally and this should act as a wakeup call to African policy makers to educate the community on the importance of seeking skilled health care instead of TBAs and traditional healers. Basic equipment should be availed and skilled birth attendants should have basic skills on Emergency Obstetric Care and be able to make arrangements for timely referral to hospital with facilities emphasized and practiced everywhere in prevention of maternal deaths (Mpemba et al., 2014).

Between 1990 and 2015, the global maternal mortality ratio (i.e. the number of maternal deaths per 100 000 live births) declined by only 2.3% per year between 1990 and 2015.However, increased rates of accelerated decline in maternal mortality were observed from 2000 onwards. In some countries, annual declines in maternal mortality between 2000-2010were above 5.5%, the rate needed to achieve the SDGs (WHO, 2016).

One target under Sustainable Development Goal 3 is to reduce the global maternal mortality ratio to less than 70 per 100 000 births, with no country having a maternal mortality rate of more than twice the global average. The maternal mortality ratio in developing countries in 2015 was 239 per 100 000 live births versus 12 per 100 000 live births in developed countries (WHO, 2016).

In Karachi, Pakistan results showed a high percentage of maternal deaths among mothers who gave birth at home because they were all conducted by unskilled birth attendants. In addition postpartum hemorrhage at 54% and retained placentas 74%,

traumatic lesions (ruptured uterus, second degree perineal tear) 48% ,puerperal sepsis 28% and postpartum eclampsia (Shah et al., 2010).

A study done in the slums of Kenya showed that women who gave birth at home missed a lot of immediate care and thereafter care because of socio-economic factors most of them could stay at home hence missing proper follow up care(Izugbara & Ngilangwa, 2010). This goes in line with (Marete et al., 2014) in their global network study which they found that a third of the women who gave birth at home were associated with high prenatal and neonatal deaths.

According to (Maawiya, 2018) the overall prevalence of adverse maternal and perinatal outcomes in Lamu, Kenya was 15.8% i.e. 7.5% following health facility deliveries and 8.25% following home deliveries respectively. It was noted Post-partum hemorrhage was the most frequent adverse maternal outcome with an overall prevalence rate of 11% of which 6.5% was severe PPH. Preterm birth was the most common adverse perinatal outcome accounting for 7% of hospital and 5% of home deliveries. Two maternal deaths Occurred which occurred due to late referrals after a home birth.(Maawiya, 2018)

Mandera County in Kenya remains the worst place for a mother to give birth and for a child to be born and thrive. Indicators such as Maternal Mortality Ratio (MMR) of 3,795 deaths per 100,000 live births3 (362/100,000 national), Skilled birth attendance rate of 20% (national 62 %) and home deliveries at 80 %(national 38%. This translates to adverse effects of high outcomes of maternal mortality due to high percentage of women who give birth under the care of unskilled birth attendants(Harvey, 2015).

The district heath information system (DHIS) of Elgeyo Marakwet County in 2015 shows that 187 maternal deaths per 100,000 births. The main causes of these maternal deaths were due to sepsis, ante partumhemorrhage (APH) and postpartum hemorrhage (PPH). These are preventable conditions but one of the factors cited is that women give birth at home and delayed arrivals to a health facility (EMC DHIS, 2015).

2.4 Perceptions of Women towards Free Maternity Policy

A study done in Ghana showed that in seven study districts, facility delivery increased significantly over time and that there were significant jumps of 2.3% and 7.5% in coverage following the 2005 and 2008 policies respectively due to free maternity policies. In parallel, health insurance uptake showed a massive jump (of 17.5%) after the 2008 policy. They also found that increases were greatest among the poorest, and that consequently inequality in facility delivery and insurance coverage decreased(Dzakpasu et al.,2012).

In Burkina Faso women perceived satisfaction with the free birth services and that there was an increased use of birth delivery services (intervention group) caused by the abolition of maternity fees, and there was no effect on the quality of care as earlier perceived that it would affect care with introduction of free delivery services These results suggest that a substantial financial burden is relieved with total fee exemption but other factors such as functioning health system, community awareness, infrastructure, and thus satisfaction is guaranteed (Philibert, Ridde, Bado, & Fournier,.2014).

Most women reported a direct relationship between patient satisfaction and utilization of free maternal healthcare services in public hospitals Nairobi County, 78% of the

respondents rated the quality of services as good hence the best pointer that patients are satisfied with free maternal health services. On waiting time 59% of the respondents indicated that it took midwives approximately 10- 15 minutes to attend to them while 33% said it took the more than 15 minutes to attend to them. Time taken for response may be attributed to increased number of women who deliver in public hospital since the introduction of free maternity services in public hospitals(Otieno et al., 2014).

In Nyatike sub-county in Kenya, most women with low socio economic status embraced free maternity care, but other women with high socio economic status cited increased no of clients hence long waiting time and few staff in the facility making them have a negative perception towards free maternity care(Mugambi et al., 2014).

2.5Theoretical Framework

Health Belief Model (HBM)(Stretcher & Rosenstock, 1997) was developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels who worked in the United States public health services. This model was developed in a response to the failure of a free tuberculosis (TB) health screening program which in this scenario corresponds to mothers giving birth at home under the care of unskilled birth attendant instead of healthy facility under the care of a skilled birth attendant(Stretcher & Rosenstock, 1997)

The underlying concept of this theory is that health behavior is determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence as it is said that personal perception is influenced by the whole range of inter personal factors affecting health behaviors (Stretcher & Rosenstock, 1997).

The model will be useful because it makes one understand why people do things in a certain behavior and how do change the behavior hence promoting utilization hospital based deliveries under the care of a skilled birth attendant (Stretcher & Rosenstock, 1997).The health belief model is also psychological models that will attempts to explain and predict behavior by focusing on attitudes and beliefs of individual health, such as perceptions of women towards free maternity care policy as an objective of the study (Stretcher & Rosenstock, 1997).

The four key areas that this model is constructed into include Perceived susceptibility, perceived severity, perceived benefits and perceived barriers. These concepts were proposed as accounting for people "readiness to act", an added concepts "cues to action" would activate that readiness and stimulate overt behavior and self-efficacy, or ones confidence in the ability to successfully perform an action, which was added to HBM to better fit the challenges of the changing habitual unhealthy behavior such as being sedentary, smoking and unhealthy eating.

Perceived susceptibility (an individual's assessment of their risk of getting the condition)

Helps one to understand why people engage in certain behaviors in order to make a difference in their health. Personal susceptibility or risk is among most powerful perceptions in promoting people to change to health behaviors meaning the greater the perceived risk, and the greater the likely hood of engaging in behaviors that decrease the risk. This is what prompts people to take care preventive measures such as vaccination against diseases. In my study ,it is expected that women who believe in giving birth at

home to be health threatening will have a higher preferences to seeking hospital birth care and Vice versa mothers who perceive themselves as not susceptible to complications will prefer home delivery.(Stretcher & Rosenstock, 1997).

Perceived severity ((an individual's assessment of the seriousness of the condition, and its potential consequences)

If women are made to understand that giving birth at home could bring many serious complications such as severe bleeding leading to death and serious complications such as development of obstetric fistulas due to obstructed labor, most of them will prefer to give birth in an hospital under the care of a skilled birth attendant who has been certified and competently trained to take of them during childbirth.(Stretcher & Rosenstock, 1997).

Perceived Barriers (an individual's assessment of the influences that facilitate or discourage adoption of the promoted behavior)

Change is not easy as it is easily said to most people. This construct addresses the issue of perceived barriers to change. This includes an individual's own evaluation of the obstacles affecting adoption of new behavior. This is the most significant construct in determining behavior change. In day to day life for a new behavior to be adopted, its benefits should outweigh the consequences of continuing with the old behavior. This therefore facilitates barriers to be overcome and the new behavior to be adopted (Stretcher & Rosenstock, 1997).

Perceived Benefits: an individual's assessment of the positive consequences of adopting the behavior).

This is a person's opinion of the value of a new behavior in reducing the risk of acquiring a disease or a health-threatening condition. People tend to adopt healthier behaviors when they believe the new behavior will reduce their chances of developing a disease. Perceived benefits play an important role in the adoption of secondary prevention behaviors, such as maternal hospital birth. When a mother perceives that hospital birth is beneficial to herself and the baby, delivery care services will be sought. However, when no such benefits are perceived, the mother may not choose to deliver in the hospital.

These major four constructs of perception are modified by other variables, education level, past experiences, socio-economic factors, motivation, skill and culture (Stretcher & Rosenstock, 1997). Personal perceptions are influenced by these individual characteristics. Application of these constructs to a health-related behavior such as maternal health seeking for pregnant women, the health belief model will predicts the use of hospital maternal health care services in that a woman will perceive susceptibility to home birth, identify the barriers, understand the severity of outcomes of home birth ,and perceived benefits of giving birth in the hospital will outweigh the dangers associated with home birth, and this is usually made admirable if the mothers are subjected to cues to action that are external , such as media promotion advertisements and health education on maternal care services which are offered in an hospital environment

2.6 Conceptual Framework

This conceptual framework focuses to, define the relationship between the independent, intervening and dependent variables which have been derived from the specific objectives.(Grant & Osanloo, 2014) It was constructed based on Health belief model (HBM)(Stretcher & Rosenstock, 1997).The objectives as independent variables were used to conceptualize the four key areas in the framework these includes perceived susceptibility, perceived severity, perceived barriers and perceived benefits and cues to act on these as intervening variable.

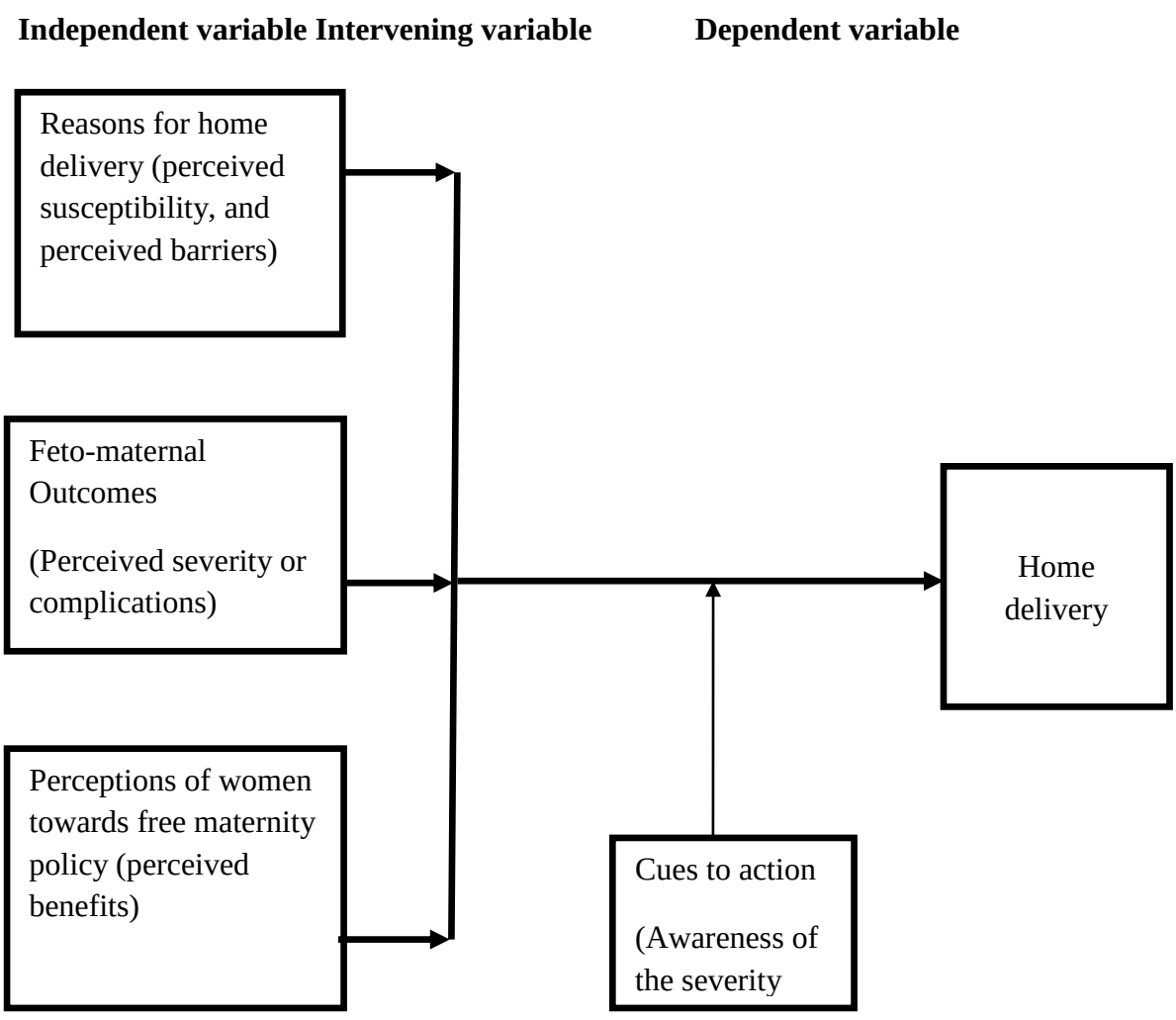

Figure 1: Conceptual framework

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents the methodology and design of the study. It describes the source of data, method of data collection and a summary of the analyses that were carried out.

3.2Study Area

This study was carried out in Elgeyo-Marakwet County which is one of Kenya's 47 counties. Elgeyo Marakwet County is located in the Rift Valley Province. Its capital and largest town is Iten. It borders the counties of West Pokot to the north, Baringo County to the east, southeast and south, Uasin Gishu to the southwest and west, and Trans Nzoia to the northwest. Elgeyo Marakwet County comprise of four constituencies which include Marakwet West, Marakwet East, Keiyo North and Keiyo South. It has 113 health facilities that comprise of one County referral hospital, five Sub-district hospitals, fifteen Health centers, eighty nine Dispensaries and two private hospitals. It has a population of 369,998 thousands (male 50% and female 50%), a population density of 112 people per km^2 and makes a national percentage of 0.96% of the total population.

The crude birth rate (CBR) is 8.2% and a total fertility rate (TFR) of 4.2. 46.4% of the population is below 15years of age while the youth and active adults (15-64) are 49.6% of the total population, while 4% of the total population is above 65 years. Women who gave birth under care of a skilled birth attendant were 65%, home deliveries at 35% and the maternal mortality ratio was 187per 100,000 live births.(Kenya National Bureau of Statistics et al., 2015).18% of home deliveries are from Marakwet East Sub-County (IDHS, 2015). Most of the people are farmers (crop &dairy) with agriculture contributing to 75% of household income. 56% of the population lives in absolute poverty (NSDSP,

2008-2010).The study narrowed to Marakwet East in Elgeyo Marakwet County because no such study has ever been done in the area, it is also an interior part of the county where community research is of essence to guide in policy making and that the region registered the highest number of home births (18%) as per County (DHIS, 2015).

3.3Study Design

The study employed a cross sectional descriptive design that employed both quantitative and qualitative methods.

3.4Study Population

This comprised of mothers aged 15 to 49 years attending the MCH Clinics at the selected health facilities who have ever had a home birth.

3.4.1Inclusion Criteria

Mothers aged 15 to 49 years who have ever had birth home within a period of five years while in the study area to answer the questionnaires.

Mothers aged between 18 years and below or 18 years and above who have had all their births at home and also mothers of the same age group who have all theirs births in healthy facility to participate in FGDs.

Mothers who had given informed written consent to participate in the study.

3.4.2Exclusion Criteria

Mothers who have had all their births at health facility in answering the questionnaires

3.5Sampling

The researcher used purposive sampling technique to identify the health facility of interest with high number of recorded home births. The information was obtained from the record at the health facilities. Consecutive sampling was used to recruit the

participants into the study so as include all the accessible subjects as part of the sample. This was used to get all mothers coming to the mother and child welfare clinic and they must have ever had home birth despite the current place of delivery during the visit.

3.6Sample Size Determination

According to Kenya demographic health survey (KDHS 2014) it showed that 35% of women in Elgeyo Marakwet County delivered at home, 18% of this is from Marakwet East Sub-County (IDHS, 2015) and this will be used as the p (proportion). The Fischer statistical formula was applied as follows (Charan & Biswas, 2013)

Fischer's formula

$$n = \frac{z^2 pq}{d^2}$$

Where, n = Desired Sample Size

p = Proportion with characteristic of interest (prevalence of home deliveries Marakwet East =0.18 according to Elgeyo-Marakwet county 2015 statistics)

Z = 1.96 i.e. Z-score at 95% confidence interval)

d = Desired margin of error, set at 0.05

q=1-p

- $n = 1.96^2 \times 0.18\ (0.82)/0.05^2$

$=214.20$

=214 participants

A 10 % increase in sample size will be included to give room for attrition making a total of 236 participants. An addition of 38 women who participated in FGDs.

3.7 Data Collection Methods

Primary quantitative data was obtained using structured questionnaires which were administered by interviewers. The questionnaire was designed in English but was translated to Marakwet language through translation and back translation and administered by the researchers and/or research assistants in the native tongue version.

The questionnaire was pre-tested in Ziwa health centre which is outside the study area in order to establish its validity and reliability.

Additional qualitative data were obtained through four (4) Focus Group Discussions (FGDs comprising of 8-12 mothers each and through in- depth interviews by the researchers. From each of the 4 health facilities in Marakwet East which were purposively selected because they had high numbers of mothers who had delivered at home as per MCH records. Thirty-eight mothers were purposively identified, an explanation of the research purpose was done. Permission was then sorted and then planned a date to meet them in four FGDS as follows:

- **FGD 1;**Have never had hospital birth and below 18 years,
- **FGD 2;**Have never had hospital birth and above 18 years
- **FGD 3;** Have had only hospital delivery and below 18 years
- **FGD 4**; Have had only hospital delivery and above 18 years

These participatory appraisal discussions aimed at obtaining more detailed information on perceptions towards free maternity services policy, reasons for home delivery and fetomaternal outcomes. Focus Group Discussions were held after the individual questionnaires had been administered. This was done on different mothers with different characteristics as those of individual respondents.

3.8 Data analysis

Quantitative data was entered and cleaned using STATA version 13.Frequencies,percentages and logistic regression were generated and presented in tables and prose.Qualitative data was written down in note form as the women answered the questions, cleaned, transcribed manually and coded into thematic themes and sub thematic themes.

3.9 Ethical Consideration

Permission to carry out the study was obtained from the Institutional Research and Ethics Committee (IREC) of Moi University who reviewed and approved the study. Permission was then sought from the health administration in charge of facilities of interest. InformedConsent was obtained from the participants in answering the questionnaires and those who participated in FGDs before they participated and those who declined to participate were respected and were not discriminated in anyway. The information given was accorded maximum confidentiality and was used strictly for the study.

CHAPTER FOUR

RESULTS

4.1 Introductions

This chapter presents the findings and results on the study.

4.2 Questionnaire Return Rate

Out of 236 questionnaires administered to the sampled participants, 230 were returned which represented 97.5%(CDC, 2018) The high return rate of the questionnaires was attributed to the simplicity of questions, researcher's availability and commitment during data collection time. The reason for the 6 (2.5%) questionnaires that were not returned was attributed to inability of the participants to attempt the questions and incomplete questionnaires. In addition, all the 4 in-depth interviews (FGD) were successfully conducted.

4.3 Sample Characteristics

Finding reveal that the highest proportion of participants 96(41.7%) were in the age bracket of 26-35 years followed by 71(30.9%) who were in the age bracket of 36-45 years. Results further shows that the youngest participants 48(20.9%) were in the age bracket of 15-25 years while the oldest were in the age bracket of 46-49 years. Results show that majority of the participants 145(63%) were married followed by 52(22.6%) who were single and the minority 33(14.3%) were widowed.

It was observed that most participants' 114(49.6%) had upper primary level of education followed by 50(21.7%) and 44(19.1%) who had secondary and tertiary levels of education respectively. The minority 22(9.6%) had lower primary level of education. Results showed that 33(14.3%) of the participants' spouses had lower primary level of

education, 8(3.5%) had upper primary level of education, 116(50.4%) has secondary level and 15(6.5%) had tertiary level. Findings showed that majority of the participants 221(96.1%) were Christians while minority 9(3.9%) practiced traditional religion.

Table 1 Sample Characteristics N=230

Variable	Categories	Frequency	Percentage
Age	15-25 years	48	20.87
	26-35 years	96	41.74
	36-45 years	71	30.87
	46-49 years	15	6.52
Marital Status	Single	145	63.04
	Married	52	22.61
	Widow	33	14.35
Education	Primary	136	59.13
	Secondary	50	21.74
	Tertiary	44	19.13
Religion	Christian	221	96.09
	Traditional	9	3.91
No. of children	2	53	23.04
	3	62	26.96
	4	44	19.13
	5	19	8.26
	6	36	15.65
	7	11	4.78
	8	4	1.74
	10	1	0.43
Occupation	Unemployed	153	66.52
	Self employed	15	6.96
	Formal employment	16	6.52
	Casual laborer	46	20.00

4.4 Reasons for Home delivery

The first objective sought to establish the reasons for home births among the women in Marakwet East in Elgeyo Marakwet County.

Table 2 Reasons for home delivery N=230

Variable	Categories	Frequency	Percentage
Place of delivery	Health facility	37	16.09
	Home	193	83.91
Distance to health facility	Less than 1km	34	14.78
	1-5km	114	49.57
	6-10km	82	35.65
Mode of transport	Walking	103	44.78
	Motor Vehicle	43	18.70
	Motor cycle	84	36.52
Spouse consulted on place of delivery	Yes	77	33.48
	No	153	66.52
Delivery planned	Yes	80	34.7
	No	150	8
			65.22
Decision on Delivery	Husband	27	11.74
	Mother	21	9.13
	Mother-in-law	50	21.74
	self	132	57.39
Who assisted you during delivery	TBA	102	44.35
	Mother in-law	66	28.70
	Friends	20	8.70
	Self	5	2.17
	Health care worker	37	16.09

It was noted that majority of the participants' 114(49.6%) distance to the nearest health facility is 1-5km followed by 82(35.7%) who cited a distance of 6-10km and the minority 34(14.8%) said the distance was less than 1km. Findings showed that majority of the participants' 103(44.8%) accessed the maternity by walking followed by 84(36.5%) who used motor cycle and 43(18.7%) used motor vehicles.

It was observed that majority 153(66.5%) of the participants did not discuss with their spouses matters relating to reproductive health while 77(33.5%) agreed that they discussed with their spouses. On the other hand, majority 150(65.2%) of the participants'

did not plan on where to deliver while 80(34.8%) said they planned on where to deliver. More so, mostly decision on where to deliver were made by the participants' themselves 132(57.4%) with 50(21.7%) being made by mother in laws, 27(11.7%) made by husbands and the minority 21(9.1%) decided by the participants' mothers.

Results show that majority of the participants who had home delivery were assisted by Traditional Birth Attendants (TBAs) followed by 66(28.7%) who were assisted by their mothers-in-laws. However, 20(8.7%) said that they were assisted by friends, 37(16.1%) assisted by health workers and minority 5(2.2%) assisted themselves.

4.5 Fetomaternal Outcomes

The second objective of the study was to determine the fetomaternal outcomes following a home birth among women in Marakwet East in Elgeyo Marakwet County. This was further analyzed as shown in table 3.

Table 3 Fetomaternal outcomes. N=230

Variables	Categories	Frequency	Percentage
Dangers of home delivery	Yes	214	93.04
	No	16	6.96
Gestation at birth	Term	210	91.30
	Preterm	10	8.70
How preterm baby was managed	Taken to hospital	10	4.35
	Treated at home	10	4.35
	Not applicable	210	91.30
Condition of baby at birth	Baby cried	181	78.70
	Baby did not cry	49	21.30
Action taken when baby did not cry	Taken to hospital	27	11.74
	Herbal medications	22	9.57
	Not applicable	181	78.70
Postpartum hemorrhage	Yes	53	23.04
	No	177	76.96
Remedy to blood loss	Taken to hospital	40	17.39
	Herbal treatment	13	5.65
	Not applicable	177	76.96
Post-delivery experience	Foul smelling	29	12.61
	discharge	21	9.13
	High temperatures	180	78.26
	Normal		
Retained placenta	Yes	36	15.65
	No	194	84.35
Treatment of retained placenta	Taken to hospital	20	8.70
	Herbal medications	16	6.96
	Not applicable	194	84.35
Perineal tears	Yes	141	61.30
	No	89	38.70
Management of perineal tears	Stitched	73	31.74
	Not stitched	68	29.57
	Not applicable	89	38.70
Uncontrolled urine	Yes	17	7.39
	No	213	92.61
Management of uncontrolled urine	Taken to hospital	8	3.48
	Herbal medications	9	3.91
	Not applicable	213	92.61

Findings reveal that majority of the participants 214(93%) agreed that there were danger associated with home delivery while minority 16(7%) disagreed. Some of the dangers

cited included bleeding after delivery, birth asphyxia, maternal death, neonatal death, infections for mother and neonate, retained placenta, perineal tears. It was observed that most participants' 210(91.3%) had a full term gestation period while 20(8.7%) had a preterm gestation period. Besides, 10(4.3%) of the participants' who had preterm gestation were taken to hospital with a similar proportion of participants 10(4.3%) being treated at home.

Results indicated that majority of the participants' 181(78.7%) heard their babies cry after they were born while minority 49(21.3%) did not. The participants' 49(21.3%) whose babies did not cry took some action with regards to the condition and majority 27(11.7%) sought assistance in hospital with 22(9.6%) opting for herbal treatment. Those who did not respond on action taken when baby did not cry 181(78.7%) were those participants' whose babies did not experience the said challenge.

Findings showed that majority of the participants' 177(77%) did not experience a lot of blood lose after delivery while minority 53(23%) did experience a lot of blood lose. Participants' who experienced blood lose took some action to curb the problem whereby 40(17.4%) sought for assistance in hospital while 13(5.7%) opted for herbal treatment. The participants' who did not respond on the action taken 177(77%) did not experience blood lose. Results show that 29(12.6%) of the participants' experienced foul smelling discharge, 21(9.1%) experienced high body temperature and 180(78.3%) had a normal experience. Majority of the participants' 180(78.3%) had a normal delivery experiences while minority 21(9.1%) experienced high body temperatures.

It was observed that majority of the participants' 194(84.3%) did not have a retained placenta after delivery while 36(15.7%) did experience retained placenta. The participants' who had retained placenta took some action where 20(8.7%) sought assistance from the hospital while 16(7%) were given herbal treatment. The 194(84.3%) who had no response are those who did not experience retained placenta. Findings reveal that majority of the participants 141(61.3%) experienced tears of the perineum whereby 73(31.7%) of them said they were stitched with 68(29.6%) admitting that they were not stitched. However, minority 89(38.7%) did not experience tears of the perineum. Findings reveal that majority of the participants' 213(92.6%) did not experience uncontrolled urine while minority 17(7.4%) experienced uncontrolled urine after delivery where 8(3.5%) of them sought assistance in hospital with 9(3.9%) opting for herbal treatment.

4.6 Logistic regression analysis findings reasons of home birth

Table 4 Logistic regression analysis

Variable	Category	COR (95% CI)	P-Value	AOR(95% CI)	P-Value
Age	26-35	1.54(0.63-3.78)	0.345	0.85(0.27-2.72)	0.790
	36-45	1.29(0.51-3.29)	0.588	0.57(0.17-1.94)	0.371
	46-49	3.68(0.43-31.77)	0.233	5.86(0.38-90.25)	0.205
Marital status	Single	1.60(0.62-3.78)	0.336	8.91(0.16-490.12)	0.285
	Widow	0.94(0.35-2.51)	0.898	4.05(0.17-98.06)	0.390
Level of education	Secondary	1.01(0.42-2.45)	0.977	0.78(0.19-3.16)	0.728
	Tertiary	1.02(0.4.-2.58)	0.967	0.90(0.18-4.57)	0.904
Spouse education level	Primary	1.05(0.41-2.72)	0.918	1.79(0.21-15.21)	0.595
	Secondary	0.82(0.18-3.71)	0.800	5.89(0.01-4052.86)	0.595
	None	1.29(0.43-3.88)	0.654	1924.88(0)	0.993
Occupation	Self employed	1.30(0.28-6.10)	0.737	1.95(0.27-14.19)	0.509
	Formal employment	0.74(0.20-2.84)	0.665	1	0.986
	Casual laborer	0.88(0.37-2.13	0.783	8.46(0)	
Partners occupation	Self employed	1		1	
	Formal employment	0.55(0.22-1.35)	0.190	0.14(0.001-14.23)	0.403
	Casual laborer	0.34(0.12-0.98)	0.046	71.84(0.03-182665.9)	0.285
Distance to Health facility	1-5 Km	1.69(0.67-4.17)	0.253	1.39(0.02-122.75)	0.885
	6-10 Km	3.33(1.16-9.56)	**0.025**	1	
Means of transport	Motor vehicle	1.72(0.60-4.95)	0.315	5.54(0.03-667.27)	0.552
	Motor cycle	1.24(0.57-2.68)	0.592	4.91(0.04-623.81)	0.520
Decision on where to give birth	Mother	0.26(0.04-1.48)	0.128	1.10e-06(0)	0.996
	Mother-in-law	0.25(0.05-1.23)	0.088	1.15e-07(0)	0.995
	Self	0.51(0.11-2.33)	0.382	3.64e-07(0)	0.996

From the logistic regression analysis, women who lived 6-10 kilometers from a health facility had 3 times higher odds of delivering at home (COR 3.33 95% CI1.16-956 $p<0.025$) compared to those who lived less than 1 kilometer away. Similarly, single

mothers were likely to give birth at home compared to their married and widowed counterparts (OR 2.7, 95%, CI 1.8-3.8, P<0.001). Women who made self-decisions on place of delivery were 0.51 times likely to deliver at home (COR 0.51 95% CI 0.11-2.33 p-value>0.05). Older women (46-49 years) had six times higher odds of delivering at home compared to their younger counterparts, (AOR 5.68CI 0.38-90.25) . Those who used motor cycle as a means of transport had reduced odds of delivering at home, 1.24(0.57-2.68).Single women were 9 times more likely to deliver at home compared to the married (AOR 8.91 CI 0.16-490.12). Women who had attained tertiary level of education were 10% less likely to deliver at home compared to their primary counterparts (AOR 0.90 CI 0.18-4.57)

However, the model did not show a statistically significant relationship between the outcome variable and the predictor variables, based on the p values.

4.7Focused Group Discussion Findings

An inductive approach to data analysis was used, guided by 7 questions based on the five determined themes and sub themes as follows:

4.7.1 Theme 1- Reasons for Home delivery

This theme focused on the FGDs respondents reasons on home births. Overall all the respondents from the four FGDS had similar reasons as stated below.

Sub-theme 1.1 Lack of means of transport

This subtheme focused on means of transport as one of the main reasons for home birth. It was found that long walking distance to the health facility which is made worse by

poor roads, hilly topography along the valleyregions and lack of means of transport were reasons why most women could give birth at home.

They had this to say;

> *"Lack of means of transportation issues especially during the night makes us not to go to hospital for delivery."(FGD 1, 39 years old)"Walking Distance to the health facility is a big problem for women in some villages. The roads are not passable during rainy seasons so many women will not think of going to the hospital". (FGD 1, 27 years old)*

Sub-theme 1.2 Cultural influences and fear of hospital birth

In this subtheme women mentioned the following as reasons for home births: Decisions on place of birth are made by their parents because some are single, underage and are dependent on them for decisions making. Moreover Mother in-law influences and trust for TBA since they were sensitive to customary practices i.e. cultural passage of rites (FGM) that demands privacy and confidentiality. They cited that they are not allowed to expose themselves to those who have not undergone the cultural passage of rite. In addition, some reported that they fear hospital birth due to bad prior experience at the health facility, episiotomy repair after birth and aversion of caesarian section. Some of them said that since they had experienced prior good birth outcome they opt to give birth at home

"I want to deliver at home because the TBA who will deliver me will always be available during labor and child birth – she is the one who will light a good fire for me. They are friendly in talking to the mother". (FGD 2, 32 years old)

"Culture and FGM- we women who have undergone FGM fear to deliver in a health facility since we fear being attended by health workers who have not undergone FGM. It's like abusing secrets that we received during FGM."(FGD 4, 39 years old).

"Decisions are made by our parents, some of us are not married and we rely on parents". (FGD 1, 18 years old)

Sub-theme 1.3 Insecurity

This sub theme focused on insecurity which was mentioned as one of the reason for home births. Inter- community animosity has instilled them with natural fear to travel out of their homes during the day and at night. This requires an additional support from the security government agents which is not feasible, hence making women to give birth at home when they are in labor.

"Some of us live far away; and insecurity is a problem in our area. You know when one starts to feel the pains, when she begins to walk, she can deliver in the on the way or in the forest which is very risky" (FGD 3, 17 years old)

Sub-theme 1.4 Precipitated labor, staff attitude,

Lastly some of the reasons established included precipitated labors which they noted with concern that you can't make to a health facility despite nearness to a healthy facility. In addition, Staff attitude especially with prior experience of hospital birth. This they reported that any woman who gets bad experience during a hospital birth will definitely develop fear and give birth at home

"Sometimes the labor pain may begin, and by the time you need to organize to go you find yourself already the waters have ruptured and you want topush, therefore you give birth under any one around at that time."(FGD 2, 30 years old)

Theme 2- Fetomaternal outcomes experienced during home birth

This theme focused on the fetomaternal outcomes after home birth. Most of the respondents had a feeling that most home births had been normal but with some women experiencing bad outcomes as stated below.

Sub-theme 2.1 Maternal outcomes

Some of the maternal outcomes cited in this subtheme include: PPH immediately or after some days and retained placenta which is characterized by excessive bleeding than normal and one can even fall down due dizziness, Maternal injuries like tears of the perineum, pelvic injuries, maternal sepsis and maternal deaths.

Members from FGDs expressed as:

"I had a tear of my private parts (perineum), and it was not easy to heal. After delivery there was a lot of Bleeding, Infectious after some days which was characterized by shivering and hotness of the body" (FGD 2, 23 years old)

"Women have gone through a lot like me I had a retained placenta which made me to bleed excessively. It was bad it took a lot of minutes to come out; I was given herbal to help the placenta come out" (FGD 1, 16 years old)

Another woman added

"Oh I got itching after giving birth at home, I kept on itching and then it took long for the wound on my perineum to heal."(FGD 2, 20 years old)

Sub-theme 2.2 Neonatal outcomes

This subtheme focused on neonatal outcomes for homebirths which included; difficulty in breathing of the newborn, neonatal sepsis, neonatal injuries and neonatal death.

Some of them said:

"Where I come from, the baby had difficulty in breathing and didn't cry immediately after home birth" (FGD 4, 33 years old)

"Umbilical cord of my baby took long to heal too, because of unconducive environments at home "Was characterized by shivering and hotness of the body". (FGD 2)

Theme 3-What Free Maternity Policy is and when it was implemented

This theme main aim was to understand from members if they knew what free maternity policy was and when it was implemented in their area.

Sub-theme 3.1 Meaning of free maternity policy

Respondents under this subtheme who had never had hospital delivery (FGD1) were not aware what free maternity policy was all about and even the implementation period but most of the members in the other 3 FGDs knew what the policy is all about and knew when it was implemented. However most of them confused with the first lady (beyond zero campaign). They heard about it during their visit to the antenatal clinic and during the political campaigns in their area.

Some of the members had this to say:

"We know what free maternity policy is- it is a service whereby the woman since the start of ANC till delivery incurs no costs" (FGD 4, 25 years old)

"It started since the last election (2013) no exact date/period" and we were told that women go to clinic and they don't pay anything up to delivery" (FGD 3, 28 years old)

Theme 4- Benefits and demerits of Free Maternity Policy in their area

This theme focused on the benefits and demerits of free maternity policy which they have encountered in their area since its inception

Sub-theme 4.1 Reduced birth costs

This subtheme focused on reduced birth cost as a merit of free maternity policy. It was noted that a substantial financial burden is relieved with the introduction of free maternity policy and No costs encountered at the health facility during child birth and their children can now have school fees paid with the money which could have been used for maternity services.

"The women who go to give birth in healthy facilities go there because they will get free services with free basic supplies such as basins, slippers but only if you are in the hospital on time" since no costs are encountered during this period"(FGD 4, 38 years old)

Sub-theme 4.2 Increased good birth outcomes.

Furthermore this subtheme cited that there's reduction on bad outcomes to mothers who have homebirths if taken to hospital on time since no cost will be incurred.

"In my village maternal and neonatal deaths have reduced since mothers and neonates with complications that used to occur at home are taken to hospital in time they will be taken for by skilled health professionals."(FGD 2, 22 years old)

Sub-theme 4.3 Demerits of free maternity policy

However in this subtheme they cited the introduction of free maternity policy as the source of congestion in the health facility hence issues of privacy and confidentiality affected. This is because they reported that culturally they are not allowed to expose their private parts to those who have not undergone cultural passage of rite. Health care givers few and they cover a wide area of the hospital. Ultrasound charges are not included until otherwise you are admitted so if an ultrasound is to be done you have to look for money

for the same. Some women have lost valuable times in the health facility as they wait to give birth since maternity services are free.

"This free maternity policy does not cover ultrasound and outpatient so we are forced to look for other amount to pay for such services during antenatal period." (FGD 2, 29 years old)

"Even if it is free Daktari……there a lot of congestion, There is no privacy and confidentiality Daktari; even the nurses no longer give advice on use of family planning methods / breastfeeding because she has many clients to attend to since the introduction of free maternity policy and she is alone on duty covering all the facility at night" (FGD 4, 34 years old)

Theme 5- Thoughts about free maternity policy

This theme focused on what mothers thought about free maternity policy:

Women cited it as helpful due to some fee exemption. Contrary they cited congestion affecting their privacy and confidentiality. In contrast, poor roadwork network, lack of means of transport to reach hospital on time, with inadequate infrastructure and few skilled birth attendants at healthy facility has made them not realize its effectiveness.

"Free maternity is good to our communities our communities, since no costs are Encountered at delivery, and they should also include services of ultrasound during antenatal period. Increase staff at health facilities and this policy should be sustained for improvement of maternal and neonatal health" (FGD 4, 30 years old)

CHAPTER FIVE

DISCUSSION

This chapter presents discussion of the findings and results on the study.

5.1 Reasons for home delivery

From this study, it was established that most women in Elgeyo Marakwet County had home births (83%). Some of the reasons found were lack of birth preparedness, lack of partners involvement in decisions pertaining place of birth and lack of autonomy to decide on the place of birth because most of these mothers were single and young, this study agrees with study by(Sialubanje et al., 2015)in Zambia which showed that most women give birth at home due to several individual, family and health system-related factors including women's low risk perception regarding their personal susceptibility to labor complications, lack of involvement of spouses, and lack of decision- making autonomy regarding child birth. This finding is also supported by (Tekelab et al., 2015) which showed that women in western Ethiopia lack autonomy in utilizing maternal and health services.

Women who depended on their husbands for financial support were more likely to deliver at home because they could not make decisions for themselves on where to deliver. The mothers reported that the decision was based on whether the husband is able to provide the money needed for transportation and other needs. This finding correlates with that of a study in West Pokot that showed that being a housewife negatively impacted on their ability to deliver in hospital (Ogolla, 2015). This is also supported by a study done by (Yego et al., 2013) that the cost of hiring a local car or motorbike ranged

from KSH1000 up to KSH2000 depending on the distance between the home and the facility.

Furthermore, this study showed that distance, poor topography, lack of means of transport and poor road networks to the health facility were hindrance for hospital birth. This agrees with a study in West Pokot with a similar finding. Women who had their labor beginning at home or during rainy seasons were more likely to deliver at home. (Ogolla, 2015). It further agrees with a study done in Kenya that found out that women(50%) cited distance or lack of transport as the main reason for delivering at home(Kitui et al., 2013). It also complement a study done by (Bhattacharyya et al., 2016) which found out that poor accessibility of the institution is a very important determinant of a woman's preference for home births. Furthermore this finding is supported by (Yego et al., 2013) who argued that to travel to health facilities, families have to hire a local vehicle, which may or may not be available when needed and during the rainy season some roads become impassable.

From the logistic regression analysis, women who lived 6-10 kilometers from a health facility had 3 times higher odds of delivering at home (COR 3.33 95% CI 1.16-956 $p<0.025$) compared to those who lived less than 1 kilometer away. Rahman et al… in their study in Bangladesh also identified poor road conditions and limited transportation as a reason that prevents women from delivering in health facilities this differs with a study by (Mwaliko et al., 2014a) which found out that long distance to a healthy facility was not a factor affecting place of delivery.

Cultural practices were also cited as reasons of home births; this included trust for TBAs since they are valued as experts in birth due to experience. They are also sensitive to customary practices and they offer the privacy and confidentiality required by women who have undergone cultural passage of rite since they are allowed to expose to anyone who hasn't undergone the rite. Moreover the TBAs are friendly and always available in the community. This finding correlates with (Bhattacharyya et al., 2016) who found that women consider the Traditional Birth Attendant (TBA) as a culturally acceptable and competent health worker. Living in the same community, she offers respectful, prompt care and personalized attention to the woman during delivery. This is also consistent with (Harvey, 2015) who found out that negative cultural and religious practices make women deliver at home. This is further complemented by a study done in In Bangladesh and India which has a MMR of 176 and 174 respectively per 100,000 live births, deliveries do still take place at home (62%) and more than (56%) deliveries are assisted by traditional birth attendants (TBAs) or relatives this are attributed to identified wide range of factors, including; traditional views, strong faith in TBAs and their experience, prevailing religious beliefs like women are not allowed to expose their sexual organs to men,(Sarker et al., 2016).

It was further established that women give birth at home because of precipitated labor despite of nearness to a healthy facility, fear of episiotomy repair, and aversion from caesarean section. This finding supplement a study by(Kitui et al., 2013) who found that women living near a health facility reported delivering at home due to abrupt child birth main barriers to health facility and more so the fear of undergoing a caesarean delivery at health facilities due to cost implication (Sarker et al., 2016).

In addition, inter- tribal animosity was also established a reason of giving birth at home since most women feared for their lives during such days, therefore any woman who goes into labor gives birth at home for safety .This finding is consistent with a study ((Harvey, 2015)in eastern part of Kenya; Mandera, which highlighted that the problems for home births are driven by; lack of access to quality maternal health services including ante-natal, giving birth, and post-natal services due to insecurity.

5.2 Fetomaternal Outcomes

Findings revealed that majority of the participants 214(93%) agreed that there were dangers associated with home birth. Some of fetomaternal outcomes established included; PPH, perineal tears and birth asphyxia. It was also found that, PPH was one of the danger outcomes which could be fatal if one is not rushed immediately to a health facility. This is in accordance to a study by (Mpemba et al., 2014) which stated that in areas where essential care and skilled health attendants are limited, PPH is the leading cause of MMR globally and African policy makers have to wake up and educate the community on the importance of seeking skilled health care instead of TBAs and traditional healers. To curb maternal and neonatal morbidities and mortalities, basic equipment should be availed and skilled birth attendants should have basic skills on Emergency Obstetric Care for timely referral to health facilities with such capacities.

Findings showed that 53(23.04%) experienced a lot of blood lose after delivery and with retained placentas at 36(15.65%) and infants born with difficulty in breathing 49(21.30%) missed the initial care which is of great importance in curbing maternal and neonatal

morbidities. A study done in the slums of Kenya showed that women who gave birth at home missed a lot of immediate care and thereafter care , most of them could stay at home hence missing proper follow up care (Izugbara & Ngilangwa, 2010). This indicates that the proportion of women that stayed at home without proper follow up were at a higher risk of developing further complications which might lead to death. This also correlates with(Marete et al., 2014) in their global network study which they found that a third of the women who delivered at home where associated with high prenatal and neonatal deaths.

In addition findings revealed cases of maternal and neonatal deaths as fetomaternal outcomes. These outcomes are preventable but it was established that women give birth at home get delayed in arriving to a health facility due delayed transfers and deficient knowledge on how to manage complications by the TBAs. This correlates with findings by (Maawiya, 2018) which noted the overall prevalence of adverse maternal and perinatal outcomes in Lamu, Kenya was 15.8% i.e. 7.5% following health facility deliveries and 8.25% following home births and two maternal deaths occurred due to late referrals after a home birth.

5.3 Perception on free maternity policy

Qualitative findings on perception of women towards free maternity policy revealed that most of them knew about the policy since inception. Some women felt that the introduction of free maternity policy is the main cause of congestion at the health facilities, therefore affecting their privacy and confidentiality due to lack of adequate infrastructure allowing women to share beds. Factors such as few skilled birth attendants

and improper infrastructure has made the feasibility of free maternity care not fully realized. This is consistent with a study done by Moyer and Mustafa (2013) who opined that safe motherhood initiatives such as the provision of free maternity services are still being underutilized by many women in Kenya especially those in poor, rural, and remote settings of the country which has led to extremely high rates of MMRs. In contrast a study in Burkina Faso, revealed that women perceived satisfaction and an increased use of birth delivery services caused by the abolition of maternity fees which suggest that a substantial financial burden is relieved with total fee exemption but other factors such as functioning health system, community awareness, infrastructure should be improved ,thus satisfaction is guaranteed (Philibert, Ridde, Bado, & Fournier,.2014).

Some of merits of the free maternity policy included increase of women and infants who were treated for complications after home births hence decrease in maternal and neonatal deaths. This is concurrent with a study in Nairobi county reported a direct relationship between patient satisfaction and utilization of free maternal healthcare services in public hospitals by women. (Otieno et al., 2014)

CHAPTER SIX

CONCLUSION AND RECOMMENDATION

This chapter presents the conclusion and recommendations from the findings and results on the study.

6.1 Conclusion

Most women in Marakwet East had home births. Main reasons for home births were; poor birth preparedness coupled with lack of involvement of their partners on place of delivery and trust for TBAs. Most women walked to the health facilities due to lack of means of transport. Coupled with poor topography, this made it hard for the women to get to the health facilities on time. Moreover other factors found were cultural beliefs, fear of episiotomies, aversion of caesarean section, precipitated labor and insecurity.

Fetomaternal outcomes associated with home birth included; PPH, perineal tears and birth Asphyxia. In addition, some of the outcomes found were puerperal and neonatal sepsis, urine leakage and neonates being born as preterm at home.

Introduction of free maternity policy was seen as the source of congestion in the health facility hence privacy and confidentiality of women who had undergone cultural passage rite affected due lack of infrastructure. This is because they reported that culturally they are not allowed to expose their private parts to those who have not undergone cultural passage of rite. However, it was noted that a substantial financial burden is relieved with the introduction of free maternity policy and reduction on bad outcomes to mothers who have homebirths if take to hospital on time.

6.2 Recommendations

County government to invest more on health education of the mothers on birth preparedness, dangers associated with pregnancy, child birth, postpartum period and importance of hospital delivery. Traditional birth attendants be educated to act as ambassadors in referring patients in labor to deliver in a hospital setting.

Moreover midwives with current education on midwifery and neonatal nursing should be posted to the community level to offer evidenced based care that will increase uptake of maternal and neonatal services and therefore positive outcomes.

To improve road networks for availability of means of transport for easy access to health facilities and upgrade health facilities to provide comprehensive obstetric care.

The county government to bench mark in counties that have shown a milestone in reducing home births. This will enable policy makers adapt the practices that could see the county achieving a no zero to maternal and neonatal death which is also a national policy target.

To improve beyond zero campaign initiative to reach hard to reach areas of the county to cater for distance and insecurity reasons for home births.

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APPENDICES

APPENDIX I: INFORMED CONSENT AND EXPLANATION OF THE CONSENT

TITLE OF THE PROJECT: DETERMINANTS OF HOME DELIVERY AMONG WOMEN IN ELGEYO MARAKWET EAST IN ELGEYO MARAKWET COUNTY

Introduction

My name is Mary Jepkemboi Kwambai, a student undergoing master's degree at Moi University, School of Nursing, undertaking the above named project. I would to collect information regarding reasons of home delivery, outcomes of the deliveries which happened at home and the perceptions of free maternity care policy.

Purpose of the study

Mothers are very important persons in our societies as without them, there would be no generations to come yet they are faced with many challenges and unfortunately, their issues may not be recognized and addressed. Women are expected to bear children and play an important role of motherhood as they raise their children into responsible adults.

During pregnancy and child birth however, many women especially in the developing world lose their lives due to complications during pregnancy and childbirth yet pregnancy is not a disease but a normal physiological process. To improve maternal health, it is important to find out where women deliver their children and who attends to them as well as reasons behind their choices so as to make recommendations to the health authorities and policy makers on how they can come to the rescue of mothers by providing the necessary health services and facilities to make pregnancy and childbirth safer. However, I need your permission and cooperation to collect information on your experiences and constraints.

Procedure

If you agree to participate in the study by signing the section at the end of this form, you will be interviewed on your reasons of delivering at home, the outcomes of home delivery and the perceptions you have towards free maternity policy.

Benefits

With the findings, we shall be in a better position to advise health authorities and policy makers on the best ways of improving maternal health not only in the study area but also in Kenya.

Confidentiality of the records

Any records relating to your household information will be maintained in confidence. Your names will not appear in any of the reports from this study. No identity of any specific individual will be disclosed in any public reports or publications.

Obtaining additional information

You are encouraged to ask any questions to clarify any issues at any time or ask questions at any time during your participation in the study. If you later think you need more information you may call the researcher on 0720-790-726

Basis of Participation

• You are being requested to participate in this study.

• Participation is entirely voluntary.

•You are free to withdraw the consent to participate in this study at any time.

• You are free to ask any questions concerning the study which may not be clear to you after the consent had been explained to you

I,…… the undersigned have understood the above information which has been read and explained to me by the researcher and I voluntarily consent to participate. I have had the opportunity to ask questions and all of my questions have been answered satisfactorily.

Name of Respondent …….. Date…….

Signature……

APPENDIX II: QUESTIONNAIRE IN ENGLISH AND MARAKWET

Determinants of Home Delivery among Women in Marakwet East in Elgeyo Marakwet County ?amunesi kosichechepyo soklago kenggaaeng Marakwet East eng Elgeyo Marakwet County

Questionnaire Number: _____ Name of facility: _____

Name of interviewer: _____ Date of interview: _____

SECTION A

SOCIO-DEMOGRAPHIC DATA

1. Mother's Age group/ kenyisikekab chepyoset (Please tick one):

   a) 15-25 [ ]
   b) 26-35 [ ]
   c) 36-45 [ ]
   d) 46-49 [ ]

2. Marital status /katunisiet

   a) Married [ ]
   b) Single [ ]
   c) Widow [ ]
   d) Separated [ ]

3. Level of highest education attained /ole kiitengsukul

   a) Lower Primary (Class 1-3) [ ]
   b) Upper Primary (Class 4-8) [ ]
   c) Secondary[ ]
   d) Tertiary (college/university) [ ]

4. Spouse highest level of education/ole kiitboiyotengsukul

   a) Lower Primary (Class 1-3) [ ]
   b) Upper Primary (Class 4-8) [ ]
   c) Secondary [ ]
   d) Tertiary (college/university) [ ]

5. Religion /kaniset

a) Christian [ ]
b) Muslim [ ]
c) Traditional [ ]
d) Others (Specify) …….

6. How many children do you have? Lagokchetinyei

Alive ……..

Deceased ……..

Total ……..

SOCIO-ECONOMIC STATUS

1. What type of house do you live in (Tick appropriately) /imenyekotneu nee

a) Permanent (stone/brick walled [ ]
b) Semi-permanent (timber walled) [ ]
c) Temporary (mud walled) [ ]
d) Other .....

2. What is your occupation? /Iyoenee

a) Unemployed [ ]
b) Self-employment [ ]
c) Formal employment [ ]
d) Casual laborer [ ]

4. What is the occupation of spouse? (If Married)?Yoeboisiet nee boiyot?

a) Unemployed [ ]
b) Business [ ]
c) Formal employment [ ]
d) Casual laborer [ ]

5. What are your sources of income in order of priority?/bunuanorobinikchoboishe?

a) ……
b) ……
c) ……
d) ……

REASONS FOR HOME DELIVERY

1. How far from your home is the nearest maternity facility? (Approximate in km) loo netiahospitaliak ole omenye?

a) Less than 1km [ ]
b) 1-5 km [ ]
c) 6-10km [ ]
d) Over 10 km [ ]

2. How do you get to the maternity facility? Ibune nee iwendibisichelakwet?

a) Walk [ ]
b) Motor vehicle [ ]
c) Cycle [ ]
d) Other means (specify) ……..

3. Do you discuss reproductive health issues like the choice of delivery place with your husband?/ongololeiakboiyongungilebisichinilakwet?

a) Yes [ ]
b) No [ ]

4. Do you decide/plan where to deliver your children? /Ichobokekotomobisichlakwet?

a) Yes [ ]
b) No [ ]

If no, who decides?/ngotkoolokongo ne wauun?

a) Husband [ ]
b) Mother [ ]
c) Mother-in law [ ]
d) Other (specify ……..

5. Where did you deliver your children? Kisichianolagokuk?

Place	Number of children
Home	
Health facility	

6. Why did you deliver at home? amunesisichlakokenggaa?

a) ……
b) ……
c) ……
d) ……
e) ……
f) ……
g) ……
h) ……....
i) ……...

OUTCOMES

1. Are there any dangers in delivering at home?/toos mi kaimutikngotkisigichilagokgaa

a) Yes [ ]
b) No [ ]

If yes, please name a few dangers that you know of/mwaakaimutikchotok?

……
……
……
……
……
……
……

2. What was the gestation of the baby at birth?/kiaroekatalakwet?

a) Term [ ]
b) Preterm [ ]

If the baby was pre-term, what was done?kokitomkoitaroekkiyai nee?

a) Taken to hospital [ ]
b) Treated at home [ ]
c) Others(specify)……

3. What was the condition of the baby?/kiu nee lakwetisiche?

a) Baby cried [ ]
b) Baby did not cry [ ]

If the baby did not cry, what action was taken?yokimarirlakwetkokikiyainee?

a) Taken to hospital [ ]
b) Herbal treatment [ ]
c) Others (specify)……

4. Did you lose a lot of blood after delivery? Toskirangtekorotikchechangkokaichutko

a) Yes [ ]
b) No [ ]

If yes, what was done? Kikiyainee

c) Taken to hospital [ ]
d) Herbal treatment [ ]
e) Others (specify)……..

5. Did you experience the following after delivering at home? toskiroocherubekokaitorretkei?

a) Had foul smelling discharge [ ]

b) Body temperatures were high [ ]

c) Normal [ ]

6. Did you have a retained placenta after delivery?/ Toskingetkotablawetkokaichutko?

a) Yes [ ]

b) No [ ]

If yes how was it removed? ngoimaankikinyainee?

a) Taken to hospital [ ]

b) Given herbal medicine [ ]

c) Others specify…….

7. Did you sustain any tears of the perineum after birth? /Toskiuumian kokaichutko

a) Yes [ ]

b) No [ ]

If yes how was it managed? /Ngotkoimaan kokikiyainee?

a) Stitched [ ]

b) Not stitched [ ]

8. Since delivery at home have you ever had uncontrolled urine leakage? /ngonget kokechut kotosbwaneiso kosechiche keikomenai?

a) Yes [ ]

b) No [ ]

If yes how have you managed? /ngotkoimaankokiyai nee?

a) Taken to hospital [ ]

b) Given herbal medicine [ ]

c) Others specify……..

APPENDIX III: FGD INTERVIEW GUIDE

TOPIC: DETERMINANTS OF HOME DELIVERY AMONG WOMEN IN MARAKWET EAST IN ELGEYO MARAKWET COUNTY

My name is Mary Jepkemboi Kwambai I am a student of Moi University School of Nursing. Before we start I would like to welcome you to this meeting and thank you all for coming. This is a participation and discussion group for all of you and everybody has an equal opportunity to contribute to the discussion. Let me encourage you to speak your minds freely and that there are no right or wrong answers in this discussion. At the end of the discussion, the contributions will be treated as having come from the group and not an individual.

Informed consent

I have understood the above information which has been read and explained to me by the researcher and I have had the opportunity to ask questions which have been answered satisfactorily. I voluntarily consent to participate in the focused group discussion.

Participant's Signature

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

The introduction of free maternity care policy was introduced and was meant to remove the burden on costs usually incurred when a woman becomes pregnant till delivery of the baby, and some women still deliver at home with unfavourable outcomes. I therefore want to know the following.

- What are some of the reasons why women deliver at home?
- What are some of the fetomaternal outcomes that you have encountered with women who deliver at home?
- Do you know what free maternity policy is?
- Since when was it implemented in your area?
- What are some of the benefits you have encountered since the inception of the free maternity policy?
- What are some of the disadvantages of free maternity policy since inception?
- What are some of your thoughts about the free maternity policy since inception?

I have understood the above information which has been read and explained to me by the researcher and I voluntarily consent to participate in the focused group discussion. I have had the opportunity to ask questions and all of my questions have been answered satisfactorily.