RELIGIOUS FACTORS AFFECTING UTILIZATION OF MATERNAL HEALTH SERVICES AMONG NOMIYA CHURCH FAITHFUL IN ALEGO-USONGA SUB-COUNTY, KENYA

BY

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DECLARATION

This research project is my original work and has not been submitted for award of a degree in any other university.

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DEDICATION

I dedicate this work to my daughter Christa, sons Mikki and Ethan, wife Carolyne who have seen my toil and journey to the completion of this thesis. This work is also dedicated to my sister Julia who has been supporting pillar and counselor.

My abounding love to you all.

ABSTRACT

Approximately 99% of all maternal deaths occur in developing countries. Previous studies have shown association between religious factors with maternal morbidity and mortality. However most of these studies have been quantitatively resulting in limited explanations on religious beliefs and practices that determine utilization of maternal health services. Whereas Kenya has reduced MMR to 362 per 100,000 live births, Siaya County still has a MMR of 691 per 100,000 live births, 4+ANC visit at 60%, skilled birth attendance at 61%, PNC at 50% and contraceptive prevalence rate at 62%, rates far below the threshold. Nomiya church has an apostolic healthcare system that promotes utilization of alternative maternal health services. Qualitative studies are yet to give explanations on how beliefs and practices affect utilization of maternal health services. Therefore, this study explored how religious factors affect utilization of maternal health services by Nomiya church faithful's. Specifically, the study sought to find out health seeking practices, to examine how religious beliefs affect utilization of maternal health service and lastly to find how religious practices affect utilization of maternal health services by Nomiya Church faithful's in Alego-Usonga Sub-County. Andersen behavioral Model of healthcare utilization (1995) was used to show how the population characteristics and health behavior affect utilization of maternal health services. In this qualitative descriptive study design, data was collected to saturation from 22 women of reproductive age who were Nomiya church faithful's. Informants were purposively recruited using snowball sampling technique. Participants were interviewed using an in-depth interview guide. The data gathered were supplemented by information from focus group discussion with 6 community health volunteers and 7 key informants including a bishop of Nomiya church and 6 health care workers who were purposively selected and interviewed. Interviews were audio recorded. Data were transcribed, translated from '*Dholuo'* into English and reviewed by a qualitative research expert. Data were analyzed thematically. Deductive coding and categorizing of themes was done. Transcripts were uploaded and analysis done using NVIVO Version 6. Findings show that women delay to start ante-natal clinic because of fear of long waiting time for test results and many re-visits demanded. Instead, they were attended to by *'madha'* (church ordained female birth attendant) who have skilled hands in massaging pregnant mothers and conducting deliveries. Mothers in-law prefer women to deliver at home, avoid family planning services with the church teachings asserting that FP initiatives lead to infertility and disgrace women. The Apostolic health system prescribed seclusion that demands the keeping of the mother and the child indoors for 33 to 66 days, with tough preaching against contraceptive use at the end of seclusion. There is need for reorientation of skilled health providers in the delivery of maternal health services, sensitization on skilled healthcare services in the community and to find contextual meaning of the religious practices to eliminate the retrogressive practices.

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ACRONYMS

ANC	Ante-natal care
CPR	Contraceptive Prevalence Rate
CHV	Community Health Volunteer
DHIS	District Health Indicator Survey
DOT	Directly Observed Treatment
FGD	Focus Group Discussion
FGD_000_CVH	Focus Group discussion - Community health workers
FP	Family Planning
HCW	Health Care Workers
IDI	In-Depth Interview informant
IDI_000_NCM	In-depth interview informant - Nomiya church member
IMR	Infant Mortality Rate
KDHS	Kenya Demographic Health Survey
KII	Key Informant Interview
KII_000_B	Key interview informant_ bishop of Nomiya
KII_000_C	Key interview informant – Clinical officer
KII_000_N	Key interview informant – Nurse
KII_000_SCH	Key interview informant – Sub-County Health Promotion coordinator
KII_000_CH	Key interview informant – County health promotion officer
KNBS	Kenya National Bureau of Statistics
MDG	Millennium Development Goals
MH	Maternal Health

MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rate
NC	Nomiya Church
NCM	Nomiya Church Member
NHIF	National Hospital Insurance Fund
SBA	Skilled Birth Assistance
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

OPERATIONAL DEFINITION OF TERMS

- **Health seeking practices** – This was a baseline objective. The objective sought to establish and explore if mothers utilized ANC, SBA, PNC and contraception services. The objective also explored on their experiences while on the service areas, attributes for the sought services, why and how they felt about the services and meaning they have attributed to their experiences.
- **Religious beliefs –** this study focused on the Nomiya church faithful's norms, principles and constructs, prescription and proscriptions influencing their roles, relations and what they attach these to and how these influence their utilization of maternal health and care services they opt to utilize.
- **Religious practices –** this study focused on those Nomiya church religious traditions, systems that the faithful's observe and get involved in performing them, their experiences and meanings they attach to them and how they affect their socialization, seeking of and utilization of maternal health services.
- **Maternal health –** the study has majorly focused on utilization of ante-natal care services, skilled birth assistance, post-natal care and contraceptive services and the exploration into the how, why and what are the religious beliefs and practices that affecting their choice to the kind of care they would prefer for the mother.
- **Traditional birth attendant (TBA) -** unskilled females popularly known for conducting deliveries in the community, often as a business or as a means of sustenance.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Globally, from 2000 to 2017, the Maternal mortality ratio (MMR) declined by 38%, from 342 deaths to 211 deaths per 100, 000 live births (UNICEF/ WHO, 2018). However, approximately 99% of all maternal morbidities and mortalities occurred in the developing countries, see appendix 8. (UNICEF/ WHO, 2018). Whereas, a significant progress in MMR in South Asia with a reduction of 59% (from 395 to 163 deaths per 100, 000 live births) during this period, while Sub-Saharan Africa (SSA) achieved only 39% (from 870 to 533 deaths per 100, 000 live births) reduction (UNICEF/ WHO, 2018). This is still fell far below the United Nations (UN) 2015 targets under Sustainable Development Goal 3, which aims to reduce the global maternal rate to less than 70 deaths per 100 000 live births.

Ante-natal care services ensures that pregnancy is safe, with screening of infections and chronic conditions like anemia in pregnancy, sickle cell disease, diabetes and hypertension , complications of HIV are mitigated upon early. Nutrition, birth planning counseling, challenges of incompetent cervix, placental implantation and fetal anomalies among other complications can be realized early (Omondi & Amolo, 2017; Cahill et al., 2018). Systematic reviews have revealed that the uptake of Ante-natal care (ANC) in developed world of the North and central America's for at-least 1 Ante-natal care (ANC) visit at 97.2% and 4+ ANC visits at 92.6%, uptake in the Sub-Sahara African remained low at 82% for at-least one ANC visit, with the 4-plus ANC visits at a deep low of 53.5% 2017 (Cahill et al., 2018). Barriers to the utilization of ANC services include religious beliefs, misconceptions about pregnancy care, poor attitude of healthcare workers, and insufficient

infrastructure, equipment and staffing (Koenig 2012; Knight, Self & Kennedy 2013). Studies are required to help understand contributions of religious factors on maternal health outcomes.

Skilled birth attendance is important at any point during pregnancy as some births happen early at 28 weeks of gestation and child survival is dependent on the technological capacity of the country to support birth outcomes. Skilled birth attendance prevents maternal deaths that may arise from complications of pre-eclampsia toxemia (PET), big baby, obstructed labour, post-partum hemorrhage, retained placenta and pre-determined Caesarean Section (CS) deliveries, all of which help improve birth outcomes (Ayele et al., 2014; Lowe, Chen & Huang, 2016). Utilization of skilled attendance at birth in 2017 stood at 71%, but in developing countries this rate was at 34% (Omondi & Amolo, 2017; Cahill et al., 2018). It is important to explore the factors affecting utilization of skilled birth assistance in the developing countries where alternative maternal health care systems are rampant.

Post-natal services have been earmarked as a key maternal health service. Near misses in diagnosis at this period would lead to devastating results. Birth complications may lead to severe anaemia, vesico-vaginal or ano-vaginal fistulas, puerperal psychosis or sepsis among other conditions. These may be realized immediately and during puerperal period, some are obvious to realize while others are not (KDHS, 2014; Shahabuddin et al., 2017). In the Sub-Sahara Africa, post-natal care services staggered at a low of 13%, while the uptake of contraceptives among married women realized a slow rise from 23.9% in 2012 to 28.5% in 2017 (Cahill et al., 2018). Use of family planning methods have been associated with improved health, quality of life and raising a family of desired size. Few studies have delved in depth to explain the factors responsible for the low uptake of PNC and contraception services, thus the need for this study.

Religious factors have been reported to influence uptake of ANC, family planning, assisted reproduction services, delivery and post-natal services, aspects that have a great bearing on maternal morbidity and mortality (Amirrtha & Reid, 2007; Lemoine, 2011; Al-Mujtaba et al., 2016). Belief in supreme beings and bad spirits is widely accepted in most African and Spiritual communities, and so are the beliefs on the local community support systems for decision making. Myths and misconceptions that some health conditions affecting mothers require only conventional care while other conditions strictly do not. These multifaceted belief situations creates a veil onto the utilization of maternal health services (Olunga, 2006; Sheik & Kwaak, 2015). Previous epidemiological studies have been lacking in explaining the complex aspects of religion influencing maternal health, as they view social realities as being stable and best analyzed by quantitative techniques (Popay, 2003). Religious threats are best studied using qualitative techniques, which are fluid, having the capacity to add issues of context and meaning to make discoveries with wide applicability with the rich information generated, leading to a broad perspective on the event (Myers, 2000**;** Jones, 2006; Khankeh et al., 2015).

Epidemiological studies done on maternal health have largely been quantitative and have addressed factors like age, HIV status and access to health information, employment, wealth, education level, parity, polygamy, distance to and place of delivery but religious factors, which form part of the construct of maternal morbidity and mortality framework (Omer et al, 2014; Ayele et al., 2014; Al-Mujtaba 2016). Despite the fact that most of these factors largely been addressed, compliance to utilization of key essential maternal health services is still low. Seeking faith based traditional birth attendant's services, adhering to religious traditions limit utilization of maternal health services, which is likely to affect uptake of essential maternal health services (Lowe, Chen & Huang, 2016). Detailed explanations are necessary for in-depth understanding of the religious

traditions to inform policies and interventions for maternal health to understand the statistics on maternal morbidity and mortality.

Studies exploring religious factors are best designed using an interpretivist theoretical perspective. Traditional epidemiology is dominated by a positivist perspective seeing social realities as stable and therefore the best way to analyze it is through the rigorous application of structured techniques (Popay, 2003). Qualitative methods are becoming integral in health service research with epidemiologists more and more recognizing the potential of qualitative evidence. Qualitative research extensively bring out the rich contextual evidence illuminating the black box of complex matters (Jones, 2007; Silva & Fraga, 2017). Generalization is not the primary aim of qualitative studies but the rich information it generates help to explain the contextual factors that have maintained the high maternal mortality ratios in Kenya for decades (Myers, 2000).

Kenya has made progress in improving maternal health outcomes during the last decade (UNICEF/ WHO, 2018; KENPHIA 2018). Basic and emergency obstetrics services have been improved, devolved, policy adjustments abolishing user fees at all public health facilities and there is provision of free skilled birth services. Despite these set of adjustments, unfortunately Kenya did not achieve her Millennium development goal (MDG) for maternal health (UNICEF/ WHO, 2018). As a signatory to the 1994 International Conference on Population Development (ICPD) declaration, emphasis was put on improving the rights of individuals and couples to safe, affordable and acceptable methods of FP of their choice, and to safe pregnancy and childbirth services. Since 1998, the pace of improvement in these indicators has been slow (NCPD, 2013).

This glaring trend of events is due to hesitancy in treatment-seeking behavior by background characteristics which is minimal with no distinct pattern in the women's age, education or household wealth (UNFPA, 2015; KENPHIA, 2018). But unconventional religious factors have been marked known to affect utilization of health services like has been seen with African Spiritual groups like the Kavonokya Church whose members do not use conventional health services, are found Mwingi, Kitui County, Dini ya Musambwa have ways to deal with some health conditions, group found in Bungoma County (Ndabu, 2018). Nomiya Church is a religious community whose headquarter is in Siaya County, have apostolic maternal care system that have not been explored to understand how their systems affect uptake, planning and policy frameworks for maternal health care in the County (Olungah, 2006; Gumo et al., 2012). The church doctrines and practices are highly regarded and respected amongst the members, traditions are sustaining law and order among the adherents.

Nevertheless, accessing health services has been made proximal and universal, infrastructures improved and maternal mortality ratio should have reduced by two-thirds as set by the ministry of health of Siaya County in 2015. In the last two KDHS reports of 2003 and 2014, Siaya County experienced improvements from 44% to 61% in the uptake of skilled birth attendance (SBA), 44% to 50% in uptake of Post-natal care (PNC) and from 2014 to 2017, a rise from 58% to 62% for Contraceptive prevalence rate (CPR). Despite these changes, utilization of maternal health services is below standards, and mothers still experience unnecessary suffering and deaths far beyond the set county government's threshold limits.

1.2 Statement of the Problem

Despite the fact that since 2015 utilization of maternal health services has been on the increase in Alego-Usonga Sub-county, it has still been below standards, and the rate of maternal deaths is 9 times higher than the set target threshold (70 deaths per 100,000 live births) by the county and national governments, as adopted from the WHO set standard. With this study birthed at the juncture of devolution, details on health programs, structures and streamlined statistics were limited for research purposes. The government had been implementing free maternal health services, free primary health care at health systems levels one and two, 'Beyond Zero Campaign' mobile clinics, expanded maternal audits and concerted efforts by partners implementing maternal healthcare programs, but with insignificant increase in the utilization of ANC, SBA, PNC and contraceptive services.

Similarly, to a larger extent, the existing literatures have failed to explain how religious philosophies dictate how mothers seek and utilize health services. Considering contextual religious beliefs and practices affecting utilization of maternal health services requires a flexible approach with fluid techniques to explore meanings and issues of context, which also take innovation, creativity, time and effort to measure complex aspects of utilization of ante-natal care, birth, post-natal and contraceptive services. The few qualitative studies done on religious factors have focused on anthropology, peace, theology, gender and conflict, but also date many years back, none focused on maternal health. Studies focusing on religious beliefs and practices cannot be assessed using statistical tools only. This has left a gap in the in-depth knowledge known about religion as a maternal morbidity and mortality framework factor. Religious beliefs and practices are often described with an iceberg model, where certain elements of the system are visible, but the majority

of the factors that shape behaviour lie well below the surface of awareness. Thus data on religious factors impacting on public health, especially maternal health is scarce in Kenya.

Two (2) previous studies conducted in Siaya identified Nomiya church as one of the religious groups whose practices affect utilization of maternal health services. Nomiya church faithful's form a significant special group in the sub-county in this study. Concentration (17,000) of Nomiya faithful is highest in the region, with its headquarters base in Siaya County. The church's Apostolic maternal healthcare system promotes utilization of church-based mother and child health care services, which are unlike the ministry of health (MOH) and the mainstream churches doctrines that promote utilization of conventional health services. There are no empirical studies among the Nomiya Church faithful who form a significant special sub-group which inform states of maternal health. It is important to zero in these pockets of the communities to find out the 'why', 'how' and 'what' is maintaining the maternal morbidities and mortalities that will be important to inform clinicians, health planners and programs that implement maternal health interventions.

1.3 Objectives of the Study

1.3.1 Broad Objective

To explore religious factors affecting utilization of maternal health services among Nomiya church faithful's in Alego-Usonga Sub-county, Kenya.

1.3.2 Specific Objectives

1. To find out maternal health seeking practices among Nomiya Church faithful in Alego-Usonga.
2. To examine how religious beliefs Sub-County affect utilization of maternal health services among Nomiya Church faithful in Alego-Usonga sub-county.
3. To find out how religious practices affect utilization of maternal health services among Nomiya Church faithful in Alego-Usonga sub-county.

1.4 Research Questions

1. What are the health seeking practices of women of Nomiya Church in Alego-Usonga Sub-County?
2. How do religious beliefs affect utilization of maternal health services among Nomiya Church faithful in Alego-Usonga sub-county?
3. How do religious practices affect utilization of maternal health services among Nomiya Church faithful in Alego-Usonga sub-county?

1.5 Significance of the study

The study results increased our deeper understanding of the maternal health seeking practices and how religious beliefs and practices affect utilization of antenatal care, skilled birth attendance, post-natal care and contraception services. The experiences of women as they interact with their religious institutions and the formal health system seriously hamper optimal uptake of maternal health services as the former has greater influence on women's practices. Further, strong adherence to religious tenets negate gains of maternal health policies aimed at improving utilization of maternal vaccines, antenatal, delivery and contraceptive service. This impacts negatively on the efforts to meet the set targets for the reduction of maternal morbidity and mortality in the County.

1.6 Scope of the study

This study included women aged 15 – 49 years faithful's of Nomiya church, a group considered sexually active and in their reproductive age bracket, living in Alego-Usonga sub-county. The study was purposeful in engaging mothers worshipping in Nomiya Church with under-5 year old children and, or were pregnant to explore on the associated factors affecting their utilization of maternal health services. The study also sought to gain mothers insights on the essence of the

religious beliefs, meanings and experiences regarding religious beliefs and practices affecting their utilization of maternal health services.

1.7 Study limitations

There was no quantitative survey done as a baseline to provide the state of uptake of maternal health services by religion, which would then inform the qualitative investigation that would zero in on a community of Nomiya church faithful's. This means that the findings may be biased towards the very strong adherents of the religion. It is possible that there are other women who use the services of the 'normal' TBAs, others may just deliver at home, while others may utilize the SBA. The diversity in health seeking behavior and experiences among women in this community under study setting is lacking. The challenge of limited literature on maternal health among the Nomiya Church faithful's sets the group as a prime research community. But previous literatures on African Spiritual churches have pointed out the potential of religious factors to affect utilization of skilled health services.

A lack of diversity into the various African Spiritual churches may also limit recommendations. Zeroing into Nomiya religion is a limitation in itself, as there could be other religious beliefs and practices in that community that influence women's uptake of maternal health services that have been left out. The investigator endeavored to do a thorough identification of the Nomiya church faithful's, getting confirmation from the church members, the husband, and also followed the rigorous inclusion criteria as set in the protocol to get to the ideal study participant.

CHAPTER TWO

LITERATURE REVIEW

2.1 Background History of Nomiya Church

In Kenya there are several independent Christian churches that have broken ties with other Christian or Protestant denominations. The largest of these independent churches was the Nomiya Luo Church, whose founder, Johana Owalo, was an early convert to Christianity in 1900. Siaya County hosts the headquarters of the church, with a majority of Nomiya faithful (Adhiambo, 1981). Nomiya church was established with, and still has unique attuning to the Luo traditions and aspirations, with the church maintaining most of the Luo cultural practices like polygamy, baptism of women and children from polygamous families that was not allowed by the European colonial Christian missions, the practice of the levirate, ensured that the widow and their children had their rights to a secure home and adherents claim a biblical basis for this in Deuteronomy 25: 5 – 10, Ruth 4, principles that have far reaching impacts in public health, especially to maternal and child health (Sudhe, Gumo & Iteyo, 2015).

Nomiya church recognizes the presence of spirits that affect adherent's psychological, social and physical health, the church also has vigorous and legalistic taboos that are observed on foods, drinking and smoking (Sudhe, Gumo & Iteyo, 2015). Members also observes patterns of fasting, visions and returning with power, which greatly influence adherents' health and wellbeing, especially the mother and child, who will delay seeking health care while they observe these practices. Nomiya church circumcises newborn boys, as is written in the book of Leviticus 12, and plays by her own rules driven by religious faith, a rite of passage by circumcision and keeping up with the Old Testament traditions (Gwengi, 2017). This is unlike the mainstream churches

doctrines in the County and unlike the Luo tribal, which did not observe circumcision as a rite of passage, but religious tradition is deeply and dearly adhered to by the faithful's.

After 7 days from child birth, it is baptized, circumcised and taken into seclusion, while it is after 14 days that a girl child is only baptized and taken into seclusion. The community has adopted these practices by following biblical teachings in Genesis Chapters 11 – 25. God commanded Abraham to be circumcised at age 99, and his son after 8 days from birth, and this was to be part of generations to come. Then the mother and the neonate are kept indoors in seclusion for 33 to 66 days without being brought outside the house for a boy and girl child respectively. If you did go out of the home with a child, that is considered an "unholy act." A couple is counseled on the traditions before the circumcision (Murigi, 2016; Gwengi, 2017). These practices could expose the child to poor health, because seclusion denies the child chance to get the rich Vitamin D, which is only synthesized by the body when exposed to the sun, which is essential for activation of minerals needed for growth and development. The practice also leads to the child delay of or missing the essentials vaccinations he needs, predisposing the child morbidity and mortality regionally, Siaya County led with infant mortality regionally, and these kind of practices exposes the children to diseases. The child is kept far away from the health care workers who can identify any health conditions during the early neonatal life.

The pregnant mother may in preparation to this prescribed practice plan to have a home birth as they may link skilled birth with being confined at the facility for days, which they see may prevent them from observing seclusion tradition. Occurrence of complications of delivery such as miscarriage may not be registered, leading to omission in vital statistics and the causes of such event. Nomiya church believe in the practice of polygamy, a culture carried on from the Luo

culture. Men are allowed to marry as many as 20 wives, while a widow is allowed to be inherited, a recipe for transmission of HIV (Gwengi, 2017). There is low education levels among women, poor wage employment, high parity levels and strong bonds to religious beliefs and culture (Murigi, 2016; Gwengi, 2017). The above factors can compound communicability of infectious diseases which can complicate pregnancy, child birth and lead to mental health challenges.

Previous studies have underscored that religious and community beliefs affect utilization of maternal and child health services (WHO, 2015; UNFPA, 2015; Gwengi, 2017), with literature from mainstream churches approving modern conventional medical interventions. But there are no empirical qualitative studies done among the Nomiya, a special sub-group of the African Spiritual churches, whose beliefs clearly vary from most of the African Spiritual and mainstream churches, on their health seeking behaviours, beliefs and practices.

2.2 Health Seeking Practices Affecting Utilization of Maternal Health Services

Among regions, women in sub-Saharan Africa face the highest lifetime risk of maternal death (1 in 38), this is about 30 to 90 times more than in the developed countries where the risk of maternal death is 1 in 5,400 (UNICEF/ WHO, 2018). With 13% of the world's population, it accounts for 52% of all maternal deaths especially among the poor and marginalized rural populations globally (Mbugua & MacQuarrie, 2018). Nzioki et al., (2015), UNICEF, (2015), Omondi & Amolo, (2017), UNICEF, (2018), N'Gbichi et al., (2019) reported that causes of maternal morbidity and deaths include hemorrhage, hypertensive diseases in pregnancy, maternal sepsis and complications of delivery and abortion as well as HIV related complications.

Fatality from pregnancy and birth are largely due to poor income, inequitable access to education, sexual reproductive health services including contraceptives uptake, the prevalence of child marriage, local customs, religious and social pressures, inadequate or poorly enforced laws and policies (Shahabuddin et al., 2017; UNFPA, 2017). Women are dependent on decisions of their husbands, are bound by religious and spiritual beliefs coupled with lack of attention of healthcare workers to their healthcare needs and the emotional support by those who have had similar experiences (Omondi, 2013, Birhanu et al., 2012)**.** It is by exploring and understanding these complexities surrounding women's health as this study focused on women of Nomiya church. The results from such enquiries can help policy makers develop standards operating procedures (SOP's), regulations and interventions reversing poor statistics posted in the county for decades regarding maternal health.

Women are cautious going to hospital for ante-natal care or get there late, among other reasons for this behaviour is the fear of mandatory HIV testing (Okomo, 2018), power relational dynamics and negative effects of culture that reduces a woman to a spectator in her own pregnancy (Olungah, 2006). Also, most mothers don't participate in 'birth-planning' health care groups formed by health care workers to inform them on how to keep healthy during pregnancy and even after giving birth, but for religious and cultural reasons, these efforts have been of little impact. Health care workers rarely have information on the causes of maternal deaths (Omondi, 2013). While assessing the factors influencing efficiency of community health strategy in providing maternal and child health services among experts in the health care service provision sector in Mwingi district, Kenya, insights revealed that challenges facing community health workers were religious and community practices (Nzioki et al., 2015).

Nzioki et al., (2015) report recommended that for Kenya to achieve maternal health targets in 2030, efforts should address known issues with emphasis on religious and cultural practices, as most communities are very religious oriented. The plus four (4+) ANC uptake is still below 40% and there is high maternal mortality ratio at 691 deaths in the region (Appendix 4) compared to 316, 531, 583 and 591 deaths per 100,000 live births in the neighbouring Kakamega, Vihiga, Homabay and Kisumu counties, respectively (UNFPA, 2015). In that regard, the health records and County Public Health departments in September, 2016, cited that among the indigenous churches in the county, Nomiya church presented the greatest challenge in achieving maternal health targets, pointing out at their unique beliefs and practices like a special caring strategies for 'their' mother during pregnancy, bith and post-delivery, unlike other churches.

In a prospective qualitative study in Bangladesh by Shahabuddin et al., (2017) exploring maternal health care seeking behavior during pregnancy and delivery among 30 adolescent girls interviewed from the community in two phases. In the first phase all the girls expressed the wish to deliver at home because of their perception of family support during labour while in the next phase, many girls delivered at the hospital following delivery complication. The study revealed that girls try to deliver at home and only when they fail do they go to the nearest hospital. Family members want home deliveries as that is part of their tradition. The girl's intention to deliver at home was because of the perceived threat of performing a CS at the hospital and its potential consequences, it is expensive. Many also reported that a lot of people see their bodies, especially the male doctors seeing your body (Shahabuddin et al., 2017). This study wished to explore if religious factors impact utilization of maternal health services.

A survey in Nigeria investigating the gender roles in women's healthcare utilization reported that a majority of women used traditional birth attendants (TBA) facilities and indicated that it was to satisfy their husbands (Azuh, 2015). A theory-driven analysis of the demographic determinants of maternal care seeking in Kenya from the 2014 KDHS conducted among women age 15 – 49 years with a live birth in the five years preceding the survey, found out that user fees, waiting times, inadequate ANC communication and knowledge, dehumanizing care at a facility affect uptake of maternal health services. This study would explore the health seeking behaviours of the Nomiya Church faithful's, a community of largely rural dwellers to understand their experiences and factors making them utilize the services they sought when pregnant and during birth.

Women with high fertility in the Western region of Kenya are less likely to access ANC, natal and postnatal care (PNC) services, as their past experiences with labour processes at the hands of TBA's or alone make them to feel a sense of wellness, and that they can manage the events of labour by themselves (Mbugua & MacQuarrie, 2018). Health seeking behaviours has been characterized by feeling of shame to go to health institutions, and some women give birth at home alone or at the TBA's homes, with some giving excuses of easy labour (Ayele et al., 2014). Giving birth at the health institutions have been influenced by being sick, health education received, saving mothers life, good services and not paying any fees for services, factors that have been given much focus by quantitative surveys (Ayele et al., 2014). This qualitative enquiry on the Nomiya explored on the religious factors affecting utilization of maternal health services by Nomiya Church faithful's.

Statistical bivariate analysis have revealed that age, education of women, perception women have of the services at the health facility, urban-rural residence significantly affected utilization of ANC

(Dahiru & Oche, 2015). Further, analysis results of binary logistic regression fitting two models, one for ANC utilization and one for institutional delivery, revealed that age, education and perception of mothers to quality maternal services were found to be significant predictors of ANC utilization. Occupation and education of the mothers and history of difficult labour were significant predictors of institutional delivery (Ochako et al., 2011, Ayele et al., 2014, Dahiru & Oche, 2015). The number of attendance of ANC is another significant predictor to utilization of delivery services (Ochako et al., 2011). Traditional, modern and religious therapies are usually combined during pregnancy and childbirth for the multiple health needs of women (Olungah, 2006; Ayele et al., 2014). Thus it is important to understand how these factors interplay with and how religious factors affect utilization of maternal health services

Deeper explanation on these factors is needed to address the complex challenges bedeviling ANC which ushers women to maternal healthcare cycle of ANC, SBA, PNC, contraceptive use and the seeking of pregnancy and SRH services. Quantitative researchers have stated some of the reasons leading to poor uptake of delivery care services to include personal beliefs, low education level among women, poor wage employment, high parity levels attitude, strong family and community values and norms to their culture and religion (Crowe et al., 2012; Pelcic et al., 2016; Shahabuddin, 2017; Kifle et al., 2017; Edu et al., 2017). These factors contribute to the risk of maternal death among pregnant women in developing countries, especially when women hesitate using skilled care services (Koenig, 2012). This study sought to explore on the other factors would be responsible for maintaining the high maternal mortality rates experienced in the area for decades using qualitative approach, as quantitative surveys have quantified, even suggested solutions to some of the factors.

Community beliefs and practices play a central role in determining health seeking behavior. A sub-study in Msambweni, coastal Kenya, involved 53 mothers to assess their own experiences of health seeking revealed that more than three quarters had gone to traditional and spiritual healers (Abubakar et al., 2013). The study also revealed that there were 2 different types of illness which required different management approaches, some best managed by medical doctors, while other diseases were most suited to be handled by traditional healers. (Abubakar et al., 2013). Could these kinds of experiences affect maternal health seeking patterns of Nomiya Chruch Faithful's in Siaya County, Western Kenya?

Systematic reviews of studies done in Africa by Nyamtema et al., (2011), Knight et al., (2013), Srivastava et al., (2015), Tran and Bero (2015), Kyei-Nimakoh et al., (2017) and Brenner et al., (2017) to identify factors affecting uptake of maternal health care revealed that social, cultural and religious factors are some of the barriers to the uptake of maternal health services. In rural community settings, healthcare seeking habits are not as high as in the urban areas. In the villages, mothers are bound by common community and religious bonds such as the likelihood of multiple risks to multi-parity, seeking for permission to go for treatment, getting money to go to hospital, going to hospital alone and mothers being the heads of household, makes them even more vulnerable (UNICEF/ WHO, 2015). Younger and unmarried women are less likely to go to hospital without cash and won't report any of the problems during pregnancy (Omondi, 2013). This study sought to explanation in-depth the factors affecting utilization of maternal health services by Nomiya church faithful's.

The unmet need for contraceptives in an African rural community setting in one way is dictated upon by the belief that women who use contraception may become promiscuous (Shahabuddin et

al., 2017). Women may not show up in public gatherings or may not be encouraged to speak up to share on factors affecting their health and uptake of maternal health services (NCCS, 2013), mothers, especially in traditional religious sensitive societies have little decision making autonomy (Shahabuddin et al., 2017). Social constraints women face such as labour division that is highly segmented by sex with minimal elasticity in rural settings, leave them to be running to meet the demanding tasks from planting food crops, weeding, doing the post-harvest work, run small scale businesses such as selling farm produce, care for the children, preparing food, cleaning the house and to collect water and firewood. These labour demands spatially restrict women to work far from home. This in turn affects their time to even seek for their own health or the child's healthcare needs, but rather look for the easiest means to remedy (NCCS, 2013). Also, some women tend to stick strongly to culturally defined norms with regards to health seeking during pregnancy and child birth. For instance, even where formal healthcare services are present, they are often bypassed for traditional providers (Ebere, 2013).

2.3 Religious Beliefs Affecting Utilization of Maternal Health Services

Kenya's population is highly religious, it is a fabric made of the Christians at 85.52%, the Muslim at 12% and the remaining are either Hindus, Sikhs, Bahais, atheists or traditionalists (KDHS, 2014). Religion influences health and development by prescribing behaviours harmful to or behaviours that promoting good health (Gyimah, 2002). Religion has become the framework through which most people interpret life events. Diseases, illnesses, deaths and calamities are often given religious associations as well as faith and healing care rather than medical care (Gyimah, 2002). Indigenized churches richly subscribe to Christian devotion and comprise approximately 15% of the country's population. These church beliefs have been cited to influence the utilization of healthcare services among the highly and those with education (Maguranyanga, 2011; Al-Mujtaba,

2016; N'Gbichi, 2019). Nomiya, Legio Maria (Legion of Mary church), Roho (African Spiritual), Dini ya Musambya, Akorino and the Kavonokya churches especially have been markedly known to have unconventional health seeking behaviours and oppose utilization of modern medicines (Ndambu, 2018).

Pregnancy, childbirth and, or the cause of some conditions have been associated with spiritual set of risk factors or ancestral displeasures and, or none adherence to some traditions. These threats make women seek for local healer's advice on their prevention (Olungah, 2006). Among the Digo of Kenya, religious norms were among the factors found to be important influences on the uptake and utilization of maternal health services including facility-based delivery and contraception (Mochache et al., 2020). A study among the Kenyan pastoral communities of Somali origin who are predominantly of Muslim faith, revealed that religious leaders negatively influenced uptake and utilization of family planning services. According to KDHS Census report (2019), approximately 85.5% of the total population is Christian and 12% Muslim while the remaining percent of the population include Hindus, Sikhs, Baha'is, and the atheist beliefs.

Different religious groups or sects may influence utilization of maternal health services in different ways, for example, in western Kenya region, women who perceived delivery to be dictated by culture and religion were sixty (60%) percent less likely to utilize skilled birth services (Mukabana & Mukaka, 2019). These complex community dynamics cannot be understood and exploited using statistical tools but qualitative tools to understand why communities still hold onto the traditions and observe the rites and practice what they believe in. This study focused on exploring the Nomiya church beliefs to bring more understanding of the factors affecting utilization of maternal health services, so that appropriate policies and interventions can be developed to solve them.

Between 1990 and 2015, countries in the Middle East and North African regions made tremendous progress in reducing their maternal mortality ratio, from 220 to 110 maternal deaths per 100,000 live births in the Middle East, and from 122 to 75 deaths per 100,000 live births in North Africa region (WHO, 2019). However, religious factors still play a role in determining access to maternal health services. For example, in the Middle East, Muslim women are required to have a male relative to accompany her outside the home, or seek husband's permission to leave the house even in the case of emergency, a factor that that leads to hesitance in seeking and utilization of reproductive health services (Marmot, 2007; Wellington, 2017). As life expectancy rose in Europe and Asia by 30 years and 13 years respectively, in Africa this rose by only 4 months, this calls for action based on the evidence across all social alliances, especially religious factors to understand the spectrum of effects on specified population's health.

Most African Spiritual churches like Nomiya church, recognizes the presence of spirits that affect adherent's psychological, social and physical health. They have vigorous and legalistic taboos that are observed on foods, drinking and smoking. Members observes patterns of fasting, visions and returning with power, which greatly influence adherents' health and wellbeing, most especially the mother, who will delay seeking health care while they observe these religious values (Olungah, 2006; Omondi, 2013). Indigenous African spirituality involves deeper human values, attitudes, beliefs and practices which arise from experiences articulated and lived in the African context, shaped by African problems (Gumo et al., 2012). It must be noted that African traditional religions continue to influence the lives of many people today, including some of the highly educated Christians and Muslims. It must also be noted that African religions are not static (Gumo et al., 2012).

By engaging in faith healing, for example, parents, family and community may endanger the health and welfare of the women. Religious association masks the supposed characteristics known to be associated with health-related behavior (Gyimah, 2002). While most studies have largely been quantitative, religious factors form part of the construct of maternal morbidity and mortality framework, which need in-depth exploration to understand more about those religious factors to prevent and control these unnecessary maternal morbidity and mortalities (Omer et al., 2014; Ayele et al., 2014; Al-Mujtaba et al., 2016). It is believed that some health conditions affecting mothers require strictly conventional care while some do not, myths and misconceptions, faithful's community influence, are threats that clouding utilization maternal health services (Olunga, 2006; Sheik & Kwaak, 2015). Myths and misconceptions, fear of medicines and contraceptives side effects, association of contraceptive use with promiscuity, straying and peer affect utilization of contraception (Sheikh & Kwaak, 2015).

Belief in supreme beings and bad spirits is widely accepted by most African Spiritual communities, and so are the beliefs on the local social support systems for decision making affecting utilization of ANC, delivery and post-delivery services (Sheikh & Kwaak, 2015). In Zimbabwe, Well controlled multivariate logit regression models showed that an affiliation with the Apostolic faith was a substantial and significant risk factor in reducing the utilization of both maternal and child health services (Ha et al., 2014). A formative study pointed out that the real challenge public health division's face in communities today is balancing religion and health, finding ways of achieving harmonized and holistic health programs and uptake of modern healthcare services (Maguranyanga, 2011).

A formative qualitative study involving 94 pregnant women who had given birth, to explore on the insights why Muslim women in Ghana did not use skilled maternal health services revealed that the potential for religious beliefs to exert some influence on behaviours and attitudes regarding use of modern maternal health services cannot be underestimated in the African context given the significant role religion plays in the social organization of many African societies (Ganle, 2016). Women are often the 'bearers' of culture, and are best positioned 'change agents' now and in the future especially when targeted with the right information on maternal health (Oluoch, 2013). Exploring on the religious beliefs among the faithful's of Nomiya church and how the belief systems affect maternal health and uptake of health services formed the focus of this study.

Some religions are subdivided into denominations, adherents of which may have their own distinct interpretation of religious teachings. These differences complicate the attempt to articulate a single position for a given religion. In addition, although individuals may identify with a particular faith, they may not agree at a personal level with official teachings, and some women and their partners may choose to ignore religious teachings (Amirrtha & Reid, 2008; Singh, 2012), aspects which can only be explored best using qualitative techniques. In Ethiopia, a qualitative study conducted by Tigabu et al., (2018) found out that modern contraceptives were available at healthcare facilities, but all mothers were influenced by religion not to use contraceptives.

Religion form part of factors that hinder utilization of perinatal services among women of childbearing age. In Uganda, it had been found that religion was significantly associated with place of childbirth, with Muslims having higher odds of utilizing health facilities compared to those of Catholics. These literatures point to the fact that religious beliefs have an influence on uptake and utilization of maternal health services (Solanke et al., 2015; Malande et al., 2019). However,

coming up with well-designed programmatic interventions might not be possible without qualitative studies to give detailed explanations which would help understand how religious beliefs affect utilization of maternal health services, in an elaborate description. Health of individuals are shaped by the religious and complex community environments that they live in. It is by exploring these wide-ranging systems and experiences that we will expand the public health knowledge, and develop a bank of deeper descriptive information to use for planning interventions for specified population health needs appropriately.

In a qualitative study done in 3 regions in Kenya, that is Nyanza, Coast and Central region to assess barriers to modern contraceptive use among young women and to discuss sexual activities among young people in a one-on-one session with thirty-four (34) young women. The study reported that most women's utilization of contraceptives is affected by fear, myths and misconceptions on the FP methods and lack of knowledge of the methods. Use of FP method was related to promiscuity among women, they affect one's fertility, lower libido and that users have difficulty in giving birth. There was preference of local methods to modern contraception (Ochako et al., 2015). The major barriers to utilization of contraceptives were myths and misconceptions that young women learn about from their social networks. This study aimed at exploring on these barriers with a focus to further understand their context in relation to religious connection to utilization of health services.

A desk review of thirteen studies, investigating the effect of religion and religiosity on contraception decisions among emerging adults, found out that emerging adults who belong to age group between 18 - 25 years old, are at high risk for unplanned pregnancy because of their relative low use of contraception. The study noted that religion had negligible influence on contraception use among the respondents (Lemoine, 2011). In the United States of America (USA), adolescent

women may delay seeking prenatal care and other services because they feel ashamed of their pregnancies and are stigmatized by their communities, especially if the community is small, rural and religiously conservative, with those considering abortion or carrying their pregnancy to term (Baudry et al., 2018). Exploring such special group's experiences would help inform the public health division of the ways to make services available to them.

Within Judaism, procreation is a religious duty for males but a meritorious act for females thus husbands must be informed of and approve the use of contraception (Amirrtha & Reid, 2007). Islam is a comprehensive system used to regulate spiritual and political aspects of individual and communal life. Family planning is not forbidden, but irreversible sterilization methods are not permitted (Rashidi et al., 2001; Hasna, 2003). Some authorities permit modern methods of contraception as lawful, given that they are temporary, safe, and legal, but they may be used only within marriage (Pennachio, 2005). Little has been done in the study area to understand specific population experiences and public health implications regarding utilization of contraception. During stressing moments people tend to anchor strongly to traditional and religious expectations regarding family, sexuality, and fertility, and as such health care providers must be cautious not to attribute stereotypical religious, social, and cultural characteristics to women seeking HC services as contraception (LaHaye, 1998; Amirrtha & Reid, 2008).

A qualitative study by Maguranyanga (2011) on determinants of healthcare seeking behaviour among Apostolic faith community in Zimbabwe, which involved in-depth interviews, Key informants, focus group discussions and informal discussions reported that religious teaching and church regulations profoundly affect utilization of healthcare services. Ultra-conservative Apostolic faith has had dire consequences on maternal and child health as some religious groups

openly object the uptake of modern healthcare services and maternal immunization (Maguranyanga, 2011). Similar studies should be done in the study area to understand women's experiences and perspectives on the religious factors that impact their health and to also help understand the interaction of the religious factors to other spheres of life that affects utilization of maternal health services.

The position some specified religious groups have regarding use of vaccines and vaccination are worth re-examining. The Catholics question the use of cell lines derived from voluntary aborted fetuses, while some Russian Orthodox church faithful's refuse to be vaccinated without clear reasons (Pelcic et al., 2016). The Russian government stated that vaccination is a powerful tool of prevention of infectious diseases some of which are extremely dangerous, and thus banned distribution of audio-video anti-vaccination literature and materials, and that refusal of the initiative could lead to serious consequences (Pelcic et al., 2016). The Protestants are divided in a group of pro-vaccine and anti-vaccine parents, while with the Muslim's tradition, vaccination serves to protect life and should be considered, but among the religions, Muslim children are not or are largely under-vaccinated compared to vaccinated children (Pelcic et al., 2016). Thus it is important to explore specific communities to expand our knowledge on how they seek and utilize health services.

In Asia and Africa, mistrust over vaccines has been often tied to "western plot" theories to sterilize or infect non-western communities, while some maternal vaccines, have been linked to cause abortions and delivery problems. In Cameroon in 1990, rumors spread that PH officials were administering vaccines to sterilize women, thwarting the nation's immunization efforts (Jiya-Doko, 2016). In 2003, similar objections halted polio campaigns in Nigeria, when religious leaders

claimed that the vaccines were contaminated with the virus that causes AIDS and sterilization and cancer-causing agents, despite tests confirming the vaccine's safety (Jiya-Doko, 2016). The impasse was eventually resolved through dialogue among religious and political leaders, WHO, and UNICEF.

"Apostolic health care system", that is a religious constituted and justified concept of glorifying God, are established in promoting maternal health, facilitating delivery and restoring health to the sick ones. Some of the beliefs were reported to increase the risk of HIV and AIDS through polygamy, wife inheritance and pledging young girls to marriage (Maguranyanga, 2011). These are the drivers of this study that digs into the Nomiya church faithful's beliefs. Some Holy Ghost churches also require mothers to observe the church beliefs and norms as has been observed by their grandmothers, as a principle which binds them all, in the hands of the experienced and avoid shame from health care givers questions (Omondi, 2013**).** Polygamy encourages women to compete in siring children and husbands may not have the money to support all the healthcare needs.

2.4 Religious Practices Affecting Utilization of Maternal Health Services

Religious practices and philosophies are vital ingredients in determining utilization of health services which can form the major recipe to those who formulate and implement government health policies. The role in which belief system, understanding the concept of disease, illness and health, improvement in the economic status of the people and well-planned health education can all help in ensuring maximum and most efficient utilization of the maternal health services cannot be over emphasized (Akpenpuun, 2013). In Nigeria, a review of relevant articles from electronic databases on practices that hinder women from utilizing maternal health services found that health

care services are influenced by community practices and health system factors (Ebere, 2013). This study explored in-depth the practices affecting utilization of health services among the Nomiya church faithful.

A study by Atenchong (2016) in Cameroon revealed that while observing seclusion regulations, a mother and child are assigned a few people to look after them, these individuals may not be able to identify changes in health conditions in the mother and, or the child which may lead to maternal morbidity and delays in presentation at the hospital for care. The sick mother during seclusion maybe subjected to cleansing and exorcism if she complains of sickness, as conventional medical practitioners may not come to interact with the mother, as they are considered unclean. The mother and the child can also contract an infection from the persons identified to take care of them, as the houses where they stay during seclusion are at times of poor ventilation and lighting. Conditions, beliefs and practices, serve majorly, to harm the mother and child as people present late for skilled care or end up dying from preventable causes without seeking skilled healthcare services (Ajiboye & Adebayo, 2012). This study aimed at exploring the experiences mothers go through from the time they realized they are pregnant to when the child is 5 years old, taking account of all about the essence of the phenomenon in Nomiya church faithful's community.

Proper nutrition is a key determinant of health, both in pregnancy, childhood and beyond. The nutritional status of girls is particularly important due to their future potential reproductive role and the intergenerational repercussions of poor female nutrition (WHO, 2009). Maternal health is surrounded by wide range of customs and practices, and all over the world marriage is universal, and the family is incomplete without the birth of a child. This has obvious implications in the context of the country's population problems where various customs especially on feeding are

considered good, bad and uncertain (WHO, 2009; Singh, 2012). Principles that govern nutritional habits are restrictive and observed to the letter by adherents impacting on indigenous church faithful's health. This study explored on these tenets to gain more knowledge on lived experiences and impact on the feeding and nutritional habits as they impact maternal health, as religious practices like fasting may have effects on fetal and maternal health if not checked.

In some rural areas, delivery is conducted by traditional birth attendants, mothers in-law in whom villagers have great faith in, whose methods are far from safe delivery (NCCS, 2013). A qualitative enquiry in Mwingi, Kenya, seeking to explore perceived community practices and beliefs influencing maternal health, revealed that various community and religious factors, various deficiencies in healthcare service provision, unreliable transport infrastructure, and poverty, illiteracy, and food insecurity significantly affect utilization of maternal health services. They recommended that efforts should be focused to address community and religious traditions influencing maternal health.

Reviews of various secondary data and information from UNFPA, Nigeria-USAID, Pathfinder International, government publications, text books, academic researches and journal articles on community practices in maternal health in less developed economies, revealed that traditional practices and norms such as unattended labour and delivery, use of herbs, and traditional gender discrimination play a significant role in maternal mortality (Shamaki & Buang, 2014). The report further stated that although such practices are predominant among women with low education attainment, their influence remains strong even in the face of extensive modernization. This study explored on the religious practices of Nomiya church to understand their effects on maternal health.

The Chinese have majorly 2 distinct traditions that is Confucianism and Taoism**.** In Chinese tradition, the greatest tragedy is a lack of descendants. Families must not merely have children, but have good, healthy, talented children. Thus, the Chinese have long been conscious of the need for careful planning to ensure quality children (Amirrtha & Reid, 2008). But according to recent studies, ethnic Chinese and Korean women in Vancouver held many negative attitudes against oral contraceptives which became barriers to proper usage (Amirrtha & Reid, 2007). It is by exploring such specified populations health and needs assessment that we can expand our knowledge of their needs and plan for them appropriately.

In a comparative study conducted among pregnant women in Western Nigeria, participants did not know how to correctly use condom to prevent pregnancy and HIV/AIDS infection because of the strong cultural attachment to having children, appeared to influence the desire for childbearing among HIV positive men and women (Amoran et al., 2012). A review of 38 quantitative studies involving relevant previous researches on factors hindering contraceptive usage and 3 qualitative studies on factors influencing the prevention of mother-to-child transmission of HIV in Nigeria underscored the need to develop effective family oriented, culture-centered community based PMTC programs to improve on the low uptake of PMTCT services (Amoran et al., 2012). It is with this knowledge on culture-centered community based healthcare programs that the researcher wished to explore into the religious community of Nomiya Church to understand those factors affecting their utilization of maternal health services as the statistics have revealed over and over again hesitancy in the utilization of health services for the mother.

In current cultural trends in Muslim societies, traditional pressure, familial pressure, and religious pressure influence the decision to procreate. The low status of Muslim women within certain

communities and the inequality is a construct of the communities in which the women live (Ebere, 2013). The low status of women is manifested on who decides where the household, including the pregnant mother should go for treatment especially in African countries where culturally, male dominance and women subjugation are normal ways of life (Ebere, 2013). Some community practices in Nigeria limit the ability of the women to take independent decisions about their lives and when to seek appropriate maternity care (Chukuezi,2010; Azuh, 2015). It is their husbands or other male relatives that determine when they should seek medical and maternal care (Ebere, 2013). International Response to the Discrimination Against Women identifies women's rights as human rights and demands their inclusion in all spheres (UN/CEDAW, 1999).

Marriage is universal in most communities. In the Indian community, a family is not complete without a male child and fertility may be an influencing factor to prove to the husband worth in the union, increasing risk due to pregnancy states (Singh, 2012). Still, community practices directly affect once choice and place of delivery, with the interaction complex web of marriage, church and cultural norms and traditions, as with delivery, there is boasting of experience, loving care, privacy and a sense of recognition with uptake of community services (Singh, 2012). This research study explored on the women's delivery experiences to help improve the knowledge gap on preferences specified populations have on preferred services for delivery. This can help plan for their contextual health needs accordingly.

Wife inheritance and ritual cleansing still persists among the Luo, where when a man dies, his widow maybe inherited by the husbands brother after being ritually 'cleansed' by sleeping with a social outcast, a factor that significantly contributes to a woman's fertility, health and the spread of HIV/AIDS in the communities where it is common (NCCS, 2013). A review of multiple relevant

documents on the associated factors of maternal mortality in Nigeria revealed that, wife inheritance compounds gender discrimination contributes to high maternal mortality and morbidity in rural areas (Chukuezi, 2010). The wife inheritors come to sire more children, and risk the women's health with HIV infection, and in most situations have no resources but depend on the deceased family for sustenance further leading to a complex web of negative impacts on women's health (Omondi, 2013). It is important to find out insights of Nomiya Church participants on how wife inheritance as practiced by the church community affect utilization of maternal health services.

The wife inheritor comes in to care for the women who just lost her husband and in return the women also assures the man of loyalty by siring children with the man. This happen as the inheritors come to these unions with nothing to offer but to be cared for, and as social factors greatly impacting on women's reproductive health, understanding women's experiences on how these factors affect their health would help expand our knowledge on these factors to plan appropriate interventions for them. Similarly, in Gambia, strong religious backgrounds have been attributed to have blinded women from utilization of maternal health services as family planning services, skilled delivery services, preventive services, health care systems and use of medications (Lowe, Chen & Huang, 2016).

Maguranyanga, (2011) further challenged technical arms and primary healthcare practitioners if we are allowing mothers to still die of preventable conditions in our quest to advance African religions. He questions on whether to ignore apostolic makeshift maternity care places to delivering babies and caring for mothers in health care delivery system. Further, he challenged that those religious tenets and practices are antithetical to universal rights of women (Maguranyanga, 2011). Answers to these questions need contextual healthy debates, dialogue and imagination to

transform and shift from religious and cultural practices that stifle the rights of women and health. This study sought to answer these questions from the users' perspective through one-on-one encounter with faithful's of the Nomiya church.

2.5 Theoretical framework

Model of study: Andersen Behavioral Model of Health Service Utilization

With qualitative methods becoming integral in health service research, Andersen behavioral model of health service utilization has become one of the valuable models of health service use. The model focuses on three core factors to explain health care utilization that is predisposing, enabling and need factors (Lederle, Tempes & Bitzer, 2021). These researcher's recent overview of the application of the Andersen model of health service utilization, reveals that there has been little attention given to this model in qualitative research. They underscored that Andersen model was suitable for obtaining and evaluating qualitative data. They further revealed that Andersen's framework provides a valid, consistent and unbiased means to code and classify qualitative data.

Lederle, Tempes and Bitzer (2021) revealed that the strength of the model lies in its consideration of both patient-related and environmental factors, allowing for a transparent comparison with findings emerging from other studies. This study explored on the Nomiya church faithful's lived experiences affecting utilization of maternal health services. Lederle, Tempes and Bitzer (2021) revealed that the weaknesses reported with the model is not sensitive to diverse cultural and structural barriers in healthcare among minority groups. Cultural barriers did not affect the results of this study as the focus was not exploring religious factors affecting utilization of maternal health services. And while describing the weaknesses of the model, no major comments were proposing changes or modifications on the model, allowing for the use of this model in this study.

Originally, Andersen and Newman model particularly focused on the individual predisposition to use acute healthcare services, enabling factors that facilitate use and one's perceived or influenced need for care (Travers et al., 2020). The model has undergone developments from the original framework of Andersen and Newman model of 1973. In 1995, Andersen himself reviewed the model to allow for understanding on how and why people use healthcare services, asses the inequalities in accessing healthcare services and in creation of policies ensuring equitable access to care. In 2000, contextual characteristics were added to the model, as in the case of this study seeking to understand the experiences of women of Nomiya church utilization of maternal health services. Other developments have been made by other authors for example, Andersen and Newman Framework of viewing Health Services Utilization (Lederle, Tempes & Bitzer, 2021). The use of this model allowed the exploration of the processes involved in accessing maternal healthcare, the environment both of the external (community) and within healthcare systems (Health facility) affecting utilization of maternal health services by Nomiya church faithful's.

Travers et al (2020) while describing the Andersen model of health service utilization, noted that the original model had inefficiencies on the beliefs construct. But with the addition of enabling or barrier and the need factors, these have expanded the scope of exploring on the factors affecting utilization of health services as attitudes, knowledge, community norms along with their perceived control, availability of support, states of financial support, objective and perceived need for healthcare services. This study's focus on religious beliefs and practices by Nomiya church faithful's to help explain in-depth of those other factors that have not been focused on by quantitative approaches. Regardless of the models expansive application, some researchers have critiqued the model, for instance, that model does not pay attention to social interactions. Andersen, however have asserted that need itself is a social concept.

In spite of the criticisms, this model was deemed appropriate for this study because of its broader applications into the constructs describing maternal health and the need to utilize maternal health services (Seidu 2020, Tolera, Gebre-Egziabher & Kloos, 2020, Andersen 1995). Andersen's behavioral model of health service utilization allows the data to speak for them, like in this case, the voice of the women of Nomiya church giving insights on experiences their experiences helps us understand the low utilization of ANC, SBA and PNC services (Travers et al., 2020, Wilding & Whiteford 2005), and permit an expansion into the existing body of knowledge on the factors affecting utilization of maternal health services, the development of new policies and interventions for the maternal health.

Over the decades, the trends of maternal mortality ratio in Siaya have been on high, and the recent survey by UNFPA in 2015 quantified that MMR was 691 deaths against the national MMR of 362 deaths (KDHS, 2014), with WHO reporting a contrasting MMR of 510 deaths per 100, 000 live births (WHO, 2015). Quantitative surveys have repeatedly reported that utilization of maternal health services is driven by factors such as awareness among service users in the community, knowledge of risks during pregnancy, community customs, previous facility use, parity and pregnancy complications, individual attitudes and health care seeking behaviours, household income, employment, decisions making power, home visits and the availability and accessibility of health facilities. However, determinants of utilization of maternal healthcare services vary across different geographical locations, contexts, communities and religions. Little has been done to exploit the why and how these trends are maintained so (Tolera, Gebre-Egziabher & Kloos, 2020), as has been evident in Siaya County. Thus, this model was used to explore on the context specific religious factors affecting utilization of maternal health services among the mothers worshiping Nomiya church, in Siaya County.

In the community, mothers have an option to choose from utilizing health facility services where they have access to skilled health professionals or to seek the services of the TBA's who are living near their homes and with them in the community.

Population characteristics

This study focused on the three core aspects of the model which included the Predisposing, Enabling and Need factors affecting utilization of ANC, SBA, contraception and PNC services.

1. Predisposing factors: Mothers belief in prayer, and experience with the use of herbal medicines, counsel of the church based TBA, church teachings, affecting mothers use of health services.
2. Enabling factors (or lack of it):

a. mothers experiences and decision on attitude of and presence of health care workers, drugs, faster services, packaging of and knowledge of a procedure/ test/ examination and by who, and knowledge of policies;

b. mothers experiences and decision on using herbs, preparation and massage services and adherence to religious traditions.

3. Need (or demand) factors: health conditions that make the mother decide to go for health care line pains during pregnancy, delivery. These can be urgent as bleeding in pregnancy, treatment of STI in pregnancy, urge to deliver or planning for a pregnancy thus visit a health provider for care.

These factors depend on the women, as they have to choose carer's to attend to them during pregnancy and delivery.

Personal choices are influenced by a number of factors as health care system factors, external environmental forces and population factors that spans the experiences mothers have gone through

the hands of skilled care or traditional birth attendants. The population characteristics encompass the community influence on the mothers decision on what services to use, health care policies and religious doctrines and, or the service provider (a TBA or the skilled birth attendant), all which affect their use of health services. The interconnectedness of these factors presents a complex relationship and therefore, results cannot be to predict, influence or expect. Experience of or being informed of the experience at the service point may affect future choice of using the health service. Thus multifaceted efforts are needed to encourage mothers to utilize skilled care services by trained and qualified healthcare providers.

Exploring the factors affecting utilization of maternal health services need to be modeled as a function of predisposing, enabling and need factors for the Nomiya church faithful's in Alego-Usonga Sub-county (Tolera, Gebre-Egziabher & Kloos, 2020). This model was used to explain how predisposing, enabling and need factors shape the experiences, and their essence in seeking and utilizing maternal health services by the individual women of Nomiya church.

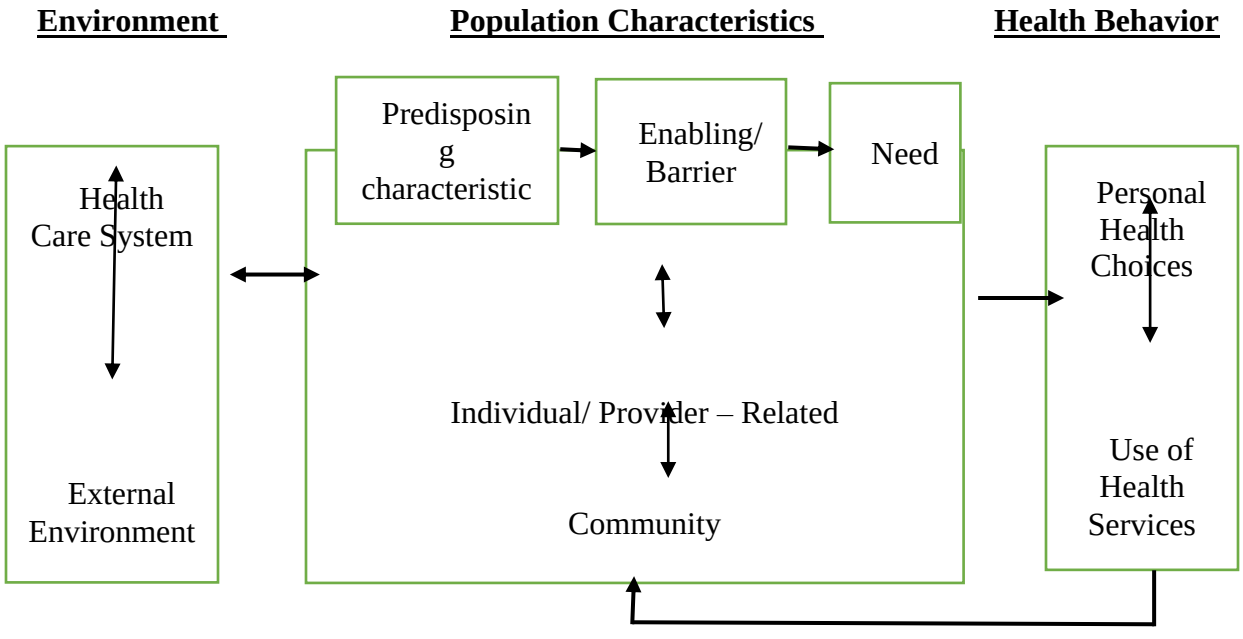

Figure 1: Andersen Behavioral Model of Health Service Utilization

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Study Setting

The study was carried out in Alego-Usonga Sub-county, host to the County headquarters, making it the most urbanized out of the 6 sub-counties in Siaya County

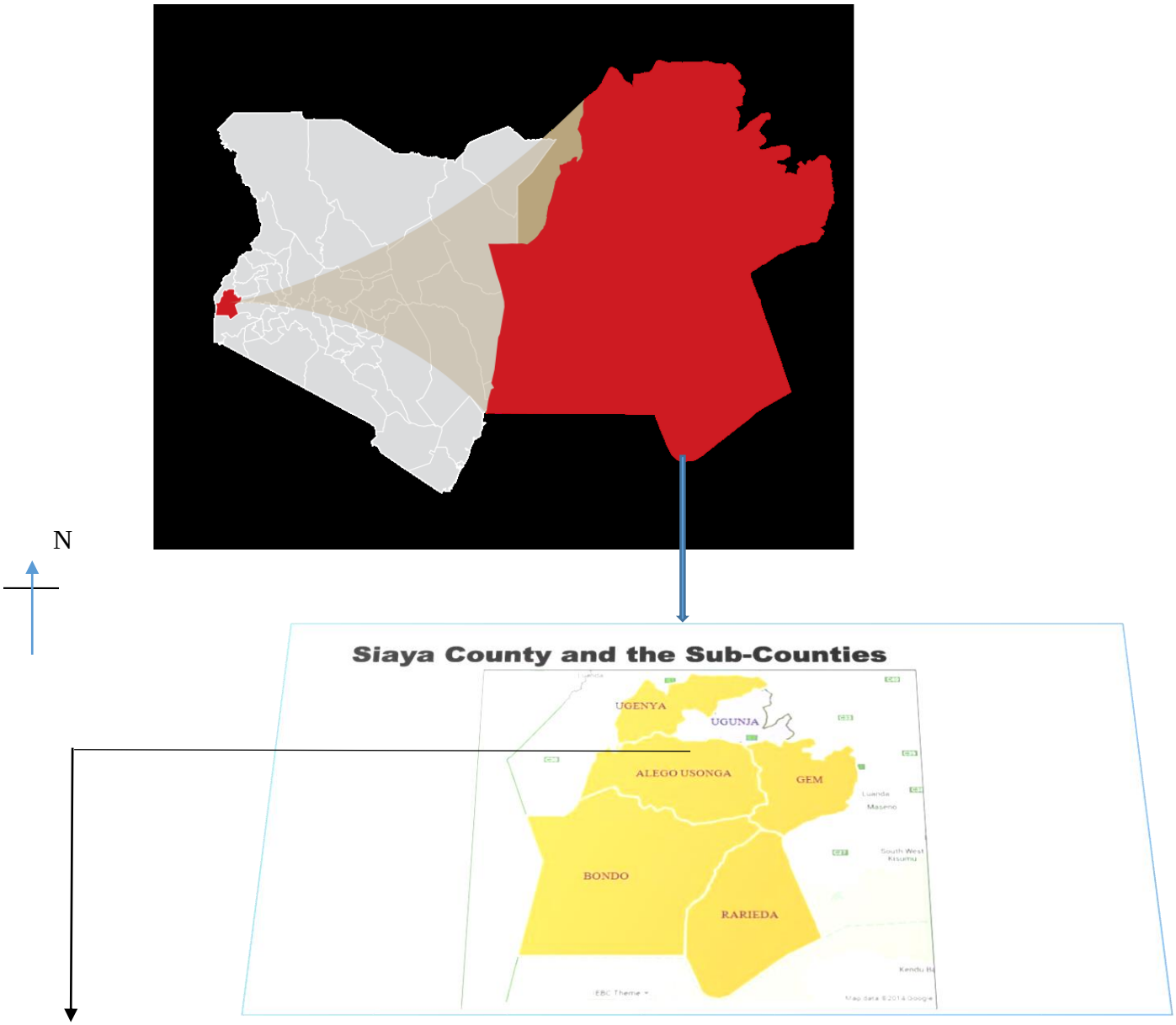

Figure 2 Map Kenya with a blown out map of Siaya County showing the 6 Sub-counties. The study area was carried out in Alego-Usonga Sub-county, (Adapted from County Maps).

The sub-county has a population of 109, 769, forty-seven percent (47%) is male population, and 123,783 females making 53% of the total population (Siaya County Integrated Development Plan, 2013/2017). The approximate number of Nomiya church faithful in Alego-Usonga sub-County is approximately 17,000 (Informal Church leadership report, 2019).

The sub-county has 51 health facilities, among them the Siaya County teaching and referral hospital, 35 are Government based, 5 Faiths based, 8 Private based, 2 Non-governmental Organization based and another one is a parastatal based health facility. There are several Non-governmental Organizations (NGO's) as Center for Health Service (CHS), International Center for AIDS Care and Treatment Programs (ICAP), Christian Health Association of Kenya (CHAK), PATH, Kenya Aids Response Project (KAP) etc., and various research funded organizations as the Kenya Medical Research Institute (KEMRI/CGHR), University of New Mexico (UNM) among others supporting various health programs including maternal health services within the county (Siaya County Integrated Development Plan, 2013/2017).

3.2 Research Design

This study adopted a qualitative descriptive research design, as widely used in the domains of health care and nursing related phenomena. There is little literature regarding this design which is a great approach for gaining rich insights from informants on poorly understood phenomena about situations, phenomenon, services and programs systematically on the utilization of maternal health services in epidemiology (Kim, Sefcik & Bradway, 2017). It is purely a qualitative approach that employs interviews, written open questions and pictures and a researcher cannot use statistical analysis to give meaning to the data, and this leads to a deeper understanding of lived experiences regarding the phenomenon that happened sometime in the past which the researcher could not find

any other way to describe, but is still influencing utilization of maternal health care (Kim, Sefcik & Bradway, 2017).

This design was appropriate to explore of the experiences of women of Nomiya church regarding their utilization of maternal health services, concepts that are difficult to measure using statistical tools to inform intervention. This design was also an approach of choice, as in areas where there is little information and there is need to explain in more depth about the phenomena, as was true in this research study, it allowed for the capture of the stories and nature of health related phenomena over time revealing the contextual dimensions of utilization of health services that have been excluded with the previous quantitative study approaches (Wilding & Whiteford, 2005).

This design offered a means through which the researcher explored and illuminated the aspects of an individual's experiences in all its complexities in real world, and by reading over and over again the words and stories of the participants in terms of what they indicate about both the specific dimensions of the phenomena and the whole phenomenon, which had not been explored before as in this study context (Wilding & Whiteford, 2005; Carel, 2012). The researcher and the participant were uniquely involved in a collaborative dialogue and process to understand the whole person in the context of her environment and taking an all-inclusive approach to research (Wilding & Whiteford, 2005). The use of this design bridged the methodological gap that has been left in understanding the religious determinants of maternal health that statistical tools cannot. The findings, thus, add to what is already known and significantly increase our understanding on the religious factors that affect utilization of maternal health services.

3.3 Target Population

The target population comprised of mothers aged 15 – 49 years belonging to 'Nomiya' church, in Alego-Usonga Sub-County in Siaya County, as at April 2019 to April 2020.

3.4 Study Population

Women worshiping in Nomiya Church who is pregnant, has an under-five year old child or a guardian of an under 5-year-old worshiping in Nomiya church.

3.5 Inclusion and Exclusion Criteria

3.5.1 Inclusion criteria

Females 15 – 49 years of age, mother of an under five-year-old child or expectant, worshiping in Nomiya Church, had lived in Alego-Usonga Sub-county for the last 2 years and consented to be a participant in the study.

3.5.2 Exclusion criteria

A woman who met the inclusion criteria but was too ill to participate in an in-depth interview session.

3.6 Sample size determination

Guest, Bunce and Johnson (2006) while experimenting documents thematic codebook development over the course of analyzing sixty interviews with female sex workers from two West African countries, reported that data saturation was fairly complete and stable after only twelve interviews and remained so even after incorporating data from a second country. They further stated that to gain high-level, overarching themes, then their experiment suggested that a sample of six interviews may have been sufficient to enable development of a meaningful themes and

useful interpretation, especially in a more homogeneous sample. Creswell's recommended between five to twenty-five interviews and Kuzel (1992) six to eight interviews tying his recommendations to sample homogeneous samples. Svend Brinkman textbook of qualitative interviewing (2013) recommend 15 interviews, Elizabeth Tolley textbook of qualitative methods in PH 2nd edition recommended 12 interviews, but underscored Guest, Bunce & Johnson (2006) as the hallmark for sample size determination in qualitative research.

The study had a sample size of 22 female participants for in-depth interviews that was determined upon reaching saturation point (Guest, Bunce & Johnson, 2006).

3.7 Sampling Procedure

While doing literature search on non-probability sampling, Guest, Bunce and Johnson (2006) opined that the samples can be varied, but the common element is that the participants are selected according to predetermined criteria relevant to a particular research objective. The majority of articles and books they reviewed recommended that the size of purposive samples be established inductively and sampling continue until "theoretical saturation" occurs. The researcher interviewed research participants probing and exploring on the arising thematic areas with subsequent participants until there were no new emerging themes coming from the interviewees.

3.8 Sampling technique

Snowball sampling method was adopted to select study participants for in-depth interviews. This sampling technique was a gradual process with a chain referral system and time influencing the selection of the participants as they were informed of the aims of the study. A participant would then recommend a similar participant from among their faithful community. The participants were not easy to find, nor were they easily identified by the TBA's manning the villages, and as there

was no lists to refer to. This was the choice method to reach the participants who are hidden and difficult to reach by the researcher. This non obtrusive, non-controlling and non-manipulative technique made the sample participants grow like a rolling snowball allowing a deeper, trustworthy, freedom in and flexible data collection among this hard to identify population (Sharma, 2017; Nadifar, Goli & Ghaljaie, 2017).

In order to find church participants, some who had just come out of the seclusion period and were not actively going to church routinely, the church leaders, especially women church leaders knew their members including those not attending the church services. They are connected by unique bonds as a religious community through visitation, taking prayers to their members' homes, and as well their beliefs and practices as observed passionately by the church community. Non-attendance was easily explained by the members, especially for the period after delivery. The county health promotion officer introduced the researcher to one of the Nomiya Church bishops who linked the researcher to the other bishops. The bishops linked the researcher to the parish pastors, who then connected the researcher to the women church leaders. The women's church leader then introduced the researcher to a mother with an under 5-year-old or was pregnant at that time. After the interview with the mother, she would connect and lead the researcher to another church member with an under 5-year-old or pregnant woman. The distant and divergent residence pattern among members only made it possible for the researcher to seek guidance to connect with the next participants with the lead of the mother who was being interviewed.

3.9 Research Assistants

The researcher trained 1 research assistant1 on the administration of in-depth interviews and data collection. The research assistant was trained on establishing rapport with the study participants

and schedule appointments for interviews. The research assistant accompanied the researcher to the field during data collection to help in note-taking, monitoring data collection tools functionality, help with debriefs post interviews and identify major issues raised. Qualification for the research assistant was to have at least a diploma in Public Health or Social Sciences, previous experience of being a qualitative research assistant, and not a member Nomiya church, to allow unbiased data collection. The research assistant was trained on the purpose, objectives, benefits and the confidentiality aspects of the study, consenting process, the methods and how to collect data and of the rights of the study participants. The research assistants were trained on the interviewing skills so as to increase on the reliability of the study. There was a back to back translation of the study tool from English to Luo, and from Luo to English versions to check on the clarity and consistency of the questions. The research assistant was also trained on establishing relations with the study participants, making appointments for interviews.

3.10 Data Collection Procedure

Three methods of data collection were used, namely In-depth interviews (IDI), Key informant interviews (KII) and Focused group discussion. During these face to face interviews and discussions the researcher also invested in collecting non-conversational details as interpreting body language, facial expression and other non-verbal cues, these formed essential building blocks of communication during this study.

3.10.1 Pilot Study

A pilot study was done to help ensure the reliability or trustworthiness of the interview guides, as guided by Creswell (2003) and Golafshani (2003). The tools were checked to determine and verify the information collected for saturation, especially from the study participants who met the

inclusion criteria during subsequent interviews. Two respondents were identified for the piloting. The pilot study was done with a mother with an under-five year old child, a member of Nomiya church in Siaya Township church. The members of the town church were not to be reached for the main data collection during the study. This helped to assess the credibility of the interview guide, and help improve the wording, language, probes, meaning and flow of the interview guides as highlighted by Majid, Othman, Mohamad and Lim, (2017). It also helped the research assistants interact and familiarize with the interview sessions thus developed confidence on their roles. A post-interview debrief with the note-taker immediately followed the interview to evaluate generally the interview session was held to ensure that data were collected objectively, identify themes and new themes and assure meaningful explanations given.

3.10.2 In-depth interviews

In-depth interviews were face to face encounter between the researcher and the informant directed towards understanding informant's perspective on their lives, experiences or situations as expressed in their own words (MacDoughall & Fudge 2001; Rustagi & Pal 2012). In-depth interviews were aimed at exploring and analyzing the health seeking practices, religious beliefs and practices affecting utilization of maternal health services within the target communities, giving the opportunity for a long, on a one to one encounter with the study respondents to give in their detailed responses of their context and experience. These were entirely a one on one encounter moment with the women of childbearing age 15 – 49 years, pregnant and/ or who have children under 5 years old. The interviews explored on the people's thoughts, feelings, behaviours, practices and important issues on religion beliefs and practices affecting uptake and utilization of maternal and child health care services. Open ended questions were used to collect in-depth data from the

respondents in their own words, with the interviewers encouraging and exploring the areas requiring more information from the respondents.

Planning for data collection began by visiting a Bishop of the church. He was informed of the goal of the study and its intention to prevent maternal morbidity and mortality that was at epidemic level in the sub-county. His permission was sought as the gatekeepers of Nomiya church community. With his consent, the bishops introduced the researcher to one the pastors and women church leader. The pastor and the women church leader were also informed of the study objectives and intention of the study. The women church leader then linked the researcher to the index study participant. After the interview, the mother then would suggest to the researcher to the next church as a woman she would know the other lady with an under 5-year-old child or was pregnant. The mother would direct the researcher to the next participant's homes and introduce the researcher to the family.

The researcher then created rapport with the family and then schedule an interview with the mother at their preferred place of privacy and time. Mothers were helpful in giving directions and how to contact the other members who were pregnant and/ or have children under-5 years. Interviews were conducted in a private and secure place of participants' choice to reduce anxiety and chances of non-response. The mothers preferred the sitting room of their homes as the private places for the interviews, this allowed them to see any incoming visitors to alert the researcher of a possible pause in the interview, as they would inform the visitors, who were largely neighbors to come back later on.

The interviews were conducted using an in-depth interview guide, this ensured every aspect of interest was explored accordingly. Most of the interviews were conducted over the weekends by the researcher, with the research assistant helping the interviewer with note taking, and ensuring that the voice recorders were functioning. During the interviews, the researcher would take control of the session while the assistant would be taking notes, observing that privacy is ensured, checking that the recorder is on, and attending to any other demands during the interview. The interviewer would notify the participant of the beginning of the interview, introduce the session, time and place of the interview, and switch on the digital recorder. Using the interview guide, and with great probing techniques, the researchers would take the interviewee through the session. The note-taker would pass a note to the interviewer to probe further in any areas not exhaustively done. In some of the interview sessions, observation technique was used to verify some records such as mother child booklet, expounding on some aspects on the health of the mother and child. At the end of the interview, the interviewer would stop the digital recorder and thank the mother. The note-taker, who would be present in some cases, would then end the session noting the start and end time of the interview.

Most interviews took approximately 50 minutes to 75 minutes. Most of the interviews were conducted after the church services about noon, as most mothers would prepare to go for the after church meetings. Only one interview would be conducted in a day. The in-depth interviews were conducted for a span of six months, running from June 2019 to December 2019. In-depth interviews with the mothers were ideal to help engage and explore the lived experiences women went through during pregnancy, birth and after delivery, explore the meaning to terms and words and explore the totality of each individual case.

The challenge the researcher met during interviews was experienced during sessions with either the second or younger wives. The men would give consent and leave but would not go far, as they sat away from the researchers sight listening to the interview or would be assumed to be away only to hear the man talking from the bedroom or behind the house contributing to the discussion. The interviewer dealt with such challenges by maintaining calm and thanking the husbands in any of such event, then gently reaffirm to the husband that the insights of the woman were very important in this study, as to gather their experiences is a way of involving them in the finding solutions to the challenges bedeviling maternal health.

3.10.3 Key informant interviews

Key informant interviews offer an affordable way to gain a big picture idea of a situation especially in the perspective of an expert in a particular subject that cannot be obtained with other methods (Kumar, 1989). Seven key informants were involved in the study. They were purposefully selected based on their expert opinion on the religious beliefs and practices that affect the utilization of maternal health services by the Nomiya church faithful.

Table 1: Coded identification of Key Informants involved in the study.

ID TYPE	ID CODE	ROLE
KII	KII_001_SCH	Sub-county Public Health officer
KII	KII_002_CH	County Public Health officer
KII	KII_003_B	Bishop of Nomiya
KII	KII_004_C_NCM	Circumciser, Senior clinician, Nomiya church member
KII	KII_005_N_NCM	Senior Nurse/ Matron, Nomiya church Member
KII	KII_006_N_SCRH	Nurse at Siaya County Referral hospital
KII	KII_007_C_NHC	Clinician based in Mission hospital

The principal researcher conducted all the key informant interviews, using key informant interview guide to collect data. This was purposefully due to the fact that the interviews desired a great deal of flexibility, detailed understanding of the objectives and ability to control the sessions especially with the technical experts during the interviews. Phone calls for face to face meetings were arranged with the key informants. The key informants (Table 1) were briefed on the study and the importance of getting their insights on the subject of the study. An appointment for the interview was made. No refusals were met during the study. The key informants were interviewed in their private spaces. For example, meeting with the bishop was at his home, while interviews with the clinicians were done at the respective hospitals where they worked. Only one key informant interview would be done in a day, as the researcher would travel for a long distance to meet with the key informants.

3.10.4 Focus Group Discussions (FGD)

Focus group discussion was aimed at exploring group views from community health volunteers (CHV's). These included views and feelings about the health seeking behaviours of Nomiya faithful, how their religious beliefs and practices affect uptake and utilization of maternal health care services. Open ended questions were used to guide the discussion. In principle, FGD's participants are meant to feel free, talk openly and give honest opinions as they are encouraged to not only express their own opinions but also respond to other members' insights and questions. FGD's lead to a depth, into detail with a dynamism data collection method into a subject not available through quantitative survey tools (Baral, 2016).

A community health volunteer (CHV) is a member of the community, who is appointed by the community to be their representative and a health ambassador. The County governments advertises

the CHV positions, and interested persons in the community then apply. The individual must be a permanent resident of the community, have basic level of education and can read and write, have good knowledge of all the homes and community members. Religious grounds is not a requisite for this position. He or she must be selected by the village members where they live. No salary is pegged on this position, and members apply for the position as goodwill health ambassadors. But, until recently due to the immense work they do, some County governments have considered providing some stipend to these individuals (CSIS, 2015).

The CHV's get various health trainings by the government and the various international and local NGO's. Their primary goal is to champion health promotion, prevention, health education, sensitization, and advocacy initiatives in the community. They are trained on home visits and taking simple health records using tools designed by the government. They report on essential primary health states in the community as water and sanitation, population health indicators as number of pregnant women, home deliveries, number of under 5 year olds, track uptake of health services as use of ANC, SBA, contraceptives and PNC in the community. They also screen for some endemic infectious diseases and refer positive screen cases to the hospitals such as in the case of malaria infections, diarrhea, cough and paleness that may signify TB and Anaemia. Due to various NGO's capacity building initiatives with them, the CHV's are very informed on various health issues. Other governmental sectors have also embraced them to further their interests in the community, such as Agriculture, Education, Gender, among others. They have been champions of One Health initiatives at the community level. Thus CHV's are best placed as the knowledge bearers of the health states of the community, hence the decision to involve them in this study.

One focus group discussion was held with community health volunteers (CHV's) of Bar-Agulu community unit. This area represents an administrative ward, offering a wider geographical focus on the community of interest in the study area as well as making it possible to examine expansive periods and previous experiences of the target group, related events in the recent and past events, as well as allowing an exhaustive discussion. This was held at a home of one of the CHV's, on a day they had planned to have their joint monthly review meeting on the health states and provide reports from their locality. The researcher met the team with the help of the Community Health Assistant (CHA). During the meeting, the CHA introduced the researcher to the whole team of CHV's and community unit CU members, and asked the researcher to give a brief of his mission to the team. The CHV's were welcoming and willing to participate in the study. Six (6) CHV's were purposively selected to participate in the FGD.

The CHV's involved in the FGD were all women, among whom two were in their post-menopausal age, 2 in their late reproductive ages and 2 in their mid-reproductive stage. All were married and worshipped in other churches and not Nomiya church. The CHV's underscored that their selection is not pegged in their religious affiliation. Most of the CHV's were women, while men were fairly represented in the CU. The FGD session was held under a tree shade, with the researcher being the moderator and the research assistant helping with taking of notes. The sitting arrangement was set in an improvised round table. Participants were given codes for their identification to avoid use of participant's names. The participant nearest to the moderator on the right was given an identification code FGD01 and the following members FGD02, FGD03, FGD04, FGD05 and FGD06 respectively. The voice recorder was placed at the center of the improvised table.

The session was held in the mid-morning and took 85 minutes. The discussants requested for a 30 minutes break to get to their meeting and give the reports from their villages before coming back to resume the meeting as requested by the CHA, as the rest of the other CHV's continued with their meeting. Focused group discussion with the CHV's also helped explore the issues and challenges they face and go through as they discharge their duties to the members of the Nomiya church, as the CHV's know almost each and every person in the homes in the areas they are allocated under the national strategy for community health policy by the Ministry of Health (MoH) - Kenya. No focused group discussion was held with the Nomiya church faithful's due to ethical reasons.

3.11 Data Analysis

3.11.1 Analysis of In-depth interviews

The In-depth interviews were recorded using a recorder and typed into Ms-Word format using Express-scribe-transcription software. Initial a priori codes were developed from the interview guide, deductive and inductive codes were generated from the transcripts, a code sheet was developed from the first few source documents and later a master code sheet was developed. The six steps to conducting thematic data analysis, namely familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report, were observed (Braun & Clarke, 2006). Transcription of the audio tapes was done concurrently with data collection to take into consideration all expressions and opinions of the interviewee. This was done while cross-checking the details with the hand written notes taken during the interview. Review of the transcribed data while listening to the audio records for accuracy of translation was done.

This process involved a sequence of reading and re-reading of transcripts, sorting, coding, creation of categories, re-classification and comparison of raw data into meaningful and useful information (Braun & Clarke 2006; Crosley, 2021; Rustagi & Pal 2012). A thematic analysis and discourse analysis approach were adopted (Shaw & Bailey, 2009), using the Andersen model to elicit the predisposing, enabling or barrier and need factors, with the aid of Nvivo12 qualitative analysis software. Thematic analysis began by the establishment of codes to summarize important concepts deductively and inductively. Themes and patterns on participant's experiences were drawn from the transcripts. Thematic analysis is largely helpful in subjective information exploring into participants experiences, views and opinion derived from data (Crosley, 2021).

Thematic analysis of transcripts generated the codes affecting utilization of maternal health services in a logical way. Computer assisted qualitative data analysis was employed for various steps of data analysis. Data were uploaded into NVIVO version 12 software for transcription analysis, coding, recursive abstraction done for thematic and discourse analysis. Post-hoc analysis did not yield any new themes after the 22 interviews.

3.11.2 Discourse analysis

Discourse analysis was adopted to help interpret to how, in what way and why people talk in a particular way when telling of their experiences. Discourse analysis would help reveal the use of specific words by some people, terms from a particular local dialect as this can help reveal deeper meaning of their life stories, influences and community practices. In addition, discourse analysis also helped to analyse the non-verbal communication as facial expression, hand or any other body movements, these are important part of the content of what people say (Turner, 2020).

3.11.3 Triangulation of findings

Triangulating the findings from the in-depth interviews with the key informant interviews and focus group discussion codes from textual data were harmonized and formulated to form the major themes and sub-themes for analysis based on the study objective and question guide. Coding of the transcripts were independently done to the respective themes as defined in the codebook. Participant's quotes were reported verbatim. Each code and sub code was numbered serially to reflect the analysis hierarchy. Analysis and reporting was done per objective guided by the Andersen behavioral model of health care utilization.

3.12 Ethical Consideration

Approval to conduct this study was obtained from Maseno University Ethics, reference number MSU/DRPI/MUERC/00634/18 and Review Board and National Commission for Science, Technology and Innovation (NACOSTI) reference number 933045. Informed consent to participate in this was obtained from the women faithful using informed consent forms. Study participants were informed of their rights which include voluntary participation, terminate their participation during the study at any time they wish. Permission was also sought from the head of the household before commencing the interviews. The men were informed of the study objectives and the intent of interviewing mothers alone. All the men agreed and allowed the researcher to interview their wives with a promise to keep what was discussed confidential.

Interviews were conducted in a private and secure place of choice by the participants to reduce anxiety and chances of non-response. Study participants were informed that their data would be handled with confidentiality and that no identifying details would be included in the reports, but special codes would be used instead. Data was stored in password protected folders with restricted

access to the study team. The study findings have been disseminated to the study community in their respective churches in 2022, and with health care providers at Siaya County Referral and Teaching Hospital in 2021. The findings have also been published in peer reviewed journal and presented at a scientific and health conference in 2023.

For the young mothers living with their parents and in school, permission was sought from their parents to conduct the interview with their daughter alone. Some participants felt enquiry into some of their religious beliefs and practices was an intrusion into their religious rights and spaces. This was overcome by sharing experiences given by church leaders involved in the study, that the church leadership had been informed of the study objectives and the benefits and risks if any to the participants, and sharing with them the approval ethical clearance documents to let the participants open up.

To explore religious issues in-depth about Nomiya church and the principles the faithful's held on maternal health, the researcher would reassure the participant of the discretion in the information discussed, ensure that the informant is assured of their privacy during the session to open up on this matter. The researcher also reiterated the importance of the discussion to help other women who may be bound by such beliefs that may affect their reproductive health, which if we open up and disclose to the health experts would then help to unpack, do more search into those issues with their community leaders, without disclosing anyone's identity to help improve maternal health.

CHAPTER FOUR

HEALTH SEEKING PRACTICES ASSOCIATED WITH UTILIZATION OF MATERNAL HEALTH SERVICES

4.1 Demographic information of the women

Table 2: Demographic characteristics of the women

Age		15 – 19	20 – 29	30 – 39	40 - 49	Total
	Freq.	3	10	4	**5**	**22**
	%age	14%	45	18	23	100
Marital status						
	Married	13				
	%age	60				
	Widowed		4			
	% age		18			
	Separated			1		
	% age			5		
	Single				4	
	%age				18	
Type of Marriage						
Polygamous	**Freq.**	13				
	%age	60				
Monogamous	**Freq.**	5				
	% age	22				
Not married	**Freq.**	4				
	% age	18				
Distribution by number of pregnant mothers (during the survey)						
No. pregnant at time of interview (All in polygamous union)		9				
% age		69				
Distribution by number of deliveries/ children						
No. of deliveries	1-2					
		Freq.	8			
		% age	36			
No. of deliveries	3-4					

		Freq.	10
		% age	45
No. of deliveries	5-6		
		Freq.	1
		%	5
No. of deliveries	Above 7		
		Freq.	3
		% age	14
Place of delivery (total number of births per woman)			
Total number of births		36	
Home deliveries	**Freq.**	19	
	% age	53	
Skilled deliveries	**Freq.**	17	
	% age	47	
Belief in traditional medicines (For pregnancy and Birth)			
Yes	Freq	20	
	% age	91	
No	F	2	
	%age	9	

Age distribution: As contained in Table 2 above, 13 mothers were still in their young reproductive ages, that is, below 30 years of age. These mothers form the bulk of the reproductive age, and having the right maternal health information will help boost utilization of maternal health services and lower maternal deaths. Targeting these women with the right health information on maternal health care and services will go a long way to improve the outcomes that NCPD (2013) had identified to be on a slow pace, to change women's attitude and desire for skilled services (UNFPA 2015) especially among African Spiritual church adherents who have been reported be hesitant and, or delay in seeking health services (Ndabu 2018).

Marital status: Out of 22 mothers, 18 mothers were ever married, with 13 currently married, 4 were widowed, and one woman separated. Only 4 of the women were of single status. Sixty percent (13) of the participants were in polygamous marriages while 22% (5) were in monogamous unions.

Number of children: most of the women had at least one child with some reporting more than 7 children.

Place of Delivery: The home deliveries were at 53% compared to the hospital deliveries at 47%. These findings are a contrast to KDHS reports for Siaya County Skilled Birth Attendance Rate at 61% (KDHS 2014). This reveals that the women of Nomiya church community still hold onto their apostolic maternal care plans as the conventional care plans gain slowly in the community circles and systems. UNFPA (2015), Nzioki et al., (2015) and Shahabuddin et al., (2017) have cautioned on the need to address known issues but with emphasis on religious and cultural practices as most communities are more religiously oriented.

Use of traditional medicines: Nearly all women (91%) reported use of traditional medicines during their pregnancy. This has an significant effect on maternal health as women will hold onto these medicines for relief and hesitate seeking ANC or SBA This leads to hesitance and delay in seeking and utilizing ANC, SBA, PNC and contraceptive services. Findings by Shamaki and Buang 2014) have revealed that use of herbal medicines play a significant role in maternal mortality.

4.2 Health Care Seeking Practices for Nomiya women

This section stands out as a formative objective and explains whether the Nomiya church faithful's seek maternal health services, if they were indeed using the services and what influenced them to use the services and products.

4.2.1 Maternal Health Seeking Pathways during Pregnancy

A majority (99%) of the informants confirmed that during pregnancy, they go to '*madha'* whenever they feel unwell or if they suspect something unusual with their bodies. The visit to '*madha'* was not pegged to time nor health condition one has as a woman, as the TBA is in the community with them. FGD_002_CHV stated that *"Women go to this lady, she massages them. The ladies say that I was feeling heavy all over my body, so I go for massage so that they can feel better to walk about."*

Utilization of maternal health services have been low as seen from the previous KDHS reports of 2003 and 2014, where skilled birth attendance was at 44% and 61%, survey reports falling short of the national target. This study has provided possible explanations on the reasons why the informants delayed and were hesitant to go to the hospitals for maternal health services, or rather opted for self-medication. Early and prompt visits before and during the first trimester of a woman's pregnancy would help prevent congenital malformations like neural tube defects, Rhesus factor incompatibility, and attend to a issues during pregnancy such as anaemia, infections like Malaria and urinary tract infections, and the non-infectious disease challenges. Challenges leading to morbidities that may set in early pregnancy such as incompetent cervix can be identified and averted if most women would appreciate and seek ANC services early. Informant's feared going

for many trips, long queues and many tests involved at the clinics. Similar findings have been by KDHS (2014) and Omondi (2013) that most mothers do not attend the WHO recommended 4 plus ANC visits. This exposes mothers to the morbidities and mortalities of pregnancy.

IDI_005_NCM who would suffer malaria in her pregnancy recalls her unfortunate experience on her visit to the hospital for her ANC, she reported that in "*the third pregnancy, it was really a difficult experience. When I visited the hospital, there were no medicines. I ended up losing that pregnancy."* Disease prevention and control especially, malaria prevention services during pregnancy is key during ANC visit, but this has not been given a lot of emphasis, as revealed by this participant expressing the loss of her pregnancy due to malaria infection as there was lack of anti-malarial drugs to treat the infection at the health facility. After such an even, a mother may resort to using local remedies for the ailments, and by the time they seek maternal health services, the delay to treat the infection could have gone to greater extent leading to fetal and maternal complications and fatalities. This finding, explain the reason why the county leads with maternal and child health mortality. The planning for maternal health services by the Sub-county health program coordinators is wanting, as lack of essential medicines means lack of preparedness to deal with the needs of the mothers during pregnancy.

It is important to note that during pregnancy the immunity of the mothers gets weak and there are chances of losing the pregnancy and, or even losing the mothers life from untreated infections and non-infectious conditions during pregnancy. Most mothers were compelled to go for treatment suspecting that they had malaria infection, if not they would not seek the services. IDI_001_NCM reported that she started ANC clinic *"after 6 months, I had malaria, when am not sick, I don't go."*

As such, lack of essential medicines such as anti-malarials may make mothers to be hesitant to go to the health facilities for maternal health services. The absence of symptoms or signs of a disease is a dangerous assumption as non-infectious disease states may creep in during pregnancy complication the health of the mother leading to severe ill health, disability like in the cases of extreme gestational diabetes complications and even death.

Mothers commenced ANC visits late, as revealed in the table 3 below. A majority 77% made their first visit after four months of pregnancy, while others (23%) commenced ante-natal care after 6 months into pregnancy. There were no reports of utilization of ANC in the first trimester of pregnancy as per the recommended ANC protocol shown in Table 3 below.

Table 3: Commencing ANC visits

Start of ANC	Freq.	%age	Reasons
1-3 months	0	*0*	
4-6 months	17	*77*	*Don't want to make many repeated visits*
7-9 months	5	*23*	*To get the mother-child booklet*

Mothers had various concerns as to when to start seeking ante-natal care. Uncomfortable with the many trips made during pregnancy, a participant said that:

> *I had just started when I was 4 months. I would have started even in the first month, but I just did not want it early. I knew but did not just want to start early. The pregnancy was problematic, at times it made me have headache, and at times I was nose bleeding. IDI_003_NCM*

An important subject and service mothers need during pregnancy is health education with every ANC visit. IDI_007_NCM hinted of the education she got during her visit and reported that *"they teach on the ways we should care for ourselves especially in pregnancy states because if the mosquito bites you, we get malaria faster in our body."*

Attendance of at least one ANC visit is at a high of above 90%, but the attendance as per the WHO 4 ANC visits, is still low among the mothers. This means that the benefits and intention of the care package is not received by the recipients who shy away from the services. With some participants still believing that seeking skilled maternal health services may come last when other local interventions fail. The faithful receive care from their leadership, a trusted church based-TBA, she is believed to have skilled hands, and is respected by many in the community in this apostolic maternal care system. The chance for decision making by the religious leaders and mothers in-law override that of the pregnant mother. They become dependent on their leaders directives especially during these times of pregnancy. Ochako et al., in 2015 revealed that the preference to local methods override conventional care, as is evidenced in these study findings when faithful's depend on their systems of care of maternal care.

The faithful's sought both conventional and alternative care services from '*madha'*. For example, IDI_010_NCM, a 27 years old women church leader expecting her last born reported that though she would seek the church's help, but reckoned that "*with the church its only prayer, they request and pray to God for blessings, but most of it is with the hospital, because I am still attending to the clinics for the expected last born!"* This pattern of seeking maternal health care services are similar to previous findings by Olunga (2006) and Ayele (2014) which revealed that mothers during pregnancy resorted to combining traditional, modern and religious therapies for the multiple health needs of women during pregnancy. Thus as healthcare workers serving these communities, it is important to learn of the local herbs the mothers use, religious traditions they have to observe and be open and non-judgmental while discharging their duties. This should also form a ground for starting sensitization programs in the community.

Dependence on church maternal care systems leads to low utilization of skilled care services, meaning complications will reach the skilled care providers late when there is at times little to do to save the mother and, or the child. According to the Andersen's behavioral model of health service utilization (Andersen 1995), the decision-making mandate by mothers in-law and church based TBA's in the community presents as a barrier to the utilization of maternal health services. This dependence on TBA affects the faithful's attitudes to seeking skilled care services. This then leads to delays in presentation of cases before skilled care providers, in diagnosis and care among women who may need urgent care in cases of infectious or acute diseases. Similar findings on attitude and behaviours to utilization of healthcare services have been by Shahabuddin et al., (2017), UNFPA (2015) and Birhanu et al., (2012). According to Andersen behavioral model on health service utilization, fear and hesitance to use skilled medical care leading to sinister results presents as predisposing factor.

Studying data from the community can be quite important, especially community-based reports provided by the CHV's. These data offer a key to diagnosing health issues such as data on home births and deaths, which can be trigger quick reaction from policy makers and health planers. Consistent community reports revealing low uptake or hesitance to utilization of the maternal health services should be indicative and pointers for action as statistics on low utilization of ANC, SBA, FP and high maternal mortality rates guided the actualization of this study, to explain the factors not thoroughly focused on by statistical approaches. The previous 2 studies by the Population Bureau of Kenya (KDHS 2003 & 2014) reports and county reports over the period of time have raised a red flag for action, as most quantifiable maternal morbidity and mortality framework indicators had been given a lot of attention and interventions put in place for their

solutions except for religious factors. This qualitative study has explicitly delved deeper to explain the factors maintaining these statistics.

Ante-Natal Care is a holistic care package given to a pregnant mother from conception to delivery to ensure they have a safe pregnancy that is assuring a safe and healthy development of the fetus and a safe experience to the mother (including counseling and health services). This is majorly a care package offered at the health care facilities by trained and qualified healthcare providers of various skillset, but there is a near alternative care offered by the TBA's in the community (UNICEF & WHO 2017). Mothers have a freedom to choose where to go to for the kind of care and assurance during pregnancy. There is no legislation criminalizing non-utilization of these essential services, which may lead to death of a mother in the community.

During pregnancy, infections for example malaria, urinary tract infections, respiratory tract infections and other febrile conditions can threaten pregnancy. Non-infectious conditions like in cases of Pre-eclampsia Toxemia (PET), Gestational Diabetes Mellitus, Placenta Abruption and Placenta Previa among other obstetrical and physiological gynecological conditions, not to mention a mix of both can also be equally threatening to pregnancy. These conditions are easy to screen, can be easily diagnosed early and controlled if not plans made to manage them. These conditions are manageable, preventable and some curable with proper care especially after delivery, this can be achieved by having an open and a receptive health care system as well as communities. This is the only way to reduce maternal morbidity and deaths to the desired target threshold set by the World Health Organization.

During ante-natal care clinic visits, abdomino-pelvic examinations are done to assess the development of the fetus in the womb. While assessing the services mothers got during a visit to

the health facility, IDI_013_NCM reported that; "*they test blood and they also touch our stomach, I don't know what else, and also they take our weights. I have always just seen them examine the baby."* But, on exploring further to gauge if mothers understood the reasons why these examinations are done, a mother reported that; *"That I don't know!"* IDI_013_NCM. These findings give an impression of health care system that is detached from one of its major stakeholder, the 'users' of the key services the system offers. This calls for a re-orientation of the services and system of doing things. It is important to educate and inform the mother of what it is that is being done, why, how it is being done, how often it will be done and when it won't be, so that the women can be the agents spreading the good message of the maternal health services amongst their peers.

Laboratory investigations, machine aided clinical examinations and scan tests are very vital during pregnancy. Participants reported that they received some of the machine aided tests and screening services. IDI_001_NCM noted that; *"they tested my blood, urine and examined my pregnancy."* A participant recalled the experience of her first ANC visit, after consulting with the clinician who took the details of her pregnancy states, lamented that;

> *The procedures being followed are so many that I … [sighs and laughs]. You also move to the next stage for testing, there are so many tests done that day, that one cannot have all of them done (disapproving tone). As for the money, it is free. But they take a lot of time with the testing. (IDI_006_NCM)*

These tests are important in the diagnosis of morbidities and co-morbid conditions in pregnancy, so as to enable clinicians to take clinical steps to manage these conditions and hence prevent the unnecessary mortalities related to pregnancy and birth. Giving mothers in-depth information about the tests and their importance will increase their knowledge and acceptance of the services leading to an increase in the utilization of maternal health services. This will in-turn also influence the

number of visits mothers have to make during pregnancy to the ANC clinics. The study revealed that mothers would not tell of how many times they should visit the ANC during pregnancy, a possible pointer explaining the low turnout on the number of 4 ANC visits require per pregnancy, as WHO recommends 4plus ANC visits. There is need for community sensitization on the number of visits and the importance of these visits among the women of the Nomiya Church faithful's in Alego-Usonga Sub County.

Confirming the services mothers are offered during a visit to ANC clinic, a discussant reported that:

> *Mothers will get a package of services, they will get to know of her HIV status, she will get tetanus vaccine, she will get to know how the child is growing in the womb, she will also be given those drugs to boost her blood levels and also make the child grow into a strong baby. (FGD_001_CHV)*

When mothers go to the health facilities and find long queues that seem not to move, harsh and unapproachable healthcare workers, lack of triaging personnel at the reception areas, waiting for the healthcare workers to turn up for work even past the official reporting time, lazy and unconcerned health workers to the plight of the mothers, long waiting time for laboratory results, and waiting further to be reviewed by the clinicians who require laboratory results to make informed decision on their care. These make them delay or be hesitant to go for maternal health services. In the rural communities, the longtime of waiting eats on the time for other multiple tasks that is before them that waits their attention as taking care of children, cooking, fetching water and firewood, gardening and going to sell or buy some items from the market in the evenings. According to Andersen behavioral model of health services utilization, these factors present as barrier factors to utilization of ANC services.

The study revealed that mothers were hesitant of seeking skilled services at health facility due many testes and long waiting time. For example, a mother reported that with the visit, if pregnant *"there are so many tests done that day, that one cannot have all of them done [disapproving tone]."* The are many tests that are ordered and mothers subjected to go for. This also mean that they take a long time waiting to have samples processed and wait even a lot more for the results get to the clinician who requested for the tests to use the test results for their care. These delays at the health facilities discourages them from going for these services and instead mothers opt to delay utilizing MHC services. A participant reported that;

> *I use drugs (over the counter) even for three months. When I go to hospital and before I tell them that I'm expectant, they can only offer me Coartem and Panadol and I go back home. They can also send you to the laboratory and when there is no disease detected, they only say a disease can be hidden. (IDI_007_NCM)*

Women tend to use home remedies using both local and modern conventional care. Health care providers are the books mothers read from, and due to the financial challenges, time constraints, mothers opt for ways easier of care, as explained by a key informant below;

> *There seem to be a lot of uncertainty in the diagnosis, care and assumptions in the treatment clinicians make in the earlier days of pregnancy. The clinician's belief in curative medicine and clinical cover for malaria is overshadowing every other effort in maternal care, and mothers are doing the same even without going for care at the hospitals. (KII_002_CH)*

Mothers copy from the health workers previous prescription patterns following repeated experiences they have had with the previous pregnancies, by taking self-prescribed medicines and herbal concoctions which could be harmful the developing fetus. Previous studies by LaHaye in 1998, Amirrtha and Reid in 2008 revealed that during stressing moments, people anchor strongly to traditional and religious expectations for their care, as is seen in most pregnancies, mothers use both the herbs and conventional medical products to treat amenorrhea after using contraception for long. Findings by Olungah in 2006 revealed that traditional, modern and religious therapies are

usually combined during pregnancy and childbirth for multiple needs of women. This maybe so because of the more traditionally inclined care seeking habits by the community that is hesitant at taking conventional care services as UNFPA (2015), UNICEF/ WHO (2015) would reveal.

Utilization of maternal health services have been low as seen from the previous KHDS 2003, 2014 survey reports and County statistics, and this has been confirmed during this study by the informants who delay and were hesitant to go to the hospital for maternal health services, or rather opt for self-medication. Early and prompt visits before and during the first trimester of a woman's pregnancy would help prevent congenital malformations like neural tube defects, Rhesus factor incompatibility, and attend to issues during pregnancy such as anaemia, infections like Malaria and urinary tract infections, and the non-infectious disease challenges. Challenges leading to morbidities that may set in early pregnancy such as incompetent cervix can be identified and averted if most women would appreciate and seek ANC services early. Informant's feared going for many trips, long queues and many tests involved at the clinics. Similar findings have been by KDHS (2014) and Omondi (2013) that most mothers do not attend the WHO recommended 4 plus ANC visits. This exposes mothers to the morbidities and mortalities of pregnancy.

IDI_005_NCM who suffered malaria in her pregnancy recalls her unfortunate experience on her visit to the hospital for her ANC, she reported that in "*the third pregnancy, it was really a difficult experience. When I visited the hospital, there were no medicines. I ended up losing that pregnancy."* Disease prevention and control especially, malaria prevention services during pregnancy is key during ANC visit, but this has not been given a lot of emphasis, as revealed by this participant expressing the loss of her pregnancy due to malaria infection as there was lack of anti-malarial drugs to treat the infection at the health facility. After such an event, a mother may

resort to using local remedies for the ailments, and by the time they seek maternal health services, the delay to treat the infection could have gone to greater extent leading to fetal and maternal complications and fatalities. This finding, explain the reason why the county leads with maternal and child health mortality. The planning for maternal health services by the Sub-county health program coordinators is wanting, as lack of essential medicines means lack of preparedness to deal with the needs of the mothers during pregnancy.

It is important to note that during pregnancy the immunity of the mothers gets weak and there are chances of losing the pregnancy and, or even losing the mothers life from some unattended to infections and non-infectious conditions. Most mothers were compelled to go for treatment suspecting that they had malaria infection, if not they would not seek the services. IDI_001_NCM reported that she started ANC clinic *"after 6 months, I had malaria, when am not sick, I don't go."* As such, lack of essential medicines as revealed above may make mothers to be hesitant to go to the health facilities for maternal health services. The absence of symptoms or sings of a disease is a dangerous perception, and non-infectious disease states may creep in during pregnancy complication the health of the mother leading to severe ill health, disability like in the cases of extreme gestational diabetes complications and even death.

The costing for maternal health care services are not standard in all facilities. Some facilities charge the mothers for the services they received while in others they are offered free without charge, a factor that would make mothers to avoid seeking healthcare services from those facilities that clients paid for the services. IDI_002_NCM reported that "*there are places you pay, others you pay less cash and some places the services are free."* In some instances, the essential drugs were not available hence mothers were forced to go and buy them from the nearby drug shops. These

claims were evident despite the robust government interventions to support maternal health services as universal healthcare delivery, free maternal care, Linda-mama program initiatives alongside other non-governmental organizations (NGO) based interventions having been intensified in the region. According to the Andersen model of healthcare utilization, these deficiencies governing maternal health services are possible barriers to the utilization of maternal health services. Similar findings have been realized by Mbugua and MacQuarrie, 2018), Knight et al., in (2013) who also revealed that cost issues, inadequate drug supply were potential barriers to utilization of maternal health services.

This study found out that the experiences of the community members about free health care means that all the medical care services are free, that is including consultation, clinical examination, laboratory investigations, delivery care and clinical reviews to receiving drugs to use even when nothing is actually the matter. 'Medical care without drugs is no care', is a deep rooted notion that has made the users to be more curative than preventive oriented. The above facts technically point out to the barriers to utilization of ANC services. Arguably, as the study model highlights personal health choices may translate to pregnant women who should visit the health facility for regular health checks to assure the mother that all is well with the pregnancy, rather deciding not to take it upon themselves to go for check- up, seeing no benefit from the health visit and come back empty handed. This presents as a predisposing factor affecting utilization of maternal health services in this study. The mothers are unaware of the risks that unnecessary use of drugs, conventional or herbal products during pregnancy have on the fetal development. Also, to note is the lack of policies spelling out clearly what services are charged and which ones are not, creating a knowledge gap among the faithful's regarding the spectrum of services.

It is true and a policy subject that maternal health care services should be offered at no cost in all public health institutions irrespective of the level or tier of the public health facility, in Kenya. But this is not the case. Healthcare watchdog at the county and sub-county levels seems to be oblivious of the happenings in the community and have left mothers to suffer from exploitation at hands of greedy healthcare providers. The neglect of the maternal health issues makes the external environment and services offered by the TBA's to be more likely. Maternal health indicators will continue to be worse in Siaya County, where MMR is at 691 deaths per 100, 000 live births (WHO, 2015), a rate almost twice that of the national rates at 362 deaths per 100, 000 live births. When maternal health services are not standard in all facilities, users then may become hesitant or seek care late.

> *The nearby health facility had lazy health care workers. The care at the health center is so bad and pathetic. The medicines are not given, when you get, they are in complete doses and at times they just write the drugs for you to go and buy. Mark you, we hear it being announced that drugs have been sent to the government hospitals, where do these drugs go?* (IDI_004_NCM)

Many factors that come to play on utilization of ante-natal services as the availability of medicinal products and vaccines. Availability of maternal Tetanus Toxoid (TT) vaccines that needs to be administered to keep the mother safe from tetanus. Fetal tetanus infection in utero-transmission is likely when a mother sustains a cut. Visiting the nearby health facilities by the faithfuls was generating little interest, as many reported not getting the essential drugs for their diseases. As a matter of fact, drugs are a marker of curative service provision, and when not available, it is no service offered. Participants especially viewed and stressed expressing that a visit to the hospital and missing drugs meant no care. Visiting the hospital and getting drugs had a big effect, a visit and missing prescribed drugs, a participant expressed that, "*No, I can't be happy when not given drugs"* (IDI_001_NCM).

Seeking healthcare services at the nearest government health facilities which were only some few tens of meters from participants homes were bypassed for far distant health facility. Mothers were not pleased to visit the health facility and miss essential drugs. Some reported lack of drugs as importantly influencing their utilization of skilled care services stating that *"With no vaccine available at the hospital especially for a pregnant mother for tetanus, then why should I go there?"* (IDI_005_NCM). "*With that state of events at the health facility, I cannot visit the hospital."* IDI_020_NCM.

It is possible for the community members to be aware of drugs being in their health facilities, as the government or the local media and leaders would tell the people when supplies are taken to the health facilities. Going to the health facility and missing the products or realizing that the infrastructure is lacking only dampen their urge to go for the services. A key informant reported that;

> *If there is no motivation amongst the health care workers, lack of proper storage of vaccines … and challenges of transport to the facility by mothers, all these can reduce uptake.* (KII_004_C_NCM)

When participants revealed that the instructions from the healthcare providers was to just take drugs until the drugs are done, with no explanation on dangers of the medicines, prescription or not, on when to stop them urgently in case of hypersensitivity. Neither were mothers told to reporting of a return date for review nor to return to the clinics in-case of any change, as the drugs too, can cause various reactions like severe skin reactions and effects like abdominal pains, vomiting and lead to untimely expulsion of the products of conceptions. *A participant revealed that;*

> "T*hey didn't really count the tablets, but they were many, it is taken one three times. … I just take them until I finish, on the revisit they don't add the medicines."* IDI_006_NCM.

These findings indicate that healthcare workers are not unpacking the education and information of the products and services they offer to help mothers understand why and how and until when the services and medicines should be utilized. About direct observational therapy (DOT) done at the clinics especially for malaria prophylaxis, as recommended by the government's MoH, Kenya, most mothers did not know that the DOTs treatment they took was for malaria or helminthic prophylaxis. This non-disclosure of the information regarding the products and services presents as a barrier factor to the utilization of maternal health services. This glaring gap in the offering information to the women features further when mother expressed that healthcare workers were not unpacking the health information that need to be given during ANC visits.

This was evidenced by the mothers inability to explain the reasons for the many visits to the ANC they are required to make, further explaining the reason for the low turnout for the 4-plus ANC visits required during pregnancy in the study area. The mothers did not have definite information as to why the drugs smell bad nor explain why they must be used for the long time they were issued, a participant stated that;

> *I was given 2 tablets just for the round worms which were white. I was given and I swallowed them there and no other drugs were given apart from these and the red one's that also smells bad. (*IDI_003_NCM)

Folic acid and Ferrous Sulphate are vital nutrients required during the 1st trimester of pregnancy, more especially folic acid use before and during the earlier days of pregnancy. Thorough pre-conception and early pregnancy counseling on taking folic acid (400 micrograms) supplements daily as soon as a mother can, is a medical weapon against central nervous system congenital

malformations as the neural tube defect. The study revealed that mothers would not identify or reveal when, for how long or why they were taking the vital vitamins. This point to lack of health education given to the mothers on this important subject, and this present as a need factor, according to the study model. Previous findings by Olubenga et al., in (2013) and Enwereji et al., (2010) reported that mothers discontinued use of iron tablets fearing that it would lead to big babies and threatened abortion, risking maternal health even the more.

Mothers lacked of the right information as revealed in this study is a predisposing factor. Health care workers need to provide information to dispel myths, misconceptions held by the Nomiya faithful's to make them have the right information about maternal healthcare products and services. This will lead to improved knowledge on the medicines (the what), and understanding the reasons for utilizing the maternal health services (the why), the many revisits, the long periods of taking medicines and the examinations conducted every time they visit the clinic. Not giving appropriate and reliable health information and counseling during ANC visits only lead to continued holding onto wrong perceptions as communities believed that the drugs lead to big babies complicating delivery, or as not right for the baby but take herbs that are believed to makes the baby grow healthier and stronger in the womb. That would only mean that there is going to be low uptake of maternal health services, missed opportunities, delays. That would also translate to not meeting the set targets by the county and national government health departments and continued high maternal mortality rates.

There is need to draft a policy focusing on maternal health, especially focusing health service delivery and on improving the initiatives of sensitization on the services available for the mother at the health facilities. A plan to remodel the training of healthcare workers and repackaging

maternal health modules amongst the various clinical disciplines that offer integrated maternal health services. Bringing stakeholders together to plan, re-organize and chart a way forward for improving maternal health in the area targeting specific groups can also go a long way in improving utilization of maternal health services.

There are programs that come as a result of a research program that seeks to improve health states of the mothers selectively or in a broader health program but are only in selected areas and for a particular period. A participant who had an experience of having ante-natal care under the Non-governmental organization (NGO) research program and an experience in a public health facility where such care was not provided, reported of her experience on malaria prevention program during pregnancy that;

> *To prevent malaria? No! Only when you are sick with malaria. They (drugs) are nowhere. Even if you go to whichever dispensary it's difficult to get them. They only give you a net to prevent malaria … I was only given the drugs when I was pregnant with my second child. That's only because there was that organization from the University of Nairobi that was here in Siaya to conduct a research on malaria in pregnancy. (IDI_005_NCM)*

According to the Andersen behavioral model of healthcare utilization, prophylaxis given for Malaria present as an enabling factor. Mothers who were enrolled in NGO research projects and were offered a health cover for all their healthcare problems during pregnancy and additional financial help for their use. Mothers revealed that during the projects activities, mothers would get other added priorities such as quick services from the laboratories to clinical services and even get special transport means back home or get transport reimbursements.

Alego-Usonga Sub-county being a prime research area with many other projects going on, these many research studies do influence health behaviour and use of health care services in the project areas. In the long run when subsequent pregnancies happen when the research or health projects

are long gone, the motivation is lost, and the drive for seeking maternal health services is lost when the extra attention and selective care to the mother is no more. According to the model, health projects presents as a barrier to utilization of maternal health services, as services offered in routine care settings would not be consistent nor given as expected.

Birth planning is an initiative that should be introduced during the early ANC visits, and intends to improve the preparedness of the mother to motherhood, preparing her to the immediate needs and requirements of the mother and child beforehand. But this is not the case as most mothers start visiting ANC late in pregnancy after the first trimester as was shown earlier in section. Birth planning helps focus and direct energies to that time of delivery by mothers (WHO 2009). The unpreparedness witnessed when mothers are rushed to the hospital without a shawl, maternal hygiene sets required after delivery for the baby, and when mothers have no knowledge of their blood type during emergencies maybe avoided by a good birth planning program.

Birth planning also help unpack and reduce the anxiety that is built in times of emergency when the child requires technical resuscitation equipment's or treatments, which have been translated to lead to death by the community. But within Nomiya church, birth planning is neither promoted nor allowed. A key informant and a bishop of Nomiya church, revealed that the church doctrines do not allow for birth planning and reported that:

> *The day a woman wants to deliver, then that is when we can talk about where she will deliver! A woman only starts preparations when she is about to give birth. Early planning is not possible since you are oblivious of what is in the womb and for us as Luo's, we believe that if you start that earlier; the woman can deliver a baby or a tortoise or something else. In my opinion I cannot prepare something in advance, but for this generation, they do it. But, in my home it is not done, neither by my wife nor my daughter's in-law.* (KII_003_B)

With appropriate messaging during ANC outlining a birth plan and unpacking any emergency outcomes and addressing maternal fears held by community members especially regarding technological infrastructure and the procedures that may follow such as the negative beliefs held regarding the use of nasogastric feeding kits, not giving injections, blood transfusion, phototherapy, Kangaroo techniques and new policies. Unpacking and giving in-depth facts on these issues may lead to increased utilization and improved maternal health outcomes. A well designed birth planning program can also explore into the community and religious traditions, practices and help understand why they are observed. This can be an opportunity to involve the mothers on finding the deeper contextual meaning to the use of herbs during pregnancy as some participants argued that some herbs make the baby grow strong and healthy. Unpacking such contextual hidden facts may help inform messaging to address the perceptions, and stress that such use of herbs may lead to birth defects, affect the baby if the contractions were false labour. It is also important to dispel the myths as revealed during focus group discussion by a participant who reported that '*There was a belief that if you buy things early then the child will die, or something terrible will happen.'* (FGD_002_CHV)

"Someone told me that when pregnant, that I should spare and keep some money, sometimes I should buy a thing or two early, so that I don't suffer when delivering." But this was not approved by the apostolic system. Efforts to have a birth plan is challenged by local community beliefs, warnings and church doctrines that the church leaders highly regard to guide mothers during pregnancy, as their apostolic maternal principles. A well utilized birth planning session would help teach and prepare the mothers of the pregnancy using teaching aids, and efforts should be planned to reach church high ranking leaders with the right information to let them have the right information on birth outcomes, in a friendly and consultation ways. According the Andersen

behavioral model of health service use, these beliefs on birth plans present as predisposing factors to the utilization of ANC and skilled birth services. Contextual policies targeting community leaders on maternal health issues and ways of improving their knowledge on maternal health services, can go a long way to improve statistics on the uptake ANC and SBA services. According to this study, the faithful's hold in high regard apostolic ways of maternal care. But a wave of change is slowly building up;

> *Now, about birth planning, we are starting to teach them, when we go to the household we talk about it a lot. Now they are starting to buy a shawl, a cloth, something that never used to happen. There was a belief that if you buy things early then the child will die.* (FGD_002_CHV)

Even as conventional programs are setting in slowly to change this norm, there is need for intensified sensitization on the need for and on benefits of ANC, SBA and PNC, to scale up utilization of these services as well as processes that would improve the outcomes or SBA as birth planning. A participant revealed that; *"The CHV normally comes to visit me and she keeps urging me that if I see any other sign, I should run to the hospital, because the labour might come with problems*" IDI_009_NCM. She further revealed that she had been given information about danger signs also reported that the teaching influenced her decision on choosing her preferred place of delivery.

Another participant noted that, the danger signs to watch for when pregnant IDI_013_NCM include *"lower abdominal pain, severe malaria,"* IDI_002_NCM added that if you see *"some bleeding when pregnant and feel severe abdominal pains, and yet your days are not yet."* Some mothers did not know about the danger signs a woman may possibly experience during pregnancy. IDI_008_NCM didn't know of any of the danger signs despite having visited the ANC clinic just recently. While reviewing the mother-child booklet with the participant, the researcher found out

that the pregnancy progress reports, clinical examinations and visits were up to date, she had attended 3 visits, all laboratory tests done and had received Tetanus toxoid vaccine. After going through the MH booklet together with the participant and seeing the pages displaying danger signs in pregnancy, she reported that; *"I really don't know, you know that book (pause) I don't go through it often, am always busy [Laughing]."*

IDI_006_NCM who also didn't have knowledge on the danger signs claimed that; *"Maybe there are those lessons that are done on the days I have not gone to the clinic, so I miss that."* These findings reveal of the missed chances for health educating and counseling the mothers during ANC visits on the services they ought to seek for during pregnancy and most especially informing them of the danger signs to expect while pregnant. Without knowledge of important risks involved during pregnancy and delivery, mothers are likely to hold on to their practices and as such, the high maternal mortality rates will still be maintained in the Sub-county. A participant who had an inevitable abortion at 24 weeks of gestation six (6) months ago and was pregnant at the time of the interview reported that:

> *My labour came but in the form of too much bleeding. It was too much blood. I had started experiencing pains in the morning and when it reached 12 noon, then the bleeding started, my tummy was now hurting consistently and blood was oozing. They rushed taking me to Akala Health Centre. The nurses there got shocked.* (IDI_005_NCM)

During pregnancy, the life of the mother and the baby are so delicate and are always at constant threat from infections, non-communicable diseases, nutritional deficiencies, immunosuppression among other health threats. Health education about what to know as normal, the abnormal and danger signs during pregnancy should be part of ANC package at every ANC visit. Among the participants, 32% (7) of the participants had no knowledge of the danger signs experienced during pregnancy, pointing to the fact that the study population is a special community which still need a

lot of Public health education, counseling and sensitization on seeking skilled ANC and other maternal health services. 68% (15) participants had knowledge of one or two danger signs, which is still not a sufficient, as knowledge of just one or 2 danger signs should be a marker for intensified health education and sensitization for uptake of ANC and SBA services.

Further, knowledge of one danger sign is not sufficient enough for there are various abnormal, occurring singularly or as multiple factors overtly or covertly warning signs during pregnancy. Among the participants, no one reported of being informed of the danger signs during peri-natal period, so as to rush immediately back to the hospital in case of any abnormality. This important novel finding possibly would be contributed to partly by the fact that there is an impending religious practice (seclusion) that need to be observed after a successful delivery. Acknowledging existence of danger signs in pregnancy or at delivery in conventional care setting would mean that management would require one to be admitted at the hospital for their management. It is in admission that members are not comfortable with for the period of admission is not known, which may progress past the set day of baptism and seclusion date.

Added to the fact that admission may clash with seclusion tradition, faithful's also believed that the facilities lack drugs and personnel and would not get the best from the health facilities. But this can also mean that there is little health information passed to educate and inform the mothers on post-natal health services and risks that may also develop around that time. This glaring lack of information, presents as a need factor according to the study model. The above factors could explain the high post-natal maternal deaths recorded in this area, as Siaya County lead in the region in MMR and post-natal maternal deaths (Appendix 4). No mother reported of ever visiting the health facility to manage a danger sign.

4.2.2 Care seeking pathways during delivery

Skilled birth assistance (SBA) is one of the mandatory services World Health Organization and the Government of Kenya prescribe and uphold that every mother in labour deserve with a lot of dignity, safety and support clinically, physically and psychologically. Utilization rates in the sub-county and Siaya County was far below the WHO set standard at 90%, especially among the Nomiya church community in Siaya County, with a skilled birth attendance rate of 47% against that of the general population in the county at 61%. Normal delivery, includes all efforts for spontaneous vaginal delivery, instrument aided vaginal delivery and Cesarean Section delivery.

Appreciating the good work of skilled birth providers, participants reported of their experience after delivery that;

> *At times, when you have labour pains and the baby is far, they give you an injection …This will help in bringing the baby closer …then, they'll tell you to lie down so that they help clean you first because there are some traces of blood that remains inside that needs cleaning.* (IDI_002_NCM)

> *When a child is born, yes! They cut the umbilical cord, clean the baby with a dry cloth and the baby is taken to a tiny bed like this [demonstrating the size of the tiny bed], for weighing him [laughs]*. (IDI_008_NCM)

While IDI_010_NCM applauded the mother-baby care initiated as soon as possible after birth, she recounted that "*after birth, they just want you to breastfeed … It takes about 30 minutes, but if there are delays, then within 1 hour."*

> *The nurses are different in their character and skills, there are some who after delivery, will come check on the child, ask if it woke up well and even ask you if you are having heavy bleeding and many things … others are just there.* (IDI_008_NCM)

An analysis of birth statistics among the Nomiya Church faithful's revealed that 53% of the deliveries were home deliveries, with less than half of all birth having had a skilled attendant.

Notably, there were reports of a prime gravida and twin pregnancy deliveries at home despite the high risks involved and the high level of at least 1 ANC visit reported in the county. The numbers realized from this study are of great contrast to the KDHS (2014) and Siaya County Health Statistics at a Glance survey reports (2014) that reported a 61% for skilled birth attendance rate. The study found out that the rate of home delivery surpass that of SBA deliveries, giving more reason to focus on the contextual factors in the communities maintaining the poor maternal health statistics in the region. Efforts involving identifying those women who had great experiences at the hands of skilled birth attendance to be ambassadors for community sensitization in a bid to scale up maternal health service utilization among the target community, can be one of the sensitization intervention to gain on utilization of maternal health services.

Giving reasons for the occurrence of home births, a participant had this to say:

> *Here at home, the timing of my deliveries is always so bad. They usually get me at the wrong time … at one or two in the night … the motorbike guy can't accept coming at that time (to take me to the hospital), he only says that he's coming, but you don't see him, am coming, but nothing!* (IDI_006_NCM)

The above narrations give an impression of intentional home births, and unwarranted delays at home about delivery time. Preference to traditional birth attendance by the faithful is a determining factor among the faithful who sought their assistance as there are so many factors that support such attempts, discussed ahead in chapter 6. There are delays to seek skilled birth services which could be contributing to the high statistics of MMR seen in the study area.

Some mothers had bad experiences at the hospital during delivery at the hands of skilled care attendants, and had these to say;

> *If you cry during labour, shout or disturb, the nurse will just be in there with you but the abuses and slaps will be yours for that day, you'll get enough of that [Laughs].* (IDI_003_NCM)

> *When I arrived at 3 am in the night, I realized I had left the mother-child booklet at home. That is a mistake. So, we had to send someone to go back home to bring the book. Now that the book was not there, they left me on the cold cement floor waiting for the book, all that while I was having labour pains.* (IDI_008_NCM)

While during delivery mothers should be treated with utmost respect, observing the principles of respect, beneficence and fairness, mothers reported that healthcare workers did not take care of them even at critical points of labour. For the reason that a mother forgot the Mother-Child Booklet at home, she was denied immediate services and access into the critical service point, that's the labour ward. In case fetal condition changes would occur requiring urgent assistance as fetal distress that chance would be missed leading to a possible still birth, leading to mental anguish to the mother, family and community. Some participants reported that when they were unable to bear the increasing contraction pains during labour and cried out loudly, that earned them a beating, an abuse or were ignored altogether. Some then delivered alone while in the delivery chambers only for health care workers to come when the baby is already born. Risks involved by such negligence include child falling on the floor which may lead to head, truck and limb injuries, child death and untold mental anguish to the mother. Another participant narrated her experience;

> *That time I got it rough, there were so many trainees. Every short while, they would come back, I don't know what they were studying in my body, they were fixing their fingers down there inside my private part. It was too much that it reached a time I was feeling numb that even when the child was coming out, it failed to even come out. The child was pulled out using a metal … And his buttock was swollen like this (demonstrating) towards the neck. And his back also had a blunt thing … on his backbone line*. (IDI_008_NCM)

This narration above by the participant gives an impression of a condition likely to be of a Neural Tube Defect (NTD), a rare congenital malformation in newborns that is prevented by the consistent use of Folic Acid tablets daily before and during the early days into pregnancy. It is notable that not having a candid talk with the mother to help her understand what condition the child had, how such kind of health conditions come about and how best they can be prevented in the future, the

health providers let the mother leave the hospital without the right knowledge of the child's condition and its cause. The faithful hinted that she left the hospital without being given full information about her child's condition, which affected her decision making in caring for her child. This further impacted on the mental health states of the mother and her family in general.

According to the Andersen behavioral model of health service utilization, characteristics of healthcare workers may influence women's choice to or not to utilize healthcare services. Undesired and disappointing results caused by interacting with healthcare workers while seeking maternal health services present as barrier factors to the utilization of maternal health services. Similar previous study by Shamaki and Buang in (2014) revealed that unattended deliveries in health facility settings play significant role in maternal morbidity and mortality, and influence utilization of maternal health services. Yet another participant narrated of her experiences that she said influenced her seeking and utilization of skilled birth services;

> *Women see and pass through a lot, at times you meet a midwife who also have an attitudes and lack of interest while pregnant themselves, so when you talk to them badly, they feel irritated and even cry. Inwardly a mother makes decisions that I will never go back to that clinic ever again. Even the young girls, who have not been married, pass through ills at the hospitals, and with such, they recoil and tend to fear going to seek health care, remember they are pregnant.* (IDI_004_NCM)

Another faithful sharply reacted to the thought of a male skilled birth attendant helping her during delivery. She stated that;

> *"I won't allow him he! he! he! The female hand is better. A fellow woman is better than a man … [sighs] mmh, No! [sighs, nodding - strongly refusing against the thought of a male SBA]*. (IDI_006_NCM, mother of 4, all delivered at home)

Some health procedures are new to the women and some women find some the procedures offending to them such as with digital vaginal examination without their full consent, having male skilled birth attendants to care for them and undressing to be examined. All these play as barrier

factors and there is need for reinforcing of the policies, training of healthcare workers on client relations, work ethics and the need to honor the Good Clinical Practices and the fundamental human rights. Principles of care, ethical concerns as informed consent, beneficences seem to be on a slope of erosion, as the patients feel vulnerable and exposed to risks at the hands of health providers. Women reported to have repeatedly experience the poor handling during ANC visits, and with that in their mind decide not to go back for hospital delivery.

The healthcare workers are unaware of the fact that they are the books mothers study, assessing their attitude and interest and character, to trust with their health and that of their unborn child. Display of skills without respect to women's body and wellbeing only drives them away from seeking health services in the future, when the young mothers are treated harshly and not given support by the trained healthcare workers, they get inclined to seek alternative community and spiritual interventions. In alternative apostolic care settings, TBA's listen to them, give more tender care and vital attention they so much need. The harsh handling has led many young mothers to be hopeless towards seeking and utilizing maternal health services, thus affecting their decision to seek and utilize professional maternal health services. The prevailing situations of complex relationship between mothers and healthcare workers who seem not to observe the ethical vows they swore to uphold in their practice, leads to a web of complex results among users of maternal healthcare services from seeking alternative health care, to delayed presentation, delayed referrals to other health institutions of care, and eventually translating to the high maternal mortality rates especially from preventable diseases.

The relationship further takes even a more complex turn when some mothers reported that the expectant nurses on duty attending to them would be so moody or even cry when mothers talk to

them and they in turn feel offended or uncomfortable. The sight of seeing a nurse crying while serving them was very disturbing to some participants that they claimed they wouldn't wish to be the cause of search reactions among healthcare providers. According to the Andersen model of healthcare utilization, health provider's characteristics affect mothers decision to use or not use the services. Health providers are core to the provision of maternal health program. If they present as a barrier to the utilization of services, that would strongly impact maternal health program. Similar findings have been by LaHaye (1998), Amirrtha and Reid (2008) whose findings reveal that during stressing moments, especially after disappointing experiences while seeking ANC or SBA leading to individuals anchoring strongly to traditional and religious expectations for their care. Olungah (2006) added that people may combine traditional, modern and religious therapies during pregnancy and childbirth for multiple needs of women.

When health care workers are perceived as unsupportive, neither welcoming expectant mothers, explain the procedures nor educate mothers on the danger signs during pregnancy, engage mothers on birth planning, breastfeeding, caring for child; nor dispel myths surrounding delivery, fears over CS delivery and misconceptions that they firmly hold on to especially during a visit for labour, these affect their utilization of maternal health services. That will call for re-orienting the training and routine of service providers, designing a policy to support and improve maternal health services. In this study, most mothers didn't know about the danger signs in pregnancy, pointing to a closed system to maternal health concerns, finally affecting uptake and utilization of skilled birth services.

Mothers cried of the health care systems and workers being insensitive to their needs, especially when their cautions were not heeded to. While giving birth without assistance mother may sustain

serious perineal tears, and get assisted by lay persons without any measure of infection prevention and control measures, a concern the WHO is working towards eliminating. In Africa a proverb from Chad states that a pregnant woman has one leg in the nursery and another in the grave (Kristof, 2004). There is need for change in the traditional way maternal health services are being discharged today, according to Andersen behavioral model of health service utilization, insensitivity of healthcare workers affects utilization of maternal health services negatively, and such experiences in the hands of skilled health providers may drive them to utilize alternative care services, where services are far from safety and infection prevention. Previous findings by N'Gbichi et al., (2019) and Azuh (2015) have revealed that mothers who face these troubles may turn to the TBA's, who they reported to be providing better delivery services than trained midwives and nurses.

Mothers need to be educated that it is important to go straight to health facilities without seeking escort of the CHV's, but can be accompanied with their husbands or close relative. This study findings reveal that the 'CHV referral' and escort could be driven by cash incentive from. This leads to delays in seeking SBA as mothers deliberately stay home until it is close enough to deliver that they rush to the CHV's home to take them to the hospital as they had planned before. This 'Chaperone Principle' promoted by the MOH has been taken in a wrong way by the CHV's and the women. With the KDHS Census 2014 report on births by CHV's and births that occur on the way to the health facility in the company of a CHV's being considered as skilled attended births, in real sense these birth are not, neither are all births at the health facility skilled birth attended, as some births happen in the hospital unattended by a skilled provider as realized before in this chapter.

The CHV's were not unanimous in agreement in accounting for the funds used and recovery which they incurred during a referral to the health facility for delivery. Discussants opined that;

"*we don't get refunded of the money we use during such events, we just offer to help."* (FGD_005_CHV). On the contrary, another revealed that; *"the CHV's get refunded a flat rate of Kenya Shillings 300 for every case they refer to the hospital for delivery" (*FGD_002_CHV). In the search for the truth about the funds used by CHV's for maternal referrals, a clinical officer in-charge of a Mission health facility confirmed that; *"the CHV's get compensated for every referral they make for delivery."* (KII_007_C_NHC)

It was notable that according to the CHV's, maternal referral for skilled delivery was not equated to a birth support partner or chaperone, on doing an in-depth enquiry on enquiring how they actually do refer mothers. This means that the policy on a 'birth partner' has been swept under the carpet to merely mean escorting mothers and giving a referral note to give the clinician at the hospital who will receive her or accompanying the mother to the hospital and leaving her in the hands of the health care provider but not being there to support the mother all the way till her delivery, as is intended by the policy framers. Most rural facilities have only one healthcare provider in the night due to limited human resources, and since mothers don't observe birth planning, mid-wives have a difficult time attending to the deliveries alone, as delivery resources are also scarce. In case of emergency, while working alone, the medical staff may have a difficult time attending to the mother alone, and preparing for transfer of the mother alone.

The CHV's unanimously reported that they were forced to attend to the deliveries at odd hours, when mothers reach out to them in their homes late in the night, as some got overwhelmed with contractions and deliver by their doors or in their compounds. The mothers preferred to go to the

CHV's home first rather than going straight to the hospitals. This only leads to a delay in mothers presenting themselves to the health facility. This trend could be attributed to the financial incentive CHV's are rewarded by sending mothers for delivery or immediately after a home delivery to the health facilities to the health facility. On the flipside, another explanation to this would be that the kind, gentle, supportive and loving handling mothers get endear them to CHVs, making them visit their homes first about the time of delivery.

The fact that most of the CHV's had been TBA's before, and have midwives skills still give mothers that hope that they can help them, as going to the health facility straight, are shrouded with fears of SC delivery or admission that most wish to avoid. Some CHV's covertly still conduct deliveries, and don't come out to say they do. As after doing so, they send the mothers to the health facility to be assessed by either the nurses, clinicians medical officers. Similar findings have been by Odhiambo (2015) which revealed that TBA's still conduct sizeable number of deliveries, as they are trusted, easy to reach and respected. In the community a TBA and a CHV are respected, loved and also referred to by one name.

The faithful complained about healthcare services offered by the immediate health facilities that are nearest to them in their communities. Most of them sought skilled birth assistance from facilities far away from their homes. A participant had this to say;

> *I went to Ngiya Mission Health Centre. It is some few kilometers away from her home to seek skilled birth assistance and not XX 'name mentioned' Health Centre. It was that time the doctors were on strike."* (IDI_010_NCM)

Most of the maternal deaths are preventable and the communities only need to be empowered with trustworthy, reliable information and education about health care services and benefits of, and the need for early diagnosis, referral systems when conditions are beyond the nearest health facility

level of care and to be involved in a dialogue to understand their perspective in decision making. This study has revealed that there is need for healthy debates (about maternal deaths as previous quantitative surveys have reported over and over again the decades) with specified communities like the Nomiya Church community, to have a dialogue and an imagination to transform and shift from beliefs and practices that stifle the rights of women of association and seeking of healthcare services.

Some of the participants reported that their births had been assisted by former casuals who worked at the health facilities. These individuals, who worked formally as casual employees at the health institutions have not only become local birth assistants but have also become quack '*doctors'* in the village as some mother narrated some of the things former casuals do in the community. They pretend and carry themselves with bravado of a trained medical worker. Their involvement in 'maternal care' lead to delays especially with maternal cases that would have been saved from the devastating results if they would have been in the hospitals where monitoring and charting of delivery progress is a great decision-making tool. According to the Andersen behavioral model of health service utilization, these providers in the community impede utilization of maternal health services. Legislations should be made to criminalize operations and punish agents maintaining such services in the community.

> *I think some research has been done, and there a few things that were found to be contributing to these: One, was the long waiting time, we don't like that because you know mothers are busy with their several chores at home. Secondly, they start clinic late because they fear making a lot of trips before the 9thmonth, so mostly they start at month 5 or 6. Some of them still don't get the value of coming for at least 4 visits. So, what makes them come is like they want to get the booklet because at the end of the day, the healthcare provider who will be attending to them during delivery must ask for that (MCH) book*. (KII_001_SCH)

> *Promoters are people and motivational factors are there. One, we are trying to reduce the waiting time. Secondly, we trying to build staff houses so that we have 24-hour services facilities. Third, there are facilities where we even give incentives like, Kaluo dispensary, if a mother delivers there, we have tried incentives but the problem with incentives if you stop the incentives, mothers stop coming to the hospitals. What again? Okay we create* awareness, we tell them it's much safer to deliver in the hospital than at home. (KII_01_SCH)

There are factors that act as pull and push factors on the utilization of maternal health services by the Nomiya faithful's. Experiences mothers went through the period of ANC affects their decision to the choice of place of delivery. Mothers hate waiting or being held at the facility for too long for services being that they have a lot of other commitments back home, as some have other younger kids to take care of. According to the Andersen behavioral model of health service utilization, this is a barrier factor to the utilization of maternal health services. While initiatives such as extending hours of operation, giving incentives and creating awareness on hospital delivery, are intended to encourage and enable utilization of maternal health services, a lot is still needed to improve on the utilization of maternal health services. Further still, utilization of maternal health services still faces financing threats. A key informant opined that;

> *Initially, it was because of finances, they feel that in the hospital set up you have to part with money. Another thing is that they are not empowered with information. Delivery is free everywhere. Some of them have not gotten the information that NHIF is covering for everything, under what we call 'Linda Mama Project'. Linda Mama actually covers mothers who are not covered by NHIF. These women are covered, so I think you need to empower them with the information on the ground, maybe trying to reach them through the CHV's.* (KII_004_C_NCM)

Communities sensitization efforts are needed to let the users of health services be aware of what services are available for the mothers free or at a cost in those facilities near them. Women should know of the programs packages, how to seek for these care packages and have the facts on why and where the services can be offered. The knowledge of the various services can help a mother

choose to go to the right place for the kind of health service provider for her condition. This will help prepare her psychologically for the demands of the services sought, thus encouraging mothers to seeking and utilization of maternal health services.

While still focusing on problems women face and go through during pregnancy and delivery, it is noteworthy that skilled birth attendance environment's is where a woman would have assurance of utmost care and support. But this anticipation can also turn out to be a point of total devastation to clients seeking SBA when the exact opposite happens at the health facilities.

> *In my case, I knew I would give birth at hospitals. When I gave birth to my firstborn, I did it alone. And only after pushing the baby out, that's when the medical team came to help. I was in the hospital and just gave birth in the hospital room there alone.* (IDI_012_NCM)

Health system inefficiencies present as barrier factor according to the Andersen behavioral model of health service utilization. Health service providers have a great influence on user's decision making power to or not utilize maternal health services. With uncertainty regarding service delivery at the service point following previous experiences as narrated above, mothers may resort to seeking and utilizing alternative care especially if this is readily accessible in their community. Having to deliver alone at a hospital's labour room without medical assistance can be devastating to the mother, the family and community at large, and such an experience have a lasting negative effect on the users. Following this kind of experience, the mother revealed that all her subsequent births were all home births. These deficiencies are not easy to pick using statistical tools. Qualitative techniques allow researchers the flexibility to investigate such information that require patience, fluidity and skill to encourage service users to disclose their experiences and pour out all emotions. Thus, the above findings calls for a re-orientation in the ways of doing business.

Mothers felt that health care systems and workers are insensitive to their concerns and that they are lesser partners in the system. This negatively influences their health seeking practices. The healthcare workers too seem divided in the best way to handle conflicting circumstances from the community. A clinician may feel that it is important to go ahead and administer care plans to save the mother during emergency situations while ignoring to share detail information for their intention and expectation with the mothers and caregivers. While on a flipside, another clinician may consider approaching the situation by observing the ethical concerns as consent, autonomy and respect of clients and their caregivers' and decide on their action based on clients decision, even if it is that they refused the life-saving procedure. Ethical situations in maternal still pose as dilemmas, as there are concerns to save the face of healthcare providers and institutions, when the mother is choosing death, while on the other side, one may save the mother but face brutal litigation from carrying out the life-saving procedure, a factor that may influence a mothers decision not to ever use health services as they see their wishes were not honored.

> *At times there are these labour pains that can come for one hour, it begins in the night, so when I think that I'll probably wake up and go to the hospital, I find myself delivering at home. Most of them are born at night.* (IDI_007_NCM, mother of 7, with only 2 SBA deliveries)

> *Men view it differently, men fear losses, so even if a man comes back and find that you have delivered your baby in the house, they will never care or mind. He won't care.* (IDI_004_NCM)

But IDI_006_NCM, a mother of four children who were all delivered at home and with a history of one decease kid, complained of ANC procedures to be too many, and asserted that she wouldn't allow anyone not even her mother in-law to help her while giving birth. IDI_006_NCM reported that *"Mmh! No. She can just come and stand next to me and just observe, and see what will come. To see the baby's sex."*.

While it could be possible that such tough stance on having as assistant could be due to fear of be seen naked by another person or fear of a male SBA during labour, the risks the woman exposes herself to high degree of danger. Also promoting home births as a faithful narrated is that practice involving the first wife, as maternal head delivering at home is a 'rite' in cleansing the home for any other family member to give birth in the home. Other reasons why women don't want to go deliver at the hospital, a participant stated that;

Confirming that home deliveries are still persistent in the community during the focused group discussion, FGD_004_CHV reported that *"I know of a lady who has 4 children, and all her kids she delivered them at home."* Another FGD participant added that;

> *Yes, there are home deliveries. Even in the last meeting, there are CHV's who reported of home deliveries. There is a delivery that happened recently. The woman is stubborn. That's why she had a home delivery, because with this woman even if you had gone to do follow-up visit at her place, then if she would see you coming from a distance, she would close herself inside the house, and will not open the door or respond to your calls. But while having the delivery in her house, the placenta failed to be delivered and she had to be rushed to the nearest hospital. These are the challenges we have. Yes, she went to the ANC clinic, but still delivered at home.* (FGD_001_CHV*)*

> *I also had one. Mmh, this was her first delivery. The mother had gone to the hospital twice to deliver that she was having labour pains, but she came back without giving birth, even the second time, she came back. Now about that time she was giving birth, she was confused. She didn't know whether it was the true pains or the usual false labour like pains, eeh. So she had the pains, after a prolonged period of these pains she came to me so we can go the hospital, it was about midnight. They came on foot. So, as the husband ran back to bring the motorbike rider to take her to hospital, she gave birth besides my house.* (FGD_004_CHV)

Some women tend to feel that they are experts in birth matters and can give birth alone, without assistance oblivious of the danger they expose themselves to. Obstructed labour, peri-partum hemorrhage, fetal distress and partograph assisted decision making are pointers and help to detect abnormalities during delivery. But these efforts are swept under the carpet when mothers opt not

to seek skilled birth services. While alone they can easily go into exhaustion, bleed profusely and die or lose the child who would be saved if in conventional environments. Death of a child from such occurrences affects not only the mother, but the family, home, the whole community and health systems as a whole. The faithful believe that local preparations can help manage some of the maternal health issues including hastening labour process and dulling pains.

Confirming home the occurrence of home deliveries, a key informant explained that:

> *In Nomiya, the church practices allows them to do that because they are not supposed to expose the young one before the circumcision so you see it's like if you deliver in a hospital, it means you have to carry the baby back home.* (KII_001_SCH)

Healthcare workers need to be aware and understanding of the sensitive individuals, their belief systems, and the religious and cultural community practices in which they are living to know and offer interventions that take into consideration the traditions both as a religious and Luo community. The faithful easily identify and accept prescriptions from TBA's, as they witness their preparation and can easily find them in their environment. Some mothers have knowledge of the herbs they can use when they need them, especially during delivery, unlike the complex prescriptions issued by health care workers. Health care providers need to explore communities to understand their practices, beliefs and find meanings to their practices and work with community leaders to understand these practices, and develop ways to counter negatively impacting traditions. According to the Andersen model of healthcare utilization availability and use of herbs by the women in the external environment, influences their choice and utilization of maternal health services, posing a challenge to the utilization of skilled birth services.

Cesarean section is a surgical procedure in which incision is made through a woman's abdomen and uterus to deliver the fetus, due to fetal, maternal or maternal-fetal complications (Appendix

5). This method of delivery is also another safe way of gaining on the high MMR experienced in the study area and the sub-Saharan Africa region (SSA). During this study, only 13% (3) of the participants accepted CS as a method of safe delivery of their children. The participants had varied perceptions regarding CS delivery. A few number of the faithful's had a positive attitude towards CS delivery. IDI_002_NCM while narrating about modes of delivery stated that *"there is the normal way and the operation way, this knife is also just used like the way one should have delivered. I can accept so that my life can be rescued."*

A discussant, during the focus group discussion revealed that opined about CS delivery and narrated that;

> *I have a daughter in law who had perceived delivery as a big problem. She had been giving birth normally, but this last time for this child, she was operated on. My daughter in-law said that the CS delivery is better for her than normal delivery. Because there is no labour pain, as within a short time the child has been born and no much pain. Some say that while giving birth they sustain tears, so to avoid these pains, that even when going for a long call it is so painful. So some like the CS delivery while other don't. So it is 50-50.* (FGD_003_CHV)

23% (5) of the participants strongly declined to the thought of and were unwilling to accept CS delivery as a method of delivery in case there were challenges in their labour process.

> *If a doctor suggests that? I cannot welcome or agree with such an idea … If I can be helped without going through the surgery, then I will choose that way, where I will be helped without the operation. I heard that if you get the trainees… they will be the ones to do the operation, and they don't know how to do wound closure, so the wound won't heal.* (IDI_008_NCM)

IDI_003_NCM resolutely rejected any attempt of intervention in difficult deliveries through surgical maneuvers reported that *"No! I cannot. You know going for an operation is a death issue."* The above sentiments give the impression of a community that lacks trust and information about

the health facts of the health procedures and services offered by skilled care givers. Discussing factors affecting utilization of CS delivery, key informants reported that;

> *Actually, it has been a major challenge especially coming to Siaya County Referral Hospital, they don't want to come here first because it's a County Referral Hospital, and we have all the facilities to help a mother. So, they prefer going to peripheries because they fear going for that CS. To them, they see a CS as hindrance. Yes, and they still go through that process. Some of them end up making decisions very late and come very late, they end up not making it, they die on the way or immediately they reach, you know they reach when they are already finished.* (KII_001_SCH)

> *Pregnant women get free services. Some cultures are still deeply-rooted in the homes and villages. Like you see, these young adolescent girls who get pregnant, at times the old women encourage them to deliver in the community. When they have prolonged labour, they believe that when they call upon the name of whoever made them pregnant, then that could hasten the delivery. That's because it's culture.* (KII_004_C_NCM)

The CHV's also noted that some individuals do not want anything to do with CS delivery. A discussant reported that;

> *I had a client who was taken to the referral hospital, she was still a young girl and she had not had any delivery. It is like the labour pains were too much for her, and she had even lost energy to push, so when she was informed that there is need to perform an operation on her to remove the baby, she declined to that suggestion. Even in her weakness she completely declined. Attempts by her mother to convince her yielded no fruits. She just insisted that she wants to go home.* (FGD_002_CHV)

While on one end a few number of the members of the faithful's community accepted CS delivery services, oddly, as a complimenting strategy to spontaneous vaginal delivery to help assist successful delivery of complicated labour, the faithful's would not prefer going for CS delivery. A key informant revealed that mothers preferred going to the peripheral facilities and their TBA's for delivery, and that they feared higher-level health facilities fearing that they would be taken to the theatres to be operated on. In this study, this presents as a barrier factor to the utilization of maternal HC services. Previous findings by Akpenpuun in (2013) would reveal that the role of belief system, understanding the concept of disease, illness and health can impact utilization of health services. As mothers sit together in their homes discussing their experiences at the hospital

on various subject, some end up making a decision based on what they just heard never to use a service like CS delivery.

Healthcare workers need to understand the dynamics in the community to make prompt and robust counter measures to influence the mothers to utilize CS delivery services by dispelling the fears about going to deliver in higher referral facilities. In the case of fear to visit referral facilities, there is need to sensitize communities to view these referral facilities as the best delivery point as when complications set in, it will be easy to diagnose and address the problem in short time, limiting delays from inter-facility transfers. There is need for community sensitization and dispelling myths and misconception help by the community on delivery process, methods and results. This way the community members will have their doubts cleared and have more information on skilled delivery services. As noted the above section covering ANC service utilization, putting aggressive efforts in sensitization and enhancing ANC services, health education, counseling and encouraging mothers to use health services will go a long way to increasing utilization of CS delivery as well as other maternal health services.

4.2.3 Health Seeking practices post-natally

During the survey mothers did not report on being informed to rush back immediately to the health facility in case of any change in condition with their child after delivery or with themselves. This finding is a great contrast to the reported statistics on post-natal care service utilization at 50% by the MOH, Siaya County, and KDHS report of 2014. PNC subject with the women of Nomiya church was a new concept and they were unaware of this healthcare package for the mother. PNC is a key indicator World Health Organization is keenly monitoring statistics especially, putting a lot of emphasis on post-natal deaths. These deaths are a pointer to the level of health status and is

also a marker of Gross Domestic Product (GDP) of a region in demographic analysis lens, where a high post-natal death rates indicate a low socio-economic states, with the reverse meaning a stronger socio-economic status. With Siaya County leading in the region with the highest post-natal maternal deaths, health policy expert should make appropriate intervention to involve multi-stakeholders to plan for not only maternal health but on public health, targeting to promote the range of health services to the users, improving health systems as well as putting emphasis on all SDG's.

It is also true that the faithful's claim not to have heard about PNC services as they did, was influenced by the impending special post-delivery religious rite. This would make them see and hold in high esteem their religious tradition. The need to baptize the child on the night 7th day, and then put the mother and child into seclusion on the morning 8th day, may mean that, for religious reasons, any mild, worsening issues in the mother or child may be delayed or ignored for religious cleansing. This may also mean that maternal deaths happening during this period may not be known to the CHV's nor the healthcare team till after seclusion. The need to observe religious traditions outweigh the need to observe conventional healthcare regulations. It is important to note that the community have 2 ways of attending to health conditions, as some requiring conventional health care attention and some totally do not require conventional care approaches. It is also important to reiterate that seclusion period is a period of holiness and when it's believed that no disease can get those in seclusion. The issues around seclusion are discussed in-depth in chapter 6. These complex issues around maternal health make it a key area to explore in this study.

While exploring about maternal death cases during the focused group discussion, a participant reported that:

> *Nowadays cases of maternal deaths are very minimal because we do an intensive follow-up on all the pregnant women, so much that even if there was a home delivery, you will get a message immediately that so and so had delivered at her house, so you rush to her immediately and take her to hospital even with your own money, so that she can be checked for any problem. For if there is any home delivery and it ends in death, then that area's CHV is in hot soup. With delivery, the mother may deliver without you knowing, but immediately you get information, then it is wise you take her to the nearest health facility for a medical check-up.* (FGD_002_CHV)

With unskilled deliveries still occurring in the community, the CHV's confirmed that they would get knowledge of a delivery almost immediately after birth. There is need for a day to day visiting of mothers due for delivery in the village. As delivery is not a short occurring event, the process can take 2 to 10 hours. And even in 2 hours, it is possible to have reached the nearest health facility to seek for health services. CHV's revealed that even today still, mother deliver at home despite the robust maternal health initiatives aimed at improving maternal health indicators. While mothers deliver in the community, chances of not recording and reporting the data of maternal deaths to avoid the maternal death audits and a possible conflict with the ministry of health management team, may limit such reports. The CHV's unanimously reported that a death of a mother while delivering would land the area CHV in 'hot soup' in laboring to explain 'the why' and 'what' happened leading the mothers death. Still deaths occurring during the puerperal period may be missed due to religious reasons. This may also translate to under-reporting of maternal deaths in the community during the perinatal period.

CHAPTER FIVE

RELIGIOUS BELIEFS AFFECTING UTILIZATION OF MATERNAL HEALTH SERVICES BY THE WOMEN

This chapter provides in-depth insights of the religious beliefs held by the women faithful of the Nomiya church that heavily affect their utilization of maternal health services. The results of this study are interpreted then discussed comparing and contrasting with findings of similar studies done by other public health scientists.

5.1 Belief in prayer and healing

All the (100%) informants said they believe in prayer and healing. In some instances, deterioration in health do not deserve hospital therapy but prayers and healing by spiritual leaders. Key informants explained that indigenous religious church members have poor patterns of utilizing health services because of their held beliefs and reported that;

> *There are these churches who don't believe in convention medicine, they don't come to the hospital because of their beliefs. There is that delay for health-seeking, as you have to be prayed for first, they believe in the spiritual healing.* (KII_001_SCH)

> *Being that the church is next to the hospital, for those people who feel that they have not been handled well or whatever problem they had is not being addressed, there are people to influence them to come to this church. Could be there was a drug given, but it takes time for one to get well. Could be he or she got well when with the 'church' people, then, now they will give credit to these churches.* (KII_002_CH)

Among the Nomiya faithful, when the mother is sick, she is prayed for and the evil is removed. The study revealed that communities engage in faith healing and religion has become the lens through which most people interpret life events, and as such religious association masks and may endanger the health and welfare of the mother. Similar findings have been by Iteyo (2015), Singh (2012) and Amirrtha & Reid (2008). Gumo et al., (2012) revealed that African religions continue to influence people's values, attitudes and practices shaped by their problems. Maguranyanga's

findings in (2011) revealed that the apostolic health care system constituted a concept promoting maternal health, but which are not of conventional concerns. By hindering an individual from utilizing maternal health services, belief in faith and healing is a predisposing factor to utilization of health services according to Andersen's behavioral model of health service use.

Various individual indigenous churches have various ways of attending to their sick. Some confine their sick, some exorcise the evil spirits, and some have their unique ways to heal the sick. A key informant had this to say;

> *With Legion of Mary church believers in comparison to Nomiya, might have a lot of issues to do with TB … But when talking about the ** (name mentioned) church the very members who are enlightened, in their case they'll be clear to you that they support people going to hospital. But the true point is that this message does not woo people to go get health services. It created a dependency to the church, most of the messages which are being released are tied to crusades, so it means an individual can be here, and is sick, but is waiting for a crusade to happen in maybe 3 months to come to be healed.* (KII_002_CH)

Utilization of skilled health care services has been received with both positive and negative interests among the population of study. Some feared utilization of healthcare services would lead to death for some of the conditions. Deep in the rural community's the faithful have their ways of interpreting illness with a religious lens. Gyimah (2002) revealed that communities use various religious frameworks to interpret life events, such that, a case of an abortion, which could have resulted from an untreated infection, could be linked to religious reasons, as the death of a mother may be interpreted as disobedience and wronging God. Among the Nomiya faithful's, most of the local cultures still appeal to them, and will also influence their interpretations of an abortion, that would require cleansing rituals with herbs. These beliefs affect utilization of ANC, SBA and PNC as well as contraceptive use.

Mothers need counseling and contraception after delivery, most especially after an abortion, where return to fertility is rather fast, but for religious reasons many do not accept use of contraception. The church has very strong opinion and ground on some healthcare services. Participant's negative attitude into seeking skilled healthcare services are due to lack of attention from healthcare workers in dealing with clients, and on another hand the community's firmly held beliefs of the church principles. Previous findings by Ganle (2016) and Shahabuddin et al. (2017) revealed that religious beliefs affect attitudes and behaviours regarding use of skilled healthcare. Religious beliefs influences attitude, perception of the services and trust in the persons offering the service. Receiving information from a church member, where most believe the church as the highest family unit, reports by a member of having had a bad experience at the health facility would make the other mothers hesitant to utilize maternal health services.

Among the Nomiya faithful, when the mother is sick, she is prayed for and the evil is removed. The study revealed that communities engage in faith healing, with religion as the lens which most people use to interpret and predict life events. Such religious beliefs and, or associations may mask diseases conditions and may endanger the health and welfare of the mother and family, who delay to seek maternal health services. A return to active sexual activity having declined use of contraceptives after and abortion, may lead to another pregnancy too soon which may predispose to STI's and Pelvic Inflammatory Disease and another abortion if one gets pregnant before elapse of period of 6 months. If one had obstructed labour, belief in prayer only leads to delayed health seeking of skilled birth services which may lead to life changing complications as vesico-vaginal fistula (VVF), ano-vaginal fistular (AVF), fetal death and, or maternal death. Findings by Iteyo (2015), Singh (2012) and Amirrtha & Reid (2008). Gumo et al., (2012) revealed that belief in

African religious principles will continue to influence people's values and attitudes on conventional healthcare.

During labour at home, delays in delivering the baby especially by adolescent mothers, is believed to be sorted by appeasing the ancestors of child by calling the father's name, explaining the reasons behind to delays in seeking skilled birth services, limiting the chance to save the mother and child when they present late to the hospital. Satisfying the demands of these traditions as prescribed by the community may not be possible at the hospital environments, making the participants opt to deliver at home with their grandmothers nearby. Similar findings have been by Abubakar et al., (2013) that revealed that some community's that believe there are some conditions that can be treated using conventional means only while others do not, promoting utilization of alternative care services.

Possible causes of delays in labour can be obstructed labour, inadequate pelvis, big baby and inability to push the baby at birth for some reasons, breach presentation and false labour. In some instances, while at the TBA's, mother are given herbs to dull birth pains, hasten labour or cleanse the baby. The use of the herbs may lead to severe adverse effects such as rupture of the uterus, intoxication of the fetus leading to its death, and further the removal of the uterus. These may affect the mental health of the mother, if she is still a young woman who expected to have other children. Belief on herbs present as the predisposing factors according to the Andersen's behavioral model of health service use to the utilization of skilled birth services. Measures should be instituted to sensitize senior community members on the use of herbs during pregnancy and labour and advocate for utilization of skilled birth services. Healthcare providers need to be caring

and tactful while delivering information to dispel the myths without being stereotypical, using various stakeholders to help address religious beliefs and practices.

5.2 Beliefs surrounding utilization of immunization services

The faithful's suspected that the previous Kenya Expanded Program on Immunization (KEPI) campaigns targeted the women in community and the church firmly rejected the calls. A faithful had this to say about community's perception on immunization campaigns;

> *There was a time they wanted women between 20's to 30's for vaccinations, we got curious about what was happening. The (Name of an organization mentioned) were targeting this group of women. Many men ignored and complained about this. Most men rejected the whole campaign and warned their wives against it that they were going to stop giving birth, and they said no!* (IDI_004_NCM)

Maternal vaccines administered especially during pregnancy was accepted in the community but when the ministry of health launched campaigns geared towards elimination of Neonatal tetanus by mass administration of maternal tetanus toxoid vaccines to the mothers, the faithful ganged-up rejecting the campaigns. The church community translated the campaigns intention to sterilize the women leading to a majority of faithful's ignoring the initiatives. Reliable communication of the right information in content and intent to specified populations especially on matters women's health and disease transmission, needs a well thought approach among healthcare teams.

Proper sensitization of the mothers on how mother to child transmission of tetanus happens has not been given a deeper thought to correct the misconception amongst these specified communities. According to Andersen behavioral model of health service utilization, belief that vaccine can sterilize mothers is a predisposing to the utilization of ANC services and finally SBA. Similar findings have been by Pelcic in (2016) who reported that the some Russian population

refused vaccination programs, with statistics revealing marked hesitance among the Muslim population.

The faithful's didn't understand nor relate how vaccinating the mother would protect the child. There is need to simplify the complex science to the mothers in a language they can understand, and in a concept they will relate with easily. This is the only way to dispel the myths that have been peddled in the community over administration of maternal vaccines. Jiya-Doko in 2016 reported that in Asia and Africa, vaccination of women of reproductive age is tied to western plot to sterilize or infect non-western communities with HIV Vaccines. These roumors and misconceptions have led to rejection and hesitance in the utilization of maternal vaccines. And according the Andersen's behavioral model of health service utilization, these myths present as predisposing factors to the utilization of maternal health service. There is need for health education of the communities, especially those seeking ANC services on the importance and benefits of maternal vaccination, disease transmission and prophylaxis.

5.3 Beliefs systems utilization of family planning services

i. Silence surrounding utilization of Family Planning

All the respondents knew about contraceptives. But the faithful have beliefs and varied experiences on the uptake of contraceptives. 58% (13) of the women reported that they were active users of the contraceptives while 42% (9) were not using any contraceptive. Nomiya church faithful's does not speak openly about contraception.

> *Here, in our Nomiya church, Family Planning talk has not been received well by the church. I have not seen or heard of the teachings. People have different perception about Family Planning." (*IDI_004_NCM, church elder and village administrator)

IDI_010_NCM added that *"They don't support it because there is a part in bible which says that women should give birth, and that children are blessings from God."* Utilization of contraception is vastly preached against, and many believe the members aren't using contraceptives. But in some quarters, some members are actually campaign for their utilization.

> *There are those women church leaders, especially when we are alone as women, they encourage the ladies to go for contraceptives, but you know when they are with those other leaders, they really … you know, they also just preach against family planning.* (IDI_003_NCM)

This double standard kind by women leaders regarding contraceptive use, gives the men an upper hand to dictate upon the women what they believe is the church's standpoint on family matters. The church's war against those promoting and use of FP was confirmed by KII_004_C_NCM stated that among the Nomiya *"on the issue of family planning, they are silent."* The CHV's also agreed with this revelation, with FGD_005_CHV stated that *"this issue of family planning has been a challenge".*

Some faithful were receptive of the use of contraception disregarding some of the church doctrines and leader's watchful eyes, citing the benefits and safety. Similar findings were realized by Amirrtha and Reid in (2008) who stated that even among the faithful, some members may not follow the teachings of the church and choose to accept and utilize contraception. It is fascinatingly strange that the leadership of the church and especially the women leaders, have very key information about contraception, but are restricted to sharing the information with the faithful. This is because of the patriarchal systems that play a considerable role governing beliefs on issues around women's health. It is also the mothers in-law who decide on where, by who and what care services their daughters in-law should use. These happenings in the community presents as

predisposing factors affecting utilization of maternal health services as is highlighted in the Andersen behavioral model of health service utilization.

The silent treatment on contraceptives was a subject of interest during the focus group discussion. The CHV's unanimously agreed that Nomiya church do not allow the women to use or preach about contraceptives. FGD_005_CHV confirmed that *"the issue of family planning has been a challenge!"*

> *But there are some individuals who don't want to hear those issues of family planning. I have a neighbor whose husband does not want his wife to use contraception. The lady has really given birth. She is still young, and even now she is pregnant.* (FGD_001_CHV)

Some of the faithful, especially the young adolescent mothers reported that they had never heard about pro-teachings on family planning from any church members. Faithful had fears that talking about contraception would make them be marked as preaching and promoting philosophies known to be against church ethos. This has a weighty bearing in the young girl's reproductive health, exposing the sexually active girls to risks of unwanted pregnancies.

The mother is the first teacher of a child, when there is a barrier in communication between the biological and spiritual mother and her daughter candidly about important topics like sexuality and contraception, then this can lead to irreparable knowledge gaps among the young girls. If sexuality issues are not taught by the mother, or trusted spiritual mentor then the young are bound to get information from their social networks, which can be inappropriate, exaggerated or missing the facts. Due to religious regulations, mothers are bound not to talk or teach their daughters about contraception. This creates a knowledge gap on contraceptive. The young women are exposed to get information on contraceptives from peers, other users and other secondary sources, and not from health professional. This information is also not elaborately given at school.

While the first and best teacher for an individual is the parent, religious beliefs on contraception presents as the immediate challenge that bars parents from teaching their adolescent and youthful women of the importance of contraceptives. This exposes the gap that need to be closed on the unmet population to reach for contraceptive use. These findings reveal why there are low rates of contraceptive uptake and high maternal mortality in the study area.

ii. Myths and misconceptions surrounding Family Planning

The faithful's held onto fears and myths about FP methods, as they are also surrounded with beliefs that create a lot of uncertainty amongst them. The faithful's lived with unfound information with no traces of truth in them. Participant's had these to say;

> *There is someone who used to teach us that, if you like the injectable method, then it causes problems in your lover's abdomen, so he keeps having lower abdominal pains, and there is clotting of blood inside your body and this brings cancer disease.* (IDI_009_NCM)

> *Some family planning method can make one give birth to an abnormal child or it can lead to a permanent block of your womb such that you can never get to conceive again. And because of that, some people totally don't want anything to do with Family Planning.* (IDI_008_NCM)

> *This issue of family planning, some of the men don't want it. They talk of these funny things like I don't maintain my erection. I suspect this woman is involved in FP (laughing). I think what should be done to them is to keep on educating them … health care workers need to go down there and understand them, and not by going down to them and criticizing them*. (KII_004_C_NCM)

Misconceptions surrounding use of family planning is real and deeply rooted in the population and include belief that it can lead to erectile dysfunction, destruction of one's eggs, stopping to give birth, getting cancer and giving birth to abnormal children. Findings by Gymah (2002) have

revealed that religion has become the framework through which most people interpret health and life events listed above. While in situations where hormonal methods are an unlikely preference method for the user, condoms may ultimately be the next option of contraception, but strong resistance on condom use came from the church. There was no use of condom among Nomiya church faithful's. In this study firmly held beliefs against condom use present as a predisposing factor affecting utilization of contraceptive commodities. The Andersen behavioral model highlights that character of a people influences choices and use of health services. While some women may not use certain hormonal contraceptives, condom may be the next option. They offer dual protection in addition to pregnancy, they also protect against sexually transmitted infections and HIV infection which the other methods fail to.

Mothers who have used or are using contraceptives seem not to be aware of their correct side effects. When some use and get to experience some of the side effects, they run to fellow women or their seniors in the community who give ill advices according to what they did or offer them treatment for the side effect using local herbs. This is believed to cleanse their blood and reproductive systems of the effects of the contraceptives medicinal effects. Similar findings by Shamaki and Buang in (2014) have revealed that use of herbs play a significant role in maternal health. False impressions continue to be peddled in the community. A participant had this to say;

> *Since I started on this family planning method, me as a woman, it's ok to see my normal monthly period. But that is what I have not seen since I started using this method. Now, I don't know what is wrong with me? Since it was put in, this thing keeps running and changing positions in my body, at time it's here, after a while it is there, and after another while it is somewhere else. This thing doesn't stay in one place in my body. Now I don't know what could be the problem?* (IDI_013_NCM)

Healthcare professionals must come to realize of these misconceptions early, recognize their threat as a gap to achieving set target on contraceptive use. Increasing community sensitization on the

benefits of contraception, giving the right information to couples and initiating community outreach programs to strengthen the drive on contraceptive use, dispelling the myths and misconceptions is a must. Misconception on some methods, such as the implants that are inserted in the body to be moving from one part to the other. The loss of experiencing of monthly periods created fear among the users, believing that their menses were collecting somewhere in their abdomen, that would make them not be able reproduce again and develop cancer. This should be the red flags to help explore what other misconceptions are regarding other methods to have local measures to address them before they get rooted on the users.

A key informant who was also a Nomiya church faithful and a senior clinician, said that as a health facility they had started an initiative to boost FP advocacy and sensitization in the community they serve, he had this to say;

> *We are using religious leaders, and we are telling them that the church will not educate for you your child, the church will not treat for you your child, it is you to get it from the pocket … We tell them that family planning is not stopping you from giving birth, but you give birth to the number of children you can take care of.* (KII_004_C_NCM)

Such kind of health programs in addition to training church leaders, CHV"S and counseling of individual users are important measures to dispel the misconceptions held by the Nomiya Church faithful's. KII_002_CH added that "*this is because family planning had been marred with a lot of negative speaking."* These sentiments show a lack of constant health education, communication and counseling community. There is need for local policy encouraging women seek counseling, information, education and contraceptive services and to freely talk about FP services. The young women of Nomiya church shy off seeking FP services, going to the health facility for SRH services, thus missing vital information, prophylactic medicines and essential vaccinations.

These findings explains the low statistics reported in the utilization of contraceptives, ANC snd skilled birth services where mothers get more information about family planning. Information on use of the contraceptives among the faithful is largely distorted. Mothers in-law approval seemed vital before utilizing FP method among the married women. The women reported that their men also believed that use of contraceptives would lead to erectile dysfunction and infidelity. One faithful reported that she lost her marriage over her use of contraception. Similar findings have been by Amoran et al., (2012) that revealed that interaction of the religious factors to other spheres of life in the communities directly affects maternal health and utilization of health services.

iii. Beliefs and experiences over adolescent girls using contraceptives

Most of the respondents had a negative attitude and opposed any attempt of teenage girls using any contraceptive. While exploring about the utilization of contraceptive uptake among young women, a faithful stated that young ladies are opposed to the uptake of FP methods, she had this to say;

> *Like these girls of today, will tell you in the face that you are lying to us, if you talk to them about FP. They will also tell you, that you know you people have given birth, and your time has passed, as we have passed out all our eggs. Don't lie to us. [Laughs]*. (IDI_004_NCM)

IDI_001_NCM, a 19-year-old girl in secondary school, daughter of one of a church bishop and a mother of one stated that *"I have not been taught about contraceptives*." A possible situation being a Nomiya church member, born and raised in the systems of the church. But on further interviewing, she opened up and reported that she was using a method.

IDI_003_NCM, a 23-year-old mother of one remarked that *"... a woman in her home who has already given birth is allowed to use FP. Girls are not allowed as these may damage their reproductive life in future."*

> *They should not touch them. Anyone who has not given birth should not use the methods. Do you know that that family planning kills the eggs you are having? Now imagine if she only has just only one, then it goes and destroys that only egg. Then she will want to have a child? … [laughing].* (IDI_010_NCM, women leader & wife to a pastor)

Young women of Nomiya Church believed that those informing them to use contraceptive methods, especially the senior community members or the CHV's had given birth and didn't want them to give birth in future like them. This is coupled by the strong church principles that work against contraceptive use, their social links may offer little help and may be lacking the right information for them. The elders whom they can approach are the very same ones who uphold negative beliefs about contraceptive users as promiscuous, not forgetting the fact that they are young girls.

> *Some people in the community have accepted, while others have not accepted this issue, because you can find that a child can go for the contraceptive without the mothers knowledge, but when she finds out that the child is using it and she does not have her own baby, then she will fear that she will become barren.* (FGD_003_CHV)

Most respondents revealed that contraception is not allowed within Nomiya church, yet family planning is one of the key pillars that ensure an individual woman is healthy and not limited physically, emotionally, socially or economically with one or more of the maternal health issues. Family planning is also ensures that communities don't experience high maternal mortality, a picture common in the study area, which is also an indicator of economic power of a population. Communities with low maternal mortality rates have strong economy (UNICEF & WHO, 2015). With an uptake of contraception at 51% in Siaya county, and with rife religious beliefs that are against use of contraception is a big blow at ensuring that maternal health is enhanced and SDG achieved as planned (Siaya County Health at a Glance, 2015). Similar findings have been by Omondi (2013) findings that reported that strong religious beliefs have effects on the utilization of contraception amongst the local community members.

Senior informants and members of the church reported that young girls are not allowed to use contraceptives fearing that they may be sterilized. According to Andersen's behavioral model of health service use, these present as predisposing factors and affect personal health choices to utilization of maternal health services. Health care workers need to counter these myths with facts. Participants believed that young teenagers who are sexually active must never try to use the contraceptives especially if one has never given birth. Similar findings have been by Pennachio (2005) who revealed that religious authorities permitted use of contraception within marriage, limiting young girls from there utilization. As this study would find out, denying young women and girls an opportunity to use FP services, this explains the high prevalence of pregnancy and maternal mortality rates experienced in the study area.

iv. Knowledge of contraceptive methods

Only about 25% of the faithful's were able to mention more than 4 family planning methods. About the knowledge of various contraceptive methods, IDI_013_NCM whose husband is church leader, reported that *"first, I can say there are 5 methods; there is implant, injections for three months, there is coil, there are tablets and the pills."* While exploring on the various times a woman can start utilizing a contraceptive method, especially immediately after birth, most of the respondents revealed that they had no idea of any contraceptive method to use. IDI_002_NCM remarked that *"at birth, no! There is none."* IDI_013_NCM reported that *"I don't know of the FP methods used immediately after birth."* These sentiments reveal the lack of appropriate information among this target group on matters contraception, calling for the need to take maternal health services to them.

a. Pro -users

Fifty eight percent (58%) of the participants confirmed that they were using a contraceptive method at the time of the interview. The faithful's who reported that they were using FP reported that;

> *Nowadays, I go for some teachings where they tell us that even if the measures offered at the hospital don't work for you, then you can use the calendar method … It's difficult to honor and keep to the teachings, and its only good when you are alone, or even if your husband goes to the work away from home.* (IDI_010_NCM)

> *Family planning is good because it makes you plan over giving births. I took aah, I took those injections [thinking]. I took 4 injections and that sorted me for ten years. The child sitting here is ten (10) years and the follower was just born recently.* (IDI_006_NCM, widow of 4 years)

And IDI_002_NCM narrated that *"Family planning helps because I may have my child make four years old before another child comes, even taking him to school becomes easy."* While referring to the community FP utilization habits, a faithful reported that life in the community is not influenced by the church doctrines, IDI_002_NCM reported that *"in the village, no one has said it is bad, but people from **(name mentioned) church say that it is a bad practice and that family planning is not good at all."*

Use of contraception among the Nomiya church faithful's was low. Members were hesitant to come out freely and report their using of contraception, as there was high suspicion and fear among faithful's of becoming subjects of disciplinary committees of the church. Fear of being accused of being as a promiscuous woman were concerns Shahabuddin et al., revealed (2017) that lead to hesitancy and delay in utilization of some maternal health services. Mochache et al (2020) revealed that fearing religious leaders may make women not use family planning commodities, women may fear of spies within their cirles, meet someone who knows them at service point or fear confiding on a friend. Church leaders strictly hold onto church principles so as to instill the doctrines on the members and future generations. The knowledge held about contraception by the majority of the faithful was low, partly because of fear among women who use contraceptives (Maguranyanga,

2011) and (Ganle, 2016), men's attitude (Omondi, 2012), and healthcare systems which do not challenge religious doctrines and complex local community systems that do not supporting use of contraception. These factors also help to explain the low statistics on the uptake of contraceptives as characterized in the study area. Contrasting findings have been by Lemoin (2011) whose findings revealed that religion had negligible influence on contraceptive uptake among women aged 18 – 25 years of age.

b. Not for Family Planning use

With 42% of the faithful's not using any method during the time of the interview, there is need to focus on specific population beliefs that may hinder utilization of health services. Some reasons faithful's sighted for none use include;

> *Let me start with the one's swallowed, they have their effects … at times it's not compatible with your body and causes a lot of bleeding, then at times you may be happy thinking that you are using the 3 months FP method, but you are in real sense pregnant.* (IDI_010_NCM)

IDI_003_NCM firmly rejected long term FP methods for eight or nine years, reported that *"no! I just don't want it … After one and half years, my mum said it was making my body look bad [Laughs]."* IDI_003_NCM reported of her mother in-law's constant remarks in suspicion to her using of FP that "*People should give birth to their babies fast and then stop. She will always retort that, those children you keep hiding in the stomach are the ones to help us, don't prevent them from coming."*

> *There are still many fears. Those who have used it say that sometimes you take long to become pregnant again and you end up going for treatment again for it to happen. So, they end up believing that this thing is destroying her eggs, so you take the herbal medicines for long to neutralize the strength of the family planning drug, then you find that one can now get pregnant. There are some that if put, they say the arm is hurting, one that if you use, you can't do hard jobs, one which makes you fat and others slim and others you are always seeing your periods. Others cause too much bleeding … until some women say that if its family planning, no! Let me just get pregnant and give birth [Laughs]*. (IDI_004_NCM)

FGD_004_CHV reported of a lady who had lost a number of her pregnancies before reaching term would tell her that "I have lost so many of my children, as for me I want to give birth." And another participant confirmed that there are challenges women experiences while using contraceptives as;

> *Some mothers have also complained that while on contraception then they experience changes in their menstrual patterns that it's either a delay between periods or they will experience a shorter time between periods. Secondly, some complain that their bodies are all paining, unlike before. Thirdly, one will say that her shape has changed having excessively increased her weight. And they know if they see one increase in weight, then you will hear them say that, that one is using the FP methods.* (FGD_005_CHV)

Since utilization of contraception is not advocated for by the church, suspicion of being a user may make one to be seen as a betrayer, adulterer and non-conformer to the church ways. These references upon a faithful may make one bypass conventional MHC service to strictly observe church teachings which are strongly against use of contraceptives. Previous findings by Ebere (2013) revealed that failure to observe religious norms, the repercussions can be deadly among the faithful. As reported by a participant that the church may form a committee to discuss your issue, an event that many did not wish to think about. In this study, such beliefs are the predisposing factors, according to the study model, that affect utilization contraceptives.

With the low uptake of contraceptives, with the high parity and HIV prevalence rates in the region likely to remain at a high, compounded by the religious beliefs and practices, contraceptive prevalence rate will still remain at a low. The County and National governments ministries of Health (MOH) need to develop policies to target maternal health, their diseases and religious beliefs for developing specific communities target model interventions. Most mothers reported that they were not aware of the measures and methods used immediately after birth. This is likely because of their leaning and seclusion practice and strong religious systems which make the

communities closed to the conventional health care systems, as allowing the teaching on use of FP by its church members. Findings by Iwelunmor et al., (2013) revealed that there is need to develop effective family oriented, community-centered programs to improve utilization of health services for the mother.

Among the Nomiya, condom use as a family planning method was not accepted and seems forbidden. This may be due to the fact that the use of condoms as a FP method in Christian circles is not well-regarded and maybe linked to promiscuity and mistrust amongst couples. The faithful's did not mention condom as one of the family planning methods. Condom use as a subject was not accepted with this group despite its positive impacts in public health. Similar findings by Amoran et al., in (2012) revealed that pregnant women did not know how to correctly use condoms because of strong attachment to religious teachings. Condom use has the potential to prevent unwanted pregnancies, sexually transmitted infections and HIV amongst those in polygamous unions as is characteristic of this religious community.

iv. Husband's knowledge of contraceptive use

Among the pro-users of contraceptives, 42% respondents reported that their husbands had no idea of their use of the FP methods.

> *Before we start talking about it, there must be something we feel is weighing us down, and becoming a burden. So, we can decide to put a break on bringing forth more children, and raise the ones we have delivered already. Then, family planning also helps the woman maintains her body, because if a woman just gives birth continuously, their body gets wasted and deteriorate fast.* (IDI_013_NCM)

A faithful narrated that if a mother approached her to share about use of FP, then she would not preach against it, but she was cautious about doing so all the same, she had this to say;

> *Even if she doesn't want this, I will just support its use because am not seeing any problem using them. You know at times she might talk to the husband about it and he*

> *disagrees, then when asked from where she got that information, she can even say that it is me [Laughs]. The husband may come to quarrel with me charging that you people pretend to go for prayers but these issues are what you talk about! [Laughs]. They can even take the issue to church and report that the wife of so and so (name changed) is teaching women about family planning.* (IDI_002_NCM)

IDI_004_NCM who had lost her marriage because of alleged use of contraceptive, reported that *"I got accused of being unfaithful, and that I had a man out there, and it led to the separation, and I lost the marriage just because of the use of FP."* Generally the CHV's agreed that there are challenges regarding uptake of FP services:

> *There are some individuals who don't want to hear those issues of family planning. I have a neighbor whose husband does not want his wife to use contraception. The lady has really given birth. She is still young, and even now she is pregnant.* (FGD_001_CHV)

> *There are those who hide to go take the method while hiding, like the one inserted under the arm, but they say men will then begin searching their bodies and search well and if they get it under the skin, it is another war. So there is a challenge.* (FGD_003_CHV)

> *There are times when the method is out of stock, and then women get into deep trouble. These methods kept women's sweet secret. As with this method they hide, go for the jab, leave their cards at the clinics but keep a good memory of the return date. There are those men who don't want their wives to take up family planning.* (FGD_001_CHV)

Most women fear using contraceptives and those who do are utilizing them without their spouses' knowledge. In this study, fear present as a barrier factor to utilization of maternal health services. Previous research by Amirrtha and Reid in (2007) revealed that in Judaism women must inform husbands who approve the use of contraception. Firmly held religious beliefs by Nomiya church faithful's may explain the low uptake rates revealed by the previous surveys as reported in (appendix 4) in the study area. There is need to involve the religious leaders and the church community to adopt male partner involvement during pregnancy, in choosing a family planning method and decision making for place of delivery.

5.4 Beliefs systems surrounding food

All (100%) the informants said that they knew and observed beliefs on foods. The church faithful are governed by strict regulations on what mothers are allowed to or not eat during pregnancy.

> "*A pregnant lady is not allowed to eat chips, bananas, eggs, avocado and things like that if it reaches 4 months, and mostly after 6 months. These foods are feared to make the baby grow bigger." (*IDI_003_NCM)

> *"In pregnancy, what am sure of is if your chicken is rescued from a wild animal, and is dead or got bitten by the animal, then you don't eat it … you might give birth to a child that has 'bite marks' in the body. And if a python killed an animal and you eat the remains of the meat, then the signs of the snake's skin will show on the baby's body. That is what our customs don't allow to be eaten.* (IDI_008_NCM*)*

These beliefs were confirmed by FGD_005_CHV who also noted that the women mistakenly believed that *"if you eat bananas, especially a pregnant lady, then the growing baby in the womb will become too big, thus bringing complications at birth."*

Further a key informant also confirmed that among the Nomiya Church faithful's, when one is pregnant;

> *She should not be chewing things like … sugarcane, it is not good …it is better to use lemon … she should also be taking herbal medicines to wash and keep the baby clean so as not to get 'yamo' (translated as 'bad-air' diseases). She should be eating 'osuga', 'mto' and 'susa' (native vegetables), these are nutritious foods which make the unborn baby strong.* (KII_003_B, bishop of Nomiya church)

It is worth mentioning that most of the foods prohibited are very nutrient rich, some are very natural and not consuming them may predispose the mother and unborn child to poor health, having a bearing on the indicators on maternal health. Poor nutritional habits during pregnancy due to hormonal changes like 'pica' may lead to increased risks to infections, anemia in pregnancy exposing the mothers to having low birth weight babies or even death in severe cases. Omer et al., (2014), Ayele et al., (2014), Al-Mujtaba et al., (2016) pointed to the need to explore on maternal morbidity and mortality framework constructs that have not been well understood to improve

maternal health outcomes attributed to nutritional factors. Poor nutritional habits after birth may lead to poor healing processes, impacting maternal health especially keeping healthy breastfeeding the baby and fighting off infections. The wellbeing of the child has a direct contribution to a mothers mental health. There is need to uphold not eating meat from animal killed by other animals, as beliefs regarding dead or sick animals may have positive bearing on protecting the community from zoonotic diseases.

According to the Andersen behavioral model of health service utilization, beliefs surrounding foods present as predisposing factors in this study. When CHV's are not armed with trustworthy and reliable information to educate and dispel myths held by their communities, which exposes the weakness in the health system in dealing with community health problems. Mothers will continue to hold on to their misconceptions and making less informed choices about their nutritional health. To gain on utilization of ANC services, CHV's should sensitize the mother with the right information on the benefits of ANC during pregnancy. During ANC visits, health providers should put a lot of emphasis on nutritional counseling and education on the need of observing dietary requirements for a healthy pregnancy. Policies addressing maternal nutrition is an adventure worth investing on. Findings by Omondi (2013) revealed some religious beliefs are not safe if observed by pregnant women like fasting.

5.5 Belief systems surrounding preservation of pregnancy

Most (75%) of the participants believed on local beliefs of preservation of pregnancy. To carry a pregnancy to term, is not an easy process, and participants believed that there are local preservation codes one has to observe. IDI_002_NCM also reported that "*what I know is that if you are pregnant, one should be careful, you should not indulge in sex with many partners."* A factor that

confer protective value to the mother to child transmission of diseases. But according to the church, this is a challenging aspect as members invited to go to the breaking of seclusion events, may be unaware of pregnancy, but due to dancing to the drum beats and night vigil prayers, individuals may engage in illicit relationships which may lead to transmission of HIV, as the faithful's highly detest the use of condoms. This is a positive belief that helps keep a mother safe from the risks of disease transmission.

Decisions to stay admitted in the hospital in during pregnancy were hampered by need to satisfy some of the community rituals, especially in times of planting, which were also connected to the preservation of pregnancy states. These beliefs are unique to African Spiritual churches and are not observed or kept by the mainstream churches as would be revealed by a county health coordinator interviewed during the study. This is largely so because there have been no studies of this kind that solely focus on contextual details to improve maternal health outcomes. Jones (2007) and Fraga (2017) reported that qualitative studies dig deeper into contextual reasons and yield more insights on the unknown to help understand the little known issues and statistics. Concerned about the beliefs that affect utilization of maternal health services as caring for anaemia in pregnancy, a condition a woman may not realize of its silent symptoms or signs while admitted in the wards, a key informant had this to say;

> *A pregnant mother may be hospitalized, and is in admission for whatever care. But because it is planting season, they need to go and plant, she will request that she be allowed to go home. She will strongly be propelled to go, and if you delay, these patients sneak and go home without permission. The exact cause of this is to go have conjugal unions with their spouses (rite of planting), to allow other family members to plant, as this will open the way for the younger family members to do the same, lest their pregnancy, their future or their children's future plans be ruined.* (KII_007_C_NHC)

With the church doctrines largely attuned to Luo cultures as reported by Adhiambo (1981), not observing some of the Luo cultural traditions maybe be interpreted as a curse, to be destined for

uneventful repercussions, thus woman are likely to observe the demand of the cultures in the belief to preserve her pregnancy. Sudhe, Gumo and Iteyo (2015) reported that the faithful's hold onto these traditional norms have far reaching negative impacts on maternal morbidity and mortality

> *During pregnancy, one should not meet a widow who just lost her husband, as that can affect the unborn baby. A woman should not get alarmingly scared as that can also scare the child in the womb, so much that when it is being born it may have developed some complications, and may be mentally unwell. (*FGD_005_CHV)

Mothers expressed various reasons on preserving and carrying a pregnancy to term, as pregnancy period carries many risks. Locally, the risks bordered on observing planting season sex rites, mother in-law not having given birth at home, accomplishing some traditional cleansing rites. Strongly held beliefs about preserving pregnancy overshadow the essence of seeking and utilizing ANC services that can include reporting any changes during pregnancy and need for obstetrics care among the faithful, which were replaced by cleansing using special herbs to wash the womb, wash the baby and in some instances make the unborn baby strong. The hold onto these beliefs by the faithful's affect utilization of maternal health services, as the faithful's hold onto the need to honor sexual rites may end up acquiring urinary tract or HIV infections, and strengthening their hold on these traditional beliefs rather than putting emphasis on seeking health services for the mother, such as staying in admission to fully help treat maternal health condition. The strengthening of apostolic care system (Maguranyanga, 2011; Al-Mujtaba, 2016; N'Gbichi, 2019) is attributable to the transmission of mother to child infections during pregnancy (Ochako et al., 2011, Abubakar et al., 2013), hesitance in utilizing ANC (Ayele et al., 2014, Dahiru & Oche, 2015), hesitance and delay in utilizing skilled birth attendance (Ayele et al., 2014, Solanke et al., 2015; Malande et al., 2019), hesitancy in utilizing contraceptive services (Ochako et al., 2015), and for the maintenance of the high maternal mortality ratio experienced for decades in the study

area ((UNFPA, 2015, WHO 2019).

When mothers lose their pregnancies, rather than seeking skilled health services for thorough investigations to determine the cause of these occurrences, religious and local reasons are blamed for the cause. According to Andersen's behavioral model of health service use, these beliefs present as predisposing factors to the utilization of ANC services. Beliefs on preservation of pregnancy also compound to hesitancy to the utilization of maternal health services, and the utilization of alternative care services to cleanse the mother and baby, which may lead to fetal poisoning in-utero. Belief on 'planting rite' traditions, influence utilization of maternal health services especially their Sexual and Reproductive Health. The strong attuning of the Nomiya Church faithful's lives to the Luo community traditions, have a heavy influence on their daily life as they observe almost all the cultural traditions which most of the mainstream churches have shed off decades back and do not observe anymore today.

5.6 Beliefs about delivering *"Nyathi Mochido"* (dirty child) hindering hospital delivery

The participants reported that they feared delivering at the health facilities fearing being accused of having delivered a dirty child. These claims had roots on beliefs surrounding sexual habits among a married couple. The informants reported that they would strictly have sex with their husbands for the first five to six months of the pregnancy. IDI_009_NCM reported that they can continue to have sex up to *"5 months, and resume after one month from delivery of the baby."* IDI_012_NCM also reported that *"if it reaches 6 and a half months I stop having sex, and take another 2 months after delivery."* Nomiya church systems prescribe that a woman needs her own time and space while pregnant, this maybe a measure to make the woman stay away from sexual union with the husband, as this was reported by all the research participants. Resuming sexual

activities after birth is likely to be factual because of the religious rite the faithful's have to observe as discussed ahead in-depth in the next chapter on seclusion practices.

But it is important to note that marriage is the only place where sex is pure and allowed leading to procreation and companionship. The word 'sex' was almost considered a forbidden word in the community under study. Eighty three percent (83%) of the informants reported that women fear to deliver at the hospitals because they will be insulted to have delivered a dirty baby. A participant had this to say;

> *They told us that it is ok for a woman to have sex with her husband until your delivery. So, when we asked them, how come when you are at the hospital, the nurses tell us that this child has come out dirty and say it is because you loved sex a lot? They also teach us that, once you conceive the opening to where the child is gets closed that nothing else can get through the closed gate. So, I don't know about those teachings, whether they are cheating us, we can't know. If we go to the side of this other organization we are taught differently, when you go to the nurse, she tells you something else, so you know, you can fail to choose which way to go.* (IDI_010_NCM, women leader and wife to a pastor)

During the focus group discussion, FGD_004_CHV stated that *"mothers report that those who deliver dirty babies are those mothers who have sex with their husbands until the last moment."* The CHV's asked the researcher to shed more light on the subject as they did not know the truth behind this issue, as another discussant added that;

> *This issue of the dirty child is real and is still there even as we speak. Women know about it and only allow having sex with their husbands for 4 months and stop, so they'll just fight with their husbands at home because they fear going to the hospital to be beaten by the medics for giving birth to a dirty baby. (*FGD_001_CHV*)*

This result about mother having to stop having sex with their husbands at about 5 months so as not to be ridiculed at the hospitals, has a real bearing on women's decision on place of delivery, women's and men's sexual life and health. There are biblical beliefs and arguments for this when the mother of Jesus went to stay with her cousin while expectant with baby Jesus, leading her to keep away from her husband for a period of time, a factor influencing the behavior of the faithful.

While keeping away from their husbands for religious reasons, the period is considered holy and diseases are at bay during this period. The potential of men straying outside their marriages and engage in extra marital affairs and the desire to be in polygamous unions is highly expected. In a bid to keep to religious tenets, women are afraid and feel ashamed to go to the hospital fearing to be seen by other faithful's, a factor that may complicate pregnancy and problems that would be easy to diagnose early (Ayele et al., 2014). During pregnancy women then go to church based TBA's to please their husbands (Azuh, 2015) and to conform to the church doctrines (Nzioki et al., 2015, Shahabuddin et al., 2017, Okomo, 2018).

Nomiya Church doctrines allowed marriage of many wives, a belief with the potential for the spread of sexually transmitted diseases and HIV infections in the family and community where polygamy is accepted. Similar findings have been by Okomo, (2018) and Olungah (2018) where women are the bearer of negative effects of these cultural norms and act as spectators on matters of their own health, as the church, community and family take the lead to decide on their health matters. A previous study by Ebere in (2013) revealed that many wives come to compete in giving birth to prove to the husband their worth in the union, increasing the prevalence rate and risk of pregnancy, transmission of HIV, STI's and a rise in poverty levels, a picture similar to the study area. Polygamy as a way of life is discussed ahead in the next chapter.

The taboo 'concept' on mentioning the word sex 'closes' that opportunity for the parents in Nomiya church to teach their adolescent children on sexual and reproductive health matters, dispelling of myths and misconceptions they would have heard from their peers and the community. While sex is supposed to be contributing to strong marital bonds, most mothers reported that they would rather stop having sex earlier during their pregnancy to prevent the

ridicule from the nurses who they said would hurl abuses at them at birth that they gave birth to 'dirty' babies because they loved sex a lot during their pregnancy. In this study, the insults from health providers present as barrier factor to utilization of skilled birth services. Compounding this, participants hold on to the fact that skilled care environments are unfriendly as they claimed there is lack of drugs, delays to be attended to, health workers strikes leave hospitals without service providers and in some instances mothers had to pay dearly for services they have been informed are free in all public health facilities.

The normal greasy deposit layering on the newborn skin at birth called Vernix Caseousa, medically is a protective layer that acts as a barrier to water loss, helps in temperature regulation, has antioxidant properties, innate immunity as well as diagnostic and prognostic implications to clinicians in assessing the child's maturity. But, most mothers revealed that this was the source of their ridicule and shame, making them hesitant to go and utilize skilled birth services, and had become a potential barrier to seeking and using skilled birth services. It is likely that the midwives are unware of the functions of that greasy deposit on a newborn skin. No one would like to have to be pointed out to have had sex with her spouse and their sexual encounters related to the immediate physical features in a child, especially in a conservative religious group as the Nomiya church community, where the word sex is a taboo. When mothers think of this, they feel more obliged to seek help from TBA's, sister's in-law or deliver alone without anyone's help in their homes. Further a participant decisively opined that:

> *That issue that the nurse's quarrel that you gave birth to a dirty child is not a good thing, and when they (mothers) come and they are barked at … will you go back there and no one is going to help you?* (IDI_010_NCM)

In the community, having sex during pregnancy is associated with a 'dirty baby' at birth, a strong and direct determinant to the utilization of skilled birth services among the faithful. According to

Travers et al., (2020), Andersen's behavioral model on healthcare utilization, being related to delivering a 'dirty baby' may influence personal health choices to utilize the health services. Still in the community, most unions are polygamous hence, creating the risk of STI's and HIV infection. These compounding factors may impact on the utilization of sexual-reproductive health, PMTCT, SBA, screening services for non-infectious diseases and HIV/AIDS care and treatment services especially in Alego-Usonga sub-county, where HIV prevalence and unskilled birth rates are among the highest rates in the region and country. CHV's and church leaders need to be sensitized with right information on sex during pregnancy, intensified community sensitization, information and communication and advocacy on the benefits of ANC, SBA and PNC. Maguranyanga (2011) thus challenged health care planners, policy makers and providers if they were allowing African religions to advance at the expense of the universal rights of women and allowing mothers to continue dying of preventable deaths during pregnancy, birth and after birth in the community. He further opined that contextual healthy assessment into ills bedeviling maternal health be given a one-on-one encounter as this study has done, to address maternal and morbidity framework factors that are best address by these scientific techniques.

5.6 Beliefs on sex determination

Though the issue of sex preference among the faithful at birth came out as a thematic area of interest that should have influenced the faithful's to go for healthcare services that was not the case. There were local beliefs of predicting a male from a female baby during pregnancy. No participant mentioned having sought the modern HC services to ascertain the sex of the child. Native ways were believed to predict the sex of the child. 50% (11) of the participants said that there are beliefs that aid in determining the sex of the baby. IDI_008_NCM who had only given birth to boys, and was 7 months pregnant, reported that "*I don't know … but those who know and*

have girls say that, a girl lies on the left side [pointing] and the boy is on the right side, [demonstrating].

> *I don't know. But there are things people seem to know, that if you found a frog in the house then that will be a baby girl, but if you find a snake in your house, then that is a baby boy. But for me I found a frog in the house [laughs].* (IDI_003_NCM)

> *I have heard that if you are pregnant with a baby boy, they take away your appetite from a lot of foods, you become choosy with some foods. But a baby girl, especially with me, I have not seen them affecting me, I eat anything.* (IDI_013_NCM)

The knowledge of carrying female child pregnancy by a parent who had previously birthed male children may be influence a mother to seek elaborate caring during pregnancy. But the UNICEF/ WHO (2015) revealed that such beliefs make some women even more vulnerable and less likely to seek care at the hospitals. Knowledge of the sex of a child may have a bearing on place of delivery, impacting on the utilization of maternal health services especially where the family was in need of a male child after having births to only girls, then this may be considered a precious baby and the family may tend to take up conventional health measures to care for the child especially in modern and urban communities. Technologies to tell a child sex maybe missing in rural areas, but such technologies may influence mothers to utilize maternal health services.

CHV's are not empowered enough to target the community health challenges on determining a child's sex. Some traditions hinder mothers from eating very essential nutrients found in some foods as avocado, eggs and bananas fearing that these foods will make the baby big in the womb complicating delivery. Poor feeding habits during pregnancy have consequences and may result in birth of babies with low birth weights or congenital malformations. In the community of tightly knit religious threads, the older generation have prescriptions to and proscriptions against what not to be observed by their daughter's in-law. The younger generation have to show their respect and adherence to senior community member's decisions to get accepted in the home and religious

community as they depend largely on them for social support. Such beliefs have a rebounding effect on the utilization of maternal health services.

As such, religious factors are not only responsible for the high maternal mortality as seen in the study area, but was also responsible for the low rates of utilization of ANC, SBA, PNC and FP services. Thus interventions targeting religious communities, CHV's and leaders and healthcare workers should be designed to improve community's knowledge on maternal health services.

CHAPTER SIX

RELIGIOUS PRACTICES AFFECTING UTILIZATION OF MATERNAL HEALTH SERVICES

This chapter provides a comprehensive analysis of the religious practices of the women faithful of Nomiya church that profoundly affected their utilization of antenatal health services. Various themes and sub-themes discussed below explored on religious practices of the Nomiya faithful's including seclusion, massaging pregnant women, TBA deliveries, the faithful's social organizations and wife inheritance and how they impact maternal health.

6.1 Experiences of abdominal massage during pregnancy

During pregnancy, there is a manner in which the church takes care of the expectant mothers. This practice has its roots from the bible. Mary the mother of Jesus went to visit and stayed at Elizabeth's place for a while away from her husband, in the Gospel books of Mathew and Luke. With belief that when Mary touched Elizabeth, the baby played joyfully in the womb. A child is revered as a gift from God, the faithful's follow these biblical traditions to guide their lives. All the women (100%) believed in this apostolic practice. This apostolic principle is championed and implemented in Nomiya church by a female carer refered to as *'Madha'*.

Who is '***madha'***? This is a church ordained female carer during pregnancy massaging the women and offer delivery services to women, are religious and health counsellors, and decision makers in maternal and child health matters, also referred to as a TBA. The practice of abdominal massage during pregnancy help ease abdomino-pelvic pains mothers feel at some point during pregnancy. 66% of the participants reported that they either utilized the services during their last pregnancy or in the current pregnancy. IDI_004_NCM reported that *"When a mother is pregnant, there is a*

way as the church we want her to care for her-self." IDI_010_NCM, while explaining about this care revealed that, "*we don't have a hospital midwife but the ones from Nomiya church,"* a role assumed by the women church leaders and pastors' wives. IDI_012_NCM reported that "*mothers go to the traditional birth attendants (TBA's) and some go to the prayer leaders. So, they have different thoughts. Some even go to witchdoctors."* IDI_007_NCM would further confirm that the church TBA's *"prohibited foods which when a mother eats makes the baby grow big, they don't allow such foods. They do the massage in church by wife of the church pastor and she usually uses Deepak and heated water."*

Participants reported that care involve massaging of the abdomen with an oil while kneeling down exposing the abdomen. This practice, made the mothers feel relaxed, relieved of the abdominal pains, and got reassured that the child who was lying in a bad position in the womb had been repositioned well. The massage conducted by the women leaders of the church, has a bearing on the uptake of ANC. Women end up missing to utilize the essential 4+ ANC visits that are important in realizing pregnancy anomalies when mothers go for abdominal ultra-sound scans and plan accordingly, diagnose an manage acute and chronic conditions and get the important health education and birth planning information. Coupled with fear of pills taken during pregnancy, there was strong belief on the cleansing power of the herbal medicines, mother-in laws and church leaders local care decisions. These complex factors interact to create a barrier to utilization of maternal health services. Expectant mothers have little to do and may not oppose these traditions but follow the instructions given by their seniors. Murigi (2016) and Gwengi (2017) observed that the women are counselled by the church representative to observe the traditions, which if not done is considered unholy act. No mother would want to be contrary to church teaching nor be seen to oppose church traditions, thus the delay and hesitance to use maternal health services.

During a massage visit, there are requirements that '*madha'* needs or she has to improvise. IDI_002_NCM remarked that "*if there is no Deepak, she uses warm water to massage the abdomen then applies any oil available. At times I feel good."* Massage can be done at the convenience of the pregnant mother, IDI_009_NCM reported *"They do massage in the church, and after the massage at times I feel great, the massage can be done even here at home."* IDI_003_NCM added *"Some people sleep there afterwards but for me, I just went back home later*." What prompts the expectant mothers to seek the abdominal massage? IDI_003_NCM reported that "a*t times it comes strong on one side with a powerful force. She loved just one side."* Meaning that the lady would feel heaviness or some pain on side of the abdomen prompting her visit to the TBA. Another faithful narrated the events during the massage;

> *When you arrive at her place you explain to her about your issue, then you kneel down at the altar, then you open up your clothes exposing your abdomen, take a little oil with your finger and you apply on your abdomen [demonstrating on her abdomen how it is done], then she massages as she shakes the baby. She then collects the contents holding them bringing them to the middle, while shaking the tummy then it's done.* (IDI_008_NCM)

Comparing the services offered by their traditional care givers to the one received at the hospital, the environments and understanding they get, a participant reported that;

> *When you lie on your side, it will be difficult to massage the whole abdomen. And if you sleep on the back, your tummy disappears, but if you kneel down then the exposure of the abdomen is great, this is at 6 months of pregnancy. At the hospital they just do their tests on you … No massage is done! That is not done at the hospitals.* (IDI_005_NCM)

Comparing the care given by the religious system to the ANC program, the faithful reported that during the ANC visit, there is no abdominal massage done, which would relieve the heaviness some claimed to have during pregnancy. The women church leaders have mastered their practice of abdominal massage and are doing great as reported by the faithful's. This makes many mothers feel less inclined to the kind of care provided during ANC visits. Olungah (2006) revealed that church has identified some health conditions and associated them with spiritual set of risk factors

or ancestral displeasures that are brought about by none adherence to the traditions of the church. Mothers would want their children to be born health and normal with no complications whatsoever. Thus, the hesitance to use maternal health services. At the hospital faithful's critically assess the attitude of care givers, environments, procedures, and relate with their religious beliefs. Health care workers (HCW) ask them to lie on their back, which most women believe makes the abdomen to reduce in size not giving the right exposure on examination, unlike when kneeling down, when they believe the abdomen is exposed well. This makes the women hesitate utilizing ante-natal services.

While this alternative care TBA's provided during pregnancy vaguely make mothers assume a false sense of wellness with their pregnancy, silent communicable and non-communicable conditions may creep-in and complicate a pregnancy as with anemia, pre-eclampsia or gestational diabetes, obstructed labour due to anatomy defects which may be diagnosed during ANC. Preference to TBA massage present as a barrier factor with the fear of taking medication pills presenting as a predisposing factor to utilization of maternal health services. According to the Andersen model, accessibility, affordability and acceptability of the TBA services in external environments affects the utilization of ANC, SBA, PNC and contraception.

The handling by the TBA's poses a great challenge to the handling mothers receive the health facilities. The massage leaves them feeling good, relaxed and even sleepy, a factor influencing their utilization of home care services that has a bearing on ANC uptake. Complicating the situations further, these traditional therapists further have prescriptions for problems during pregnancy and delivery. A faithful recounted that;

FGD_003_CHV also added that "*there are also other traditional herbs that are introduced for the mother to take to wash the womb and wash the baby."*

> *To treat abdominal pains, sometimes, I have seen them give traditional medicines for one to chew and there are those she comes with. At times she comes with boiled water mixed with candles. And she gives you this to drink with lemon water and ginger*. (IDI_009_NCM)

During the focused group discussion, participants unanimously agreed that traditional medicines are still being used by the mothers. FGD_004_CHV reported that *"Yes they are there. Especially there are those that are chewed to help give birth without labour pain."*

> *The lady who gave birth on the way told me that, you know those labour pains that take so long to delivery, I don't like them. I don't like having those long labour pains, not even 2 hours, that's a lot. If you start feeling the pain, there is something you take, throw into your mouth, and when you chew it and the water lands in your stomach, then the baby is out.* (FGD_001_CHV)

> *I reached there only to find the lady in a pool of blood. The child was lying on the bloody floor. After cutting the umbilical cord, I informed them that we are taking the lady to the hospital. But the lady retorted back that her mother in-law has gone to bring some herbs, as the other one I just used has failed. Just leave me, it will just come out, they have gone to bring another medicine.* (FGD_002_CHV)

> *There are local traditional medicines, like the bark of a local tree called "Ober', with another herb called 'Nya-lwet Kwach', the roots of 'Yago tree', together with 'Otange' and lemon.* (IDI_008 _NCM)

Understanding community contextual ways of dealing with the sick would help healthcare providers plan for individual and community-based health messages targeting the practices (Mukabana & Mukaka, 2019). With over 91% holding onto the belief that local herbs provided by their TBA's helped manage some health conditions during pregnancy, at birth and after delivery, knowledge of their use is important. Most especially after birth, the mother and child immunity is low and maybe subjected to use this medicinal products for their illness. Helping to demystify the concept of disease and their management in a friendly way without criticizing community's

methods of caring for their sick can help change the trends and have a shift towards utilization of maternal health services. Previous researchers Amirrtha and Reid in (2008) revealed that stereotyping and criticizing individuals or communities' ways should be avoided, if we wish to promote a good relationship and enhancing enabling environment to utilizing health care services, but by deeper analysis of complex dynamic contextual factors affecting maternal health (Mukabana & Mukaka, 2019). According to the Andersen behavioral model of health service utilization, use of traditional medicines presents as predisposing factor, affecting utilization of ante-natal services.

The women offering the services are known, loved and are famous in the villages, FGD_001_CHV reported that *"even Phiona (a TBA,* name changed*) is still massaging the pregnant mothers. Mothers come to her, even when we are sited there in the market, we see them come and she massages them."* Mothers love coming for the massage because,

> *When being massaged, they massage even the thighs, those offering the service claim it is a God given gift. As they do it, they can tell you that the child is not lying well in the womb, and the ladies will not be feeling well in the body. And after the visit, she says she is feeling lighter in the abdomen*. (FGD_004_CHV)

> *Let me add something that massaging is like an exercise. It's like when you feel tired, you will be told to do some exercises to feel better. So the massage makes them feel just like that.* (FGD_001_CHV)

The mothers feel that in conventional care set up they are demeaned and feel helpless as they cannot voice any concerns but have to take the services anyway. But in the community they feel accepted, handled in a friendly way in their homely environment where they are at ease. A key informant reported that;

> *Our traditional birth attendants are still around in the community, we find most mothers are not coming early for clinics … they get good handling at home. They claim that the healthcare providers are harsh versus the TBA's who handle them soundly. We are telling our health workers to change their behaviours and talk to these mothers and they should*

> *feel at home, we also provide some food-stuffs for those who deliver in the hospital. We also try to inquire what makes them prefer the TBA's services than the hospital care. We also follow them up through community health volunteers.* (KII_001_SCH)

The above experiences are unique to the women of Nomiya church and key to their health and living. Addressing these gaps can lead to an increase in utilization of maternal health services and a decrease in maternal morbidity and mortality (MMM). The above experiences point to a 'healthcare systems' that has failed to measure up to the demands for maternal health services. Similar findings have been by Kyei-Nimakoh et al., (2017), Brenner et al., (2017), Srivastava et al., (2015), Tran and Bero (2015), NCCS (2013), Knight et al., (2013) and Birhanu et al (2012) that pointed out that poor hospital policies, inadequate training of personnel to caring for maternal healthcare needs, shortage of staff and the fact that women waiting for too long for services deny them ample time to meet other demanding tasks and thus restrict their seeking of professional healthcare services.

6.2 Experiences with traditional birth attendant's services

> *She (TBA) gave me two injections, and after 3 days I was clean. And with these other babies, I normally take 2 weeks while seeing blood. So, in this case, I saw she was of much help. Again, there is no tender care in the hospital when one is giving birth. The sisters (*nurses*) cannot beg you to do something, while at the TBA, you are tenderly being taken care of. At the hospital if you meet a sister that came to work in a bad mood, you'll never know which demons came her way … you can be met with all sorts of insults. (*IDI_005_NCM*)*

The faithful's had various reasons for their hesitance in utilizing skilled birth attendant services, some claimed that they are demeaned and feel helpless to voice any concerns which are never considered by the healthcare provider but have to take the services anyway. But in the community, the participants reported that they feel well handled and are at ease. The study revealed that TBA's are still conducting a number of deliveries in the village. With half of the total births reported in this study having been home deliveries. Some TBA's have been trained previously on delivering

mothers and that their services would be monitored by the training NGO's, but this was never the case and after the NGO's wound up their program and their support to the TBA's is no more, monitoring safety and data from these TBA's is lost. Thus, there is use of both traditional, modern and religious therapies for maternal care, as previously reported by Olungah (2006) and Ayele et al., (2014). With no finances, this becomes an income generating venture. And when mothers die under such instances, no reports are done.

> *I gave birth to this child (pointing at the child) with the help of a traditional birth attendant when I was staying in Nairobi, I confirmed first that she was a woman from Nomiya church (madha). I had gone to some hospital called 41, but since I didn't deliver early on time as they expected, my time was not yet. To them, it seemed that I was wasting their time, as the doctors were on strike. They wrote a transfer letter to Pumwani Hospital [laughs sarcastically]. Pumwani! (Sighs) that place 'aah' you won't like it [laughs]. I heard it's not a place that you will like spending your time in from morning to evening without giving birth [laughs]. Because, if you stay for that long, then they list you for 'theatre direct' for an operation. When I heard about my transfer to Pumwani, I got so scared. I decided to go back home. I rushed to traditional birth attendant, and she helped me.* (IDI_005_NCM)

> *When I arrived, I confirmed first that she "madha" was a woman of Nomiya church and a leader in Nomiya. At first, she prepared and gave me tea to drink, at that moment I did not have too much pain. I was just okay. Because, she took good care of me and asked if I really felt any pain. I went there at 4 pm and for her to do all that staff on me, it was already 6pm. By 7 pm, she cooked for me ugali and eggs but I could not eat because I was having too much such abdominal pains. By 11 pm, I delivered my baby, mmh! It was just a normal delivery. After delivery, she has some beds, and curtains which she hangs for you. So, the person who comes in cannot see you once you deliver.* (IDI_011_NCM)

Mothers have developed sense of confidence in their church based TBA's whom they have to be assured of as being their church leaders. Other African Spiritual churches too have their TBA's. So, it is important for the mother to confirm her birth attendant's church roots to win their trust and to give them a chance to birth their baby. NCCS (2013) had similar findings where TBA's and mothers in-law had preference on particular TBA's to be their birth attendant. Shamaki and Buang (2014) noted that dependence on TBA's is a recipe for high maternal mortality, this also explains

the high prevalence in maternal mortality experienced in the area of study for decades as well as the low statistics on the uptake of skilled birth and PNC services.

Many mothers of the Nomiya Church still believe that TBA services are comparable to the conventional healthcare services, and some believing that the TBA's are better compared to trained healthcare provider's services because of religious reasons. Therefore, there is need for a re-orientation of how healthcare services are packaged for maternal health. There is need for sensitization of the African Spiritual church communities on Maternal Health Services, highlighting to the religious leaders and the target audiences of the specific services, their uniqueness to the mother, child, family, community and nation. There is need to have a focus on having a healthy and safe delivery and to adhere to programs to see that the mother and child have a healthy life beyond 5 years by highlight the uniqueness and benefits of the various post-natal service packages for the mother.

During the focus group discussion CHV's agreed that TBA assisted deliveries was an issue of concern. There were also diverging opinions on what they do, participants reported that;

> *I have one in my village, but with her she has continued with offering the services. She refused any attempts to stop with her trade, though only a handful still go to her for help. But those who reach her, she serve them soundly.* (FGD_003_CHV)

> *'Madha' are still present with us in the villages. Previously they worked freely with nothing to worry about. But today, following the health education we give to the pregnant women about the benefits they stand to get if they visit the health facility, many of them have changed and are not going to 'madha' so frequently.* (FGD_001_CHV)

CHV's unanimously agreed that TBA's still offer massage services to pregnant women that affect utilization of ANC services. TBA's offer delivery services at home and some participants reported that TBA were better at delivering that skilled birth attendant. With women having a firm personal belief that TBA's can be better and assisting in birth that a trained healthcare worker, this generates

into the community of faithfuls who consider the church as the highest family unit. Similar findings have been by Crowe et al (2012) Pelcic et al., (2016), (Kifle et al., 2017) and Edu et al., (2017). These are responsible for the sustained low uptake of ANC, SBA and PNC services.

A participant revealed her fears when there were cases of retained placenta, known as the "after birth' in the community, and reported that;

> *In most instances what I have seen and heard is that, some give birth but the after birth is not delivered, as it remains adhering to the womb, and when arrangements are finalized to transfer the woman to the hospital, they die on transit.* (IDI_004_NCM)

The fears expressed above should propel the faithful's to utilize skilled birth services, but that is not the case, the faithful's still opt to be assisted by the church based TBA's. IDI_002_NCM, a mother of 3, confirmed that pregnant mothers prefer delivering at the TBA's by stating that *"What I can say is that the traditional midwives are at times better and know how to deliver babies. They are good."* A CHV confirming and expressing on the relationship the women in their religious circles have with their church-based TBA's stated that these women report that their TBA's; "*serve them well."* FGD_003_CHV reported.

Maintaining 'status quo' in regards to maternal health statistics is an area that inevitably needs urgent and radical change. i. This must be with the regions health personnel that needs reorientation on how they do business, ii. There must be improvement in the infrastructure for maternal health, iii. Improvement in the management of maternal health data and iv. The re-training and re-orientation on maternal health services for the specific mother, especially mothers whose details are easy to pick from the Mother-and-Child booklet, and considering them as a high priority to achieve above 90% skilled birth rate, and also to gain on the WHO and SDG's set targets.

6.3 Barrier to skilled birth attendance: a perspective of the key informants

> *You see, issues of deliveries a lot is tied to cultural issues. One, there is a belief that you should bury the cord of your firstborn at home. So, in the event that they come to deliver in the hospital, obviously the cord will remain in the hospital and they don't like it. Secondly, there is that use of herbs, in the first three days they have to use herbs I don't know to cleanse what, their cultural issues and there are various religious practices. Actually, when a woman is pregnant, they will have to consult a lot with mother-in-law who will give them directions in regards to religious beliefs or cultural practices. So that's how a mother-in-law becomes very key especially when they're staying together in the same home. You have to comply because they are the people who will assist you eventually.* (KII_001_SCH)

> *For the expectant lady to gain the status in the community, they'll do exactly according to what the grand-mothers are saying. Mark you when you are married in these homes, the lady, if she wants to be relevant in the community, first goes and show honesty and loyalty to the mother of her husband. So, it means, the grand-mothers are the ones given chance to inform the other family members where their child will be born, regardless of the knowledge the mother of the child has.* (KII_002_CH)

Husbands may not oppose much nor stamp their authority about matters place of birth and will let their wives deliver from home. The mothers in-law, the TBA's have the upper hand in making decisions on where a woman will deliver. This is designed so in the community for the women to be accepted and to carry on the traditions of the community. With the mothers in-law maintaining that their daughters in-law must observe religious demands like delivering their first born and burying the placenta at home would culturally open ways to anyone who will then later on deliver in the compound, which mostly is conducted by the church TBA's. Findings by NCCS (2013) revealed that utilization of local and religious practices affect utilization of maternal health services. Women tend to strongly stick to culturally prescribed norms to seeking maternal health services for their own health sake, to the extent that even where formal healthcare services are available, they are bypassed for alternative maternal care services (Ebere, 2013). Still promoting home delivery, key informants opined that some Nomiya church faithful's believed that;

> *They were also birthed by the traditional birth attendants, so they are not ready to change. He is staying well, and the wife is able to deliver at home, and the child is there. Some of them just believe that it's best to deliver at their homes. They are comfortable doing it at home […Laughs].* (KII_004_C_NCM)

The study revealed that the faithful's, senior family members and their spouses were not bothered about their delivering at home, which negatively impact negatively on maternal health statistics, especially the high perinatal death reports experienced in the study area . When mothers deliver at home, the pressure of spending is waived off their spouse's shoulders, which is normal among the family, making mothers inclined to the TBA's services, and according to the model of the study, this presents as a barrier factor to the utilization of SBA services. A mother resolutely affirmed that "*Your wife must give birth inside that compound so that she opens up the homestead."* (IDI_010_NCM).

Previous findings by Azuh (2015) revealed that some mothers deliver at TBA's places to please their husbands, while Chukuezi (2010) revealed that some religious beliefs limit the ability of women to seek skilled healthcare services. It is noteworthy that this study findings were in contrast to Ebere's (2013) findings, which revealed that in Nigeria, it is the husband's and male relatives who decided where mothers would seek and utilize maternal care services. But this study has revealed that it is the mothers in-law, church based TBA's who had more authority on decision making about place of delivery. This study findings also contrast Koenig's (2012) findings that reported that social support networks encourage utilization of health services.

6.4 Experiences with practice of seclusion

All the 22 informants said that they practice seclusion as it is an order practiced by the Nomiya community as a directive from God to them as found "*in the book of Leviticus chapter 12. More is in Genesis 17"* narrated IDI_013_NCM. While expressing about the types of seclusion that are

practiced by different groups of people, KII_003_B revealed that *"there are three kinds of keeping; number one; we have the keeping of Christ, number two; we have traditional or the tribal type of keeping and the third one: we have keeping of the government."* Seclusion covers the period from the 8th day after delivery when a child is baptized and circumcised for a boy child and from the 14th day after a girl child has been baptized until after 33 days and 66 days for a boy and girl child respectively. Seclusion practices affected various aspects of maternal health.

i. Seclusion and getting sick post-natally.

Important to note is that no report was made by any of the participant of getting sick during seclusion, as many believed that this is a period of purity, dedication, and dwelling in divine protection of God. The faithful's remarked that maybe if one ever got sick, she was taken care of by the church system, with the church TBA taking lead. In some instances over-the counter drugs bought for the member to use. Ebere's (2013) in Nigeria, and Atenchong (2016) in Cameroon study findings revealed that seclusion is believed to have a compounding effect on the high maternal mortality. When the mother is taken in for seclusion, during that time as the sole caretaker of her child, she is believed to remain spiritually clean and healthy. It is believed that diseases cannot affect those in seclusion.

> *Previously once you had given birth, you were put indoors and you were not allowed to greet any person and people were not allowed to enter into that house, even if it was a visitor. Meaning a visitor may have communicable disease and through greetings they believe the visitor is unclean*. (KII_005_N_NCM)

Seclusion practice overshadows the whole essence of post-natal care policies. It is worth mentioning that early detection, diagnosis and management of acute and chronic conditions after delivery including vesico-vaginal fistula, puerperal psychosis and other communicable conditions of the mother and child may be delayed or missed while in seclusion. This is a key period in the

woman's life where near misses may lead to devastating results. During seclusion, if a mother is seriously ill then the women leader is first given a notice, then the pastor is called to pray for the mother, and a ceremony like event dubbed as 'small removal ceremony' to release the mother out of seclusion is held, as procedural with the church doctrines. This is the apostolic system that controls much of everything that concerns maternal and child care weeks after delivery and to the resumption of active reproductive roles in the family.

Important to note is that no report was made by any of the Nomiya church faithful's of getting sick during seclusion, as many believed that this is a period of purity, dedication, and dwelling in divine protection of God. But in case one got sick, she is taken care of by the church system and in some instances over-the counter drugs are bought for the member to use. Ebere's (2013) in Nigeria, and Atenchong (2016) in Cameroon study findings revealed that seclusion is believed to have a compounding effect on the high maternal mortality. After breaking the event of seclusion, the couple will practice a ritual as stated by the participants as 'crossing over the child,' which is a must be done by the parents of the child. If that is not done, the mother will remain in bondage and unclean. This instills fear and makes faithful's enslaved to following the church practices.

In cases where a participant is removed from seclusion earlier than expected for any reason, then this is communicated to worshippers who may be in the neighbouring sub-counties. The big and flashy celebration that is usually held at the end of seclusion period influence some mothers not to open up about their illness and their need for medical care. The celebrations held brings a sense of recognition, pride, belonging and self-actualization to the mothers, family and community of faithful. When people come together from far parishes to celebrate the new member's spiritual breakthrough, there is a sense of approval of the faithful by the church family. According to

Andersen model of healthcare utilization favorable practices in the external environment affect uptake of contraception, seeking skilled delivery, post-natal care and maternal mortality.

> *I think they are following some biblical message and to the positive part of it, I think it does some good to the health of the mother and the child … when you exclude that mother from social interaction, to some degree, I think you are preventing a lot of infections to this mother.* (KII_001_SCH)

> *As the one I just told you about was delivered in the hospital then later on I heard that the child is kept, no one can take the child anywhere."* (FGD_001_CHV)

Relating to this religious practice is the control of infections practiced unconsciously by the faithful's. This religious practice in fact has some public health significance, as a visitor may be having "bad airs," which they could transfer to the mother. During the FGD, the CHV's confirmed that when a child is subjected to seclusion, then the church principles must be observed to the letter. Keeping the mother from possible interaction with outsiders from the community who may be carrying infectious pathogens that may easily affect the mother and child, may have beneficial effect, knowing that their immunity about this period is still weak. Seclusion also prescribes that the mother may not to leave her house and home for any other thing. This is a covenant that the mothers must bear alone, as the church culture dictates. According to Ebere (2013), he noted that seclusion as practice infringes on women's right and denies them their freedom of movement, association and of seeking social services. The confinement prevents the mothers from going to church, markets, peer meetings and to seek and utilizing maternal health services.

ii. Seclusion and Food restrictions

While explaining the food restriction during seclusion, the faithful's reported that the mother is also considered *'mo gak'* meaning 'unclean', and cannot go to the altar until the end of seclusion and all traditions observes. During seclusion, there are foods that are allowed and others prohibited and if taken are considered to make one unholy.

> *The mother has to 'keep herself pure' while in seclusion. There are foods the family can't eat like pork meat, mud fish that smooth fish … ducks, an animal that dies on its own, or a hen that has been killed by a mongoose.* (IDI_010_NCM)

These findings reveal that during seclusion, beliefs regarding food are strictly adhered to just as is observed in pregnancy. Mothers are not allowed to eat carcasses from dead animals whose cause of death are not known or even after having been attacked by a wild animal. This belief has a positive bearing on protecting the mother from acquiring zoonotic infections which are eliminated by these practices. But it is also important to note that if one was rearing ducks, pigs and, or is doing mud fish farming, then, in instances where there is no money and one is in financial hardship or during drought, they are still not allowed to eat these foods which are a rich source of proteins, even if they are advised to consume such meat.

It is also worth noting that uptake and utilization of healthcare services come in late after seclusion practices and special rites have to been observed. Women will wait until they are ceremoniously released from the bounds of seclusion to seek other health services. Thus there is delay in diagnosis of health conditions that are developed during the puerperal period. Olungah (2006) revealed that Spiritual African church adherent vigorously and legalistically observe prescribed and proscribed terms on foods. These terms contextually need to be explored and understood to design health messages to counter them to change and promote healthy nutritional habits during seclusion. It is worth noting that not education nor status in the community affect these stance held by the faithful's (Gumo et al., 20212).

iii. Seclusion and seeking chronic healthcare services

Leaving the house during seclusion to go to the health facility was a thorny issue among the members to overtly share about. Some members were positive to fact that they could leave their seclusion customs to go for health care services. A mother reported that;

> *Our church does not prohibit anyone from going to pick their drugs. You can leave the baby with another little child. You are not allowed to go anywhere with the newborn … you can meet with someone who is not clean*. (IDI_010_NCM)

Strict observation of the seclusion practice may lead to negative health consequences such as a rise in viral load, opportunistic infections (OI's) amongst the HIV positive, and in mother to child transmission of HIV. Leaving the newborn baby with another child to go to the hospital is a risky affair no woman may dare. This is coupled with the knowledge of delays at the hospital waiting to be served, affecting utilization of PNC services. Some faithful's reported that they are not allowed to leave the house for whatsoever reason until the seclusion period is done. IDI_009_NCM reported that the church will ensure that *"if there is any problem, they can help you."*

With the faithful's having knowledge that the church would help them while observing church traditions, they will delay and be hesitant to utilize skilled birth services knowing very well, as Murigi (2016) and (Gwengi 2017) reported of the strong religious bonds amongst the members, influence their utilization of skilled birth services. They fear being marked as rebels with the church doctrines. Also the gifts, recognition and approval that many expect at the break of seclusion affect their desire to utilize skilled birth and PNC services. While in the hands of the TBA's they are exposed to HIV infection, where infection prevention practices are far from safety, peri-natal bleeding, use of herbs that may affect the mother and baby. As the faithful's identify with their church delivery systems, mainstream churches faithful's have adopted and assimilated the conventional maternal health care systems.

iv. Seclusion as a 'Rite of Passage'

During the breaking of seclusion, the faithful's also practice the rite of '*kalo nyathi'* translated literally as 'crossing-over the baby,' an event marked by 'shaving of the child' as a rite, celebrated to the mark to the end of his or her seclusion. The couple will practice a ritual as stated by the participants as 'crossing over the child.' If that is not done, the mother will remain in bondage and unclean. Strict observation of the church doctrines by the faithful was confirmed during the focused group discussion. FGD_002_CHV reported that *"during seclusion, the child will not be shaved until they come to break the seclusion."* A key informant and bishop of the church, KII_003_B revealed the deeper meaning to this practice beyond the face value explaining that *"it is said the father will unite in the bed with the mother. That is the meaning of the ritual."*

> *They have their beliefs that they try hide on the child not becoming fat. 'Shaving the child', 'crossing over the child', all those things. They just rush for sex after delivery. The episiotomy sutures will be coming off, in the name of you want 'the rite' to be fulfilled, you wonder! If you have not done it, this lady is going to bewitch herself.* (KII_007_C_NHC)

> *That's why we keep on renewing messages time and time again, to handle the new challenges that come on board. Because when you are done with one, there is another one that is emerging. The information you will get, at the action you think that is happening, is actually totally different … You know culture is dynamic. The funniest thing is that when you study a community, you will find that when they are shifting from behaviour then they are going to the next."* (KII_002_CH)

This study aimed at exploring the phenomena, their essence, and the meanings attributed to them in totality so as to develop key messages to address the negative aspects of religious traditions to maternal health. Unpacking the meanings of events around rite of passage of the child after completing the days of seclusion, it is confirmed a full member of the church. But on the flipside, there was another deeper meaning to crossing over the child, that affects a woman's sexual and reproductive health as she resume sexual activities exposing her to risks of early pregnancy, STI's

as they are involved in polygamous marriages, puerperal sepsis and exposing the child to infections acquired through breastfeeding like HIV.

With other African Luo based Spiritual churches not practicing neonatal circumcision strictly as the Nomiya, which is also in line with the Luo rite of passage to adulthood, Murigi (2016) and Gwengi (2017) revealed that the events around child circumcision has confounding effects on maternal health as it is the mother to hold the child during circumcision, a practice done traditionally, may affect the mental health status of the mother seeing the neonate bleed and become pale with persistent bleeding, that may turn fatal with time. No studies have looked at the effects of this practice on maternal health, as after the event mothers are kept away from seeking post-natal health services for their health or neonatal and child health care services.

v. Seclusion and the use of contraceptives

While exploring the happenings around the closing the seclusion period, IDI_002_NCM reported that on that day *"we play drums, run dancing on the roads, it is such a big celebration."* IDI_008_NCM recounted that *"faithful's and church leaders from far parishes come and pray, cleansing you, that's when you are allowed to go to church. That's when you can come out of seclusion."* Prioritized during the break of seclusion period, a participant reported that the leaders use this time to hammer their campaign against utilization of contraceptives.

> *When they come to the ceremony to break the seclusion period when the days are done, they really preach against Family Planning so viciously, hitting at those who go for them. So much that if you are using any family planning method you feel the guilt deep within you.* (IDI_010_NCM)

The rite is marked by a sexual union with the father of the child. This time is crucial in a woman's reproductive health, marking the return to active sexual relations as most of the faithful don't strictly adhere to exclusive breastfeeding leaving chance to a possibility of pregnancy, STI's,

puerperal complications. Contraception is strongly preached against by the church leaders, with the peak being the night of the ceremony to break the seclusion ritual. Pastors preach so strongly against the use of FP methods during the celebrations. Visiting teams from various parishes during night vigil prayers with dancing and merrymaking, some may engage in illicit relationships, compounding to spread of sexually transmitted infections, HIV and pregnancies. a women is exposed to various health challenges that come with pregnancy. Seclusion in religious sense is a potential to barrier to the utilization of maternal health services especially with the tough preaching against the use of contraception, which according to the Andersen behavioral model of health service use.

vi. Seclusion and immunization

> *This issue of seclusion, mmh, it has surely disturbed me. There's this one person who disturbed me so much. She kept the child for 60 days without any immunization administered to this child. Religion still poses as a big problem, eeh! A big problem to us. People don't go to the hospital, yes, those are their practices.* (FGD_04_CHV)

While at the face value we only see and believe the seclusion is over, behind the scene we need to find out what it is that is really happening. Information, education and communication messages should always be on dynamic trend to meet changing dynamics in the religious spheres, especially for African Spiritual faithful communities. As the effects of such traditions are far reaching. CHV's unanimously agreed to the fact that seclusion happens in the community. Similar findings by Ajiboye and Adebayo (2012) noted that religious practices persist despite social change and modernization, as people still strongly adhere to their religious and community practices that are crowded with misconceptions on causes of maternal morbidity and mortality. But in cases where there are disease outbreaks among children, the death of the child may in-turn affect the mothers mental wellbeing, thus impacting maternal health.

6.5 The wife inheritance

Fifty percent (50%) of the respondents strongly held to the belief and would be involved in this practice, 25% reported that they know of the practice but may not observe its strict requirements, as 16% reported that the practice is not mandatory today. The participant women had various reasons for observing or not considering the practice a top issue in their life, and religious commands. The Luo's as a tribe practiced wife inheritance with the brother to the deceased marrying the widow to his late brother to keep her and make her a home. A mother believed that wife inheritance is a worthy practice that is important according to her and noted that;

> *"if my husband dies, I can surely be inherited, I cannot lie about it, because my husband has died when am still young… so that he can build a house and put up for me my own compound, and he must go to our home and pay my dowry … Even the bible supports you be inherited, especially those women who their husbands die before they get to the age of 60 years." (*IDI_010_NCM)

> *If you refuse, that can be a terrible disaster and a bag omen may befall the first born or the last born. First, when they want to inherit a woman, then the small and big children must be around. It is demanded that you cook some food that they will eat together, to 'set them free in this house' as a rite, setting free the new."* (IDI_004_NCM)

Maternal health is surrounded by a wide range of customs, beliefs and practices as revealed in this study, posing potential challenges where customs are considered good, bad and uncertain, as previous studies by NCCS (2013), Singh (2012) and WHO (2009). Wife inheritance still runs deep amongst the Nomiya church community. The Nomiya faithful's hold onto the practice is with an added reverence, as the women find a lifeline with the church accepting the inheritance of the widow after burying the husband. The faithful's hold onto this practice with biblical references complementing the Luo cultural ways makes the practice appealing among many. Similar findings have been by Gwengi (2017) who reported that the church system allow for wife inheritance, as she finds a new lifeline to siring an heir, have their bride price paid, have a house build for her and the kids in their land.

Another key informant observed that;

> *These wife inheritors, dealing with all of them is not easy. You will find that today he is inheriting this lady, the next day he is going to another. They normally put conditions! Okay, about food, you find that when they cook chicken, then the child are not to eat the back of the chicken, that is given to the husband, and when food is served, you find that the man is served more than anyone in quality and amount. These things happen, yes, in nearly all the homes, but it is done in secrecy.* (KII_004_C_NCM)

> *Economically he can't even buy clothes or food. He should be taking care of the children he brings forth, but, you find that he has so many kids at his home, he comes to this new lady and give birth to so many kids with her, and they don't even own a piece of land, this will only bring poverty.* (KII_004_C_NCM)

Participants in the focused group discussion unanimously agreed that the practice is still being observed but under different terms;

> *Today the family doesn't sit to choose one of them to take care of the widow. That practice is seldom observed. It's coming to an end. In the community sittings they would pick one of them and direct him to go take care of the brother's house. Today it is the woman who can decide to be remarried. So it's her sole responsibility to choose whether or not to get a new partner.* (FGD_003_CHV)

The Levirate practice, today, is a practice that only the woman has a choice to make. But this practice also has a great bearing on maternal health especially in regards to disease transmission with sexually transmitted diseases, HIV and the Human papilloma virus that's responsible for cancer of the cervix. While wife inheritance is a good practice to some of the faithful's, KII_C_004_NCM, a key informant pointed out that the practice has its danger too, and stated that: *"Yes, wife inheritance would lead to HIV/Aids and STI's. Inheritance also brings children that people we are not prepared for."*.

The practice also has a potential to drive families into poverty, posing a challenge to affording, accessing better social amenities as school, healthcare services among other services. So, as much as the women have the chance to choose what they want after losing their spouses, they are still bound by the church beliefs and tradition, and are subjects to women leaders or mother-in laws

opinions. Their decisions to pick an inheritor should be made with great caution, deserving psychosocial and health counselors input and collaborative approaches. Omondi (2013) reported that wife inheritor's intent is in siring many children, being fed well, becoming agents of disease transfer as HIV compounds. These aspects dig into the household's financial abilities exposing the widow to poverty having to deal with many mouths to feed and disease to treat.

The inheritors in most cases do not have land, are usually poor and are hoping to be fed, paid and, or be pampered by the woman. The study revealed that they are usually fed better than any other family member in quality and quantity. Whereas the woman should plan to feed the kids, her desire to keep the man overrides others in her program, and this may lead to poor maternal health especially during pregnancy, when a woman may deny herself food to feed the man exposing self to risks of infections, poor health and healing from diseases and retarded fetal growth. On the other hand, a responsible wife inheritor may be a father figure to the children, way maker to help raise family living standards and caring for family health states of all. These men often don't encourage use of maternal health services as contraceptives, whose health benefits have been proven by the WHO. But their interest are in siring children with the widow.

The faithful reported that men need to take an active role to ensure the wife is or wives are well fed. In the eyes of the respondents, this was scored as an enabling factor leading to good maternal health outcomes. A man accompanying them to the ANC clinic to give moral support and get the much-needed information to ensure the life of the mother and fetus is safely guarded, and involving them in birth planning was highly desirable amongst the participants. But the church and society have laid down alternative regulations, making men spectators rather than supporter's during

pregnancy. This has made men believe it's the wives, women leaders and mothers in-law responsibility to take care of the pregnant women.

This study insights reveal that wife inheritors should encourage and help their wives by reminding them to take the supplements which most mothers were not taking complaining that the of too many tablets, given to mothers without satisfying information, yet some of these drugs help prevent congenital malformations, which have serious psychological impacts on women who give birth to children with disabilities. They should accompany their women to the hospital and get prompt information regarding the use of the drugs. The men should also be involved in planning and utilization of ANC services, protection and in the prevention against malaria, nutrition health education during pregnancy and plans for delivery and post-natal care, but this is never the case. According to the Andersen's behavioral model of health service use, the practice of wife inheritance plays as a barrier factor to utilization of maternal health services. KDHS (2014) reports have cited that men should ensure unhealthy religious practices are avoided, conditions that the mothers are living at home are clean, healthy and safe, and in cases of any abnormal presentation during pregnancy, medical assistance is immediately sought.

Educating and sharing more information about maternal health with their inheritors, may be beneficial to the couple than to the woman alone, as both may be careful to ensure safety, be watchful of danger signs during pregnancy, delivery and during the post-natal period. This would help guard against harmful traditional practices, as dictated upon by the mothers in-law that are injurious to the maternal and child health. Findings by Mbugua et al., (2017) and UNICEF/ WHO (2015) revealed that women from western Kenya are less likely to utilize maternal health services as their hold onto harmful religious and community practices is so strong among certain

populations. Such harmful religious practices are attributable to the high maternal mortality, poor statistics on ANC, SBA and PNC services utilization. Nzioki et al., (2015) noted that a lot of efforts should be focused on contextual religious and community orientations to address the perennial poor statistics on maternal health.

6.6 Faithful's community organizations affecting maternal health

The church permits polygamy, which causes risks to diseases. One key informant observed that;

> *The bishop is allowed to have at-least 6 wives … he cannot satisfy most of them. So, within the church you will find that there are some other people who are helping bishop to manage these ladies to be satisfied sexually*. (IDI_004_NCM)

> *Being that we are Luo's and our church traditions has much fun. At times people dance, and we also have celebrations, and it goes till night, and at night, dancing brings love, this is when they become promiscuous, so if the faithful blunders, they try and compare it to David's and the previous kings.* (KII_005_N_NCM)

The risks heighten during church events like breaking from seclusion, parishes from far places send representatives to the celebrant home. Representatives come in pairs and some choose those coming with them purposefully. As mentioned above, these events have a bearing on pregnancies, contraceptive use, MTCT of HIV/AIDS and STI's, which have become issues of great concern. These especially have a bearing on the utilization of maternal health services especially among the females who are the majority of adult worshippers. Some community members were involved with some community organizations as regards support when a member needs the health services, a member narrated that;

> *Welfare groups are there … some groups that have rules, you can't just go there and get help [Laughs]. They cannot help unless you go to the ward, and is admitted in there, in that case, there is a constitution clause that allows … that you to get money.* (IDI_010_NCM)

> *When there is calamity like in death or sickness we usually solicit for money from members. We don't have an account to go and borrow money from when one of us is bedridden or is having a chronic illness.* (KII_004_C_NCM)

> *The income of these people is not really good … I met a sick woman carrying a baby, and she was carrying a small sack of maize on her head that she wanted to sell so that she could go to the hospital, have some money to buy drugs if prescribed and even have motorbike fare from here, it's a far distance. So, one can even die while waiting to get money to go with to hospital.* (IDI_004_NCM)

Community organizations, especially the financial group's, are established on strict foundations of financial support of its members. Support is limited only to those who are very sick and admitted at the hospital, and not to women who are sick and may be still at home, as stated in their organizations as not admitted in hospital. This may be because they may be in need of financial help to reach the hospital for urgent medical care, but cannot receive financial aid as the group regulations don't recognize support of those still at home or those treated as out-patient clients who would have been advised to buy medicines or referred to a referral health facility and they cannot afford transport or cost or drugs at that moment. This may have a bearing on maternal morbidity and mortality, as faithful's are faced with a challenge of accessing and utilizing maternal healthcare services. And during illness, when funds are needed to pay hospital bills, the church members collectively raise money to help their sick member.

Members contributed funds when their faithful member was sick to support the sick individual's family. This attempt come late and complements to the delay to seek care for the conditions. This habit of responding to illness may turn tragic that if of acute severe process. The identified community practices among the faithful will only fuel use of alternative care measures which are easily accessible, medication products found locally, preparation easy and used accepted. These are either used by inhalation of boiling herbs, drinking and bathing with water mixed with herbs to treat some conditions and hasten labour. Communities conform to and identify with these practices. Similar community findings have been by Shahabuddin et al., (2017) that revealed that girls preferred to deliver at home because that was their community tradition, and Azuh (2015)

noted that this was also happening to please the husbands. Thus there is need to have sensitization programs in the community on skilled maternal care services and their importance.

Mothers sought permission to go to the hospital, a factor that may only encourage utilization of community's alternative TBA services whose services are easily accessible, affordable and accepted by many of the faithful's in the community, a factor that may encourage high MMR. Similarly, the order and organization in the community have led to creation of community groups and structures built on pillars that don't support maternal health, neither are their missions and core values aimed at preventing diseases, but reacting to worse health events as reported in cases of hospital admissions only, rather than coming in to assist at the earliest stages of the detection of the conditions at home to steer fast reaction to seek healthcare. Community organizations have been established on pillars that only react to very severe health conditions pegged to individual's admission in a health facility. This complements the strong adherence to home remedy that would rather contribute to the high maternal mortalities. These community practices act as predisposing factors in this study affecting utilization of maternal health services

IDI_010_NCM who was pregnant at the time of interview, while explaining about concerns of her husband sexual needs reported that *"It depends, from one to another, because, as for me, when I become pregnant, I don't even want to be with him."* Because polygamy is allowed among the Luo tribe, and by the Nomiya church with a prevalence rate of 59% among the members, most of the women were comfortable to reveal if they were in a polygamous union or not. IDI_012_NCM while sharing about her staying away from her husband during pregnancy would reveal confidently that *"Am relaxed because he has other women."* A key informant confirmed that *"Nomiya encourages someone to marry up to 4 wives, if you want to be polygamous."* KII_004_C_NCM

Polygamy was common, as there was high parity amongst some faithful's. The faithful's held onto the church practices firmly explaining that the church is the highest family unit, but poses a risk to maternal morbidity and mortality. Previous studies by Gwengi (2017) and (Murigi 2016) have sighted that communities today are challenged with rampant infectious diseases and polygamy provides a platform for spread of infection by a common agent, man, especially STI's and HIV, and HPV that has been associated with cervical cancer.

Community practices present as barriers to utilization of ANC, SBA, PNC and FP services in that mothers will put all their hopes to the local practices and remedies and ignore seeking conventional maternal health services. Healthcare workers ought to learn and get to know about these traditional procedures, medicinal products and community member's attitude towards the use of alternative care services. Healthcare workers also need to understand the probable causes of these community's behavior and the probable results practices. Healthcare workers need to be aware of the traditional medicines used by the local traditional healers and the conditions they treat, how they give their dosages, for how long and in what amounts.

CHAPTER SEVEN

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

7.1 SUMMARY OF FINDINGS

With close to 99% of maternal morbidities and mortalities occurring in developing countries, public health studies have been aimed at finding solutions to end preventable maternal deaths. This study aimed to explore on the religious factors affecting utilization of maternal health services by Nomiya church faithful's in Alego-Usonga Sub-county, Kenya. Religious factors is the least studied component among the other maternal morbidity and mortality framework factors as enquiry into religious components requires qualitative research approaches to dig deeper into the contextual and find meaning to the factors. This study involved 22 women in their reproductive ages, were interviewed in-depth to saturation, using a snow-balling sampling technique to reach the study participants.

The first objective sought to assess health seeking practices of women of Nomiya church. Women of Nomiya church sought maternal care from both the skilled health providers and from *'madha'*, the church ordained TBA who live with the women in the community. The women cited challenges in the formal health system such as waiting in long queues, many tests and trips made before delivery, fear of higher health facilities likely to take them for CS delivery, fear of new and offending procedures, being left alone to deliver without assistance by a midwife, the harsh healthcare providers, lack of being given proper information and lack of essential drugs when they visit the health facilities as major barriers. Much of the care during pregnancy and delivery was provided by '*madha'*. The women explained that the TBA's were easily accessible, affordable and their services more acceptable. The interpersonal level influence of senior family members such

as the mothers in-law and the women church leader plays a great role in supporting church systems of maternal care. Community health volunteers played an important role as the preferred link to the health system for maternal health services, but attended to women who delivered in their compounds. Caring for pregnancy and delivery in the community had been relegated to '*madha'* and mothers in-law and the other women at home. Women sought permission and asked for money from their husbands to visit the hospitals while a visit to the TBA did not.

The second objective reveals the religious beliefs affecting utilization of maternal health services such as belief in prayer and healing, ancestral and evil spirits to affect pregnancy. The women had local ways to tell the sex of the unborn child. There were foods allowed and some not allowed during pregnancy for the mother. The women were averse to some health interventions for example maternal tetanus toxoid vaccines and use of contraception due to social views and fears. Birth planning was not allowed, as women feared delivering at the hospital for fear of being ridiculed for delivering a dirty child. Young and adolescent mothers were encouraged to deliver at home. Teaching about and promoting utilization of contraceptives was not allowed, as adolescent girls were prohibited from using FP products.

The third objective sought to identify religious practices affecting utilization of maternal health services by women faithful of Nomiya church. The study realized that the church had prescriptions for mothers to observe during their pregnancy, and seeking services of church TBA for massage and prescription herbs. Deliveries at home under the care of the TBA allows woman burry the placenta at home. The women practiced seclusion, which dictated strict staying in the house caring for the child without associating with any outsider. At the end of seclusion period, the practice of *'kalo nyathi'* and harsh teachings against use of family planning at the end of seclusion.

7.2 CONCLUSIONS

This study has yielded deep insights on the Nomiya women's experiences on utilization of maternal health services as greatly influenced by their religious beliefs and practices. In conclusion, it can be inferred that conventional maternal health service environments are harsh for the mother and as such mothers were hesitant and delay the utilization of maternal health services. The mothers felt more inclined to utilize church based apostolic systems. These systems entail seeking the services of the church based TBA for reproductive health issues, contraception care issues, and massage during pregnancy, delivery and post-natal care.

The second objective reveals evidence of religious beliefs affecting utilization of maternal health services. Women sought church TBA for counseling, prayers and healing. Apostolic maternal care system prescribed foods to be taken by the women during pregnancy and after pregnancy. Maternal vaccination was believed to target women and sterilize the women. Using contraceptive products was believed to lead to sterilization, cancers and giving birth to an abnormal child. An emerging issue was that use of contraceptives was not allowed and users were perceived as non-conformists to the church regulations and adulterous. Birth planning was believed to lead to sinister births, as giving birth at the hospital was feared for fear of being ridiculed to have birthed a dirty child which was linked to engaging in sexual activities with the husband until late periods of pregnancy.

Lastly, there was evidence that religious practices indeed affect utilization of maternal health services. Women of Nomiya church adhered to the prescribed apostolic ways of life during pregnancy under the guidance and care of '*madha'*, prescribing herbs for use and massaging mothers during pregnancy. Mothers preferred delivering at home under the care of '*madha'* which allowed for effecting other traditional rites. Mothers observed seclusion practice requirement to be

accepted and recognized by the church community and have the child a rite of passage into adulthood and Christian family.

7.3 RECOMMENDATIONS

The study recommendations are as follows:

1) Despite there being interventions and programs focusing on improving maternal health indicators and outcomes. There is need for a reorientation in the delivery of maternal health service in a friendly and respectful manner, on the delivery of maternal health services.

2) There is need for sensitization of the women of Nomiya church on the maternal health services available at the health facilities.

3) There is need to work with church leaders to understand the contextual meaning, content and intentions of the practices and relating these with maternal health indicators. There is need to strengthen and align those practices that improve maternal health outcomes, but also work to eliminate retrogressive practices without criticizing and placing punitive measure to those still observing them.

Recommendation for further research

A mixed method study is recommended to provide a comprehensive insight on all religious beliefs and practices that influence uptake of maternal and child health services in Alego-Usonga sub-county. The quantitative part of the study will benefit from constructs derived from the findings of this study. It is possible that the beliefs of the Nomiya permeate within the general community informing the pervasive home deliveries and reliance on TBAs.

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APPENDICES

Appendix 1: Individual In-Depth Interview Consent Form and Guide

Interviewer Code: …….. Venue: …….

Introduction

Good morning / afternoon / evening. My name is _____ _____ _____. I/ (On behalf of our research team leader) am/ (we are) conducting a study on 'Nomiya' Church and health issues in Alego-Usonga Sub- County, Siaya County as regards maternal and child health. This study seeks to learn from the Nomiya church members how they make decisions about their health and what they do in dealing with illness with regards to their religious beliefs and practices and also explore communities' health practices.

Your participation is voluntary and you are free to participate in the study or leave any time you feel uncomfortable. No direct monetary compensation will be given for your participation in the study. The information you share with us will be handled confidentially. If you withdraw from the study it will not affect your relationship with the Ministry of Health or Maseno University. Other than an identity key, no other form of identification involving taking participants name will be used, and this will be kept in a secure location. Interview documents will be labeled by a number not name.

The information gathered from this study will assist our county and nation in developing and improving health policies and interventions as well as making them acceptable to members of the community. The information will also help in highlighting various health issues affecting the African Spiritual church members. Should you have any queries about this study feel free to call Maseno University Ethics and Review Offices on Tel No: 057 351 588.

Therefore, I sincerely request your cooperation in responding to the following questions, the interview will take approximately up to an hour of your time (up to 60 minutes). However, at any time during the course of the interview, you are free to terminate the interview. May we proceed with the interview?

Yes: Proceed _____ No: Terminate the Interview _____ Agree to be interviewed: _____

Tel: …….

Official Checks Date: Time: From _____ to _____

IN-DEPTH INTERVIEW (IDI) GUIDE

I wish to inform you kindly that I will record this interview Serial No: ……

Now I would like to ask you some additional questions/ am going to ask you some questions about maternal and child health issues. Please feel free to answer the questions with any examples or relevant quotes, references if you so wish.

Health Seeking Practices

Icebreaker.

1. Tell me more about yourself and your roles in your church? Probe age, marital status and type, Number of children
2. How long have you been a Nomiya church member? How long have you been staying here in Alego-Usonga?
3. Tell me more about the pregnancy you have heard, you are having now? Tell me more about where you go when expectant/ pregnant as prescribed by your church? Probe.. how are the services are offered, by who, when, how frequent, what services
4. Tell me more about where, when and what are services a pregnant mother go when feeling unwell? Probe…
5. Where did you deliver your children? Probe: why did you chose this place, mode of delivery… probe; why? Where else would you prefer for delivery?
6. Explain some of the danger signs in pregnancy?
7. Tell me about CS delivery? Would you go for CS delivery again? Tell me of the experiences you have heard from friends who have gone thru a CS delivery? What are your views on hospital services ... probe
8. What happens after delivery? Why does such occur after delivery? Are there things to worry about after delivery? How are they solved?
9. What is your opinion about TBA's who help mothers in their pregnancy and during delivery? Explore church based TBA's

Religious Issues

1. Belief systems and pregnancy and delivery
2. Tell me about the belief systems in your church about pregnancy? How do they affect pregnancy and delivery? How are they maintained in the church?
3. probe about preservation of pregnancy, foods, saving pregnancy, birth planning…
4. Tell me about the biblical facts that support church doctrines on pregnancy?
5. Belief systems and Family Planning and Post-partum issues.
6. Can you explain to me what happens after delivery (religious seclusion) Probe. Explain the reasons for seclusion days for girls and for boys
7. How are the traditions observed? Probe …in-case of single birth, twin or triplets births, child death, feeding of child and mother?
8. Explain to me what you understand by FP? Probe…tell me more about the different methods you know? What is your experience with the ones you have used? If not why? Are there any church doctrines involved…probe… who is allowed by religion to use FP - multi-parous women, unmarried, school going girls,.
9. Tell me about spousal blessing on FP use?
10. Tell me about vaccines/ immunization during pregnancy? …Probe
11. Tell me about norms to be observed when pregnant? Probe.. Foods, sex, determine sex of child, what is done to keep pregnancy

12. Religious Practices

13. Tell me about some of the practices in you church esp. regarding the mother? During pregnancy, delivery and after birth. Who takes care of an expectant mother? Probe…what is she allowed to do?
14. Can you tell me about 'seclusion' as a practice is observed within your church systems? probe…how long, what care involved
15. Tell me if wife inheritance is practiced within your church members? How is the community involved in caring for the mother during delivery?

Appendix 2: Key Informant Interview (KII) Consent Form & Guide

Interviewer Code: …….. Venue: ……

Introduction

Good morning / afternoon / evening. My name is _____ _____ _____. I/ (On behalf of our research team leader) am/ (we are) conducting a study on 'Nomiya' Church and health issues in Alego-Usonga Sub- County, Siaya County as regards maternal and child health. This study seeks to learn from the African Indigenous church members how they make decisions about their health and what they do in dealing with illness with regards to religious beliefs and practices and also explore communities' health practices.

Your participation is voluntary and you are free to participate in the study or leave any time you feel uncomfortable. No direct monetary compensation will be given for your participation in the study. The information you share with us will be handled confidentially. If you withdraw from the study it will not affect your relationship with the Ministry of Health or Maseno University. Other than an identity key, no other form of identification involving taking participants name will be used, and this will be kept in a secure location. Interview documents will be labeled by a number not name.

The information gathered from this study will assist our county and nation in developing and improving health policies and interventions as well as making them acceptable to members of the community. The information will also help in highlighting various health issues affecting the African Spiritual church members. Should you have any queries about this study feel free to call Maseno University Ethics and Review Offices on Tel No: 057 351 588.

Therefore, I sincerely request your cooperation in responding to the following questions, the interview will take approximately up to an hour of your time (up to 60 minutes). However, at any time during the course of the interview, you are free to terminate the interview. May we proceed with the interview.

Yes: Proceed ___ No: Terminate the Interview ___ Agree to be interviewed: _____

Signature: …… Official Checks Date: Time: From _____ to _____

Key Informant Interview (KII) Guide

10. Tell me more about seclusion as a practice as practiced by the Nomiya church faithfuls? Probe ..any changes from the original church beliefs and practices, who took care of a pregnant woman?
11. In your opinion are Maternal Health (MH) services offered freely by the HC around? Are there promoters that can make Nomiya church faithful mothers come for services? In your opinion how do the community utilize these services? Explore more…
12. Tell me about the lower religious structures of this community? Is this affecting utilization of MH services in any way? Are there any community saving services in the community? **(Nomiya based Bishop & Clinicians)**
13. In your opinion who in the family makes the decision regarding the place of delivery?
14. Tell me about how the mothers are fed pregnancy, birth, below 2 years? Probe … note religious maternal health systems requirements among 'Nomiya' faithful. Do these feeding habits promote MH?
15. Tell me about community traditions; beliefs that are binding that one must follow affecting MH?
16. Tell me about reports that HCW have encountered with the church members or church members with the HCW?

Appendix 3: Focused Group Discussion (FGD) Consent Form & Guide

Interviewer Code: …….. Venue: ……

Introduction

Good morning / afternoon / evening. My name is _____ _____ _____. I/ (On behalf of our research team leader) am/ (we are) conducting a study on 'Nomiya' Church and health issues in Alego-Usonga Sub- County, Siaya County as regards maternal and child health. This study seeks to learn from the African Indigenous church members how they make decisions about their health and what they do in dealing with illness with regards to religious beliefs and practices and also explore communities' health practices.

Your participation is voluntary and you are free to participate in the study or leave any time you feel uncomfortable. No direct monetary compensation will be given for your participation in the study. The information you share with us will be handled confidentially. If you withdraw from the study it will not affect your relationship with the Ministry of Health or Maseno University. Other than an identity key, no other form of identification involving taking participants name will be used, and this will be kept in a secure location. Interview documents will be labeled by a number not name.

The information gathered from this study will assist our county and nation in developing and improving health policies and interventions as well as making them acceptable to members of the community. The information will also help in highlighting various health issues affecting the African Spiritual church members. Should you have any queries about this study feel free to call Maseno University Ethics and Review Offices on Tel No: 057 351 588.

Therefore, I sincerely request your cooperation in responding to the following questions, the interview will take approximately up to an hour of your time (up to 60 minutes). However, at any time during the course of the interview, you are free to terminate the interview. May we proceed with the interview.

Yes: Proceed ____ No: Terminate the Interview _____ Agree to be interviewed: _____

Official Checks Date: Time: From _____ to _____

Focus Group Discussion (FGD) Guide

1. Tell me about the services you offer as a Community Health Volunteer (CHV) in your community? What can you tell me about MH services at the hospital …in your opinion are they free? Tell me more… how is it in the community?
2. Tell me more about seclusion practice? Probe ... any changes from the original church beliefs and practices, who took care of a pregnant woman?
3. Tell me about the church member's economic plans that may affect maternal health? Are these affecting utilization of MH services in any way?
4. In your opinion who in the family makes the decision regarding the place of delivery?
5. Tell me about how the mothers are fed during pregnancy? Probe … note religious aspects and cultural requirements
6. Tell me about cultures, traditions; beliefs that are binding that one must follow affecting MH service utilisation among the Nomiya?
7. Tell me about reports that mothers encountered with HCW on ANC, delivery, ANC, PNC.

Appendix 4: Global, Regional and Kenya's Maternal and Child Health Indicators and Set Targets and Ranking of Counties by Burden of Maternal Mortality

INDICATORS	Global	Sub-Sahara Africa	Kenya (2014)	Kenyan Targets	Siaya (2014)	Siaya Targets
MMR (Deaths per 100,000 live births	216	546	362 - KDHS & 510 -WHO	To reduce by 2/3	691	Reduce by $^{2}/_{3}$
SBA (%Age)	71	52	60	90 (WHO)	61	Increase above 90%
Contraceptive Prevalence Rate %age			58	70	51	Increase by 70%

RANKING OF COUNTIES BY BURDEN OF MATERNAL MORTALITY

County	Maternal deaths	MMR	Percent of deaths during		
			Pregnancy	Delivery	2 months after delivery
Migori	257	673	24	45	30
Siaya	246	691	22	28	50
Kisumu	249	597	18	33	48
Homa Bay	262	583	22	34	43
Kakamega	364	316	20	44	36
Vihiga	531	531			
Kenya	6,623	495	26	48	26

Source: (WHO 2015, WHO & UNICEF, KDHS 2014), Global Health Initiatives Kenya strategy (2011-2014), MICS 2011 and Siaya County Health at a Glance 2014. http://kenya.unfpa.org/news/counties-highest-burden-maternal-mortality#sthash.tt7GUS3y.dpuf

Appendix 5: Cesarean Section (CS)

Definition: It is a surgical procedure in which incisions are made through a woman's abdomen and uterus to deliver the fetus.

Indications

1. Fetal
2. Non reassuring fetal heart pattern
3. Malpresentations
4. Cord prolapse
5. Macrosomia, Congenital anomalies, Multiple pregnancy
6. Maternal-Fetal
7. Obstructed labour
8. Placental abruption
9. Placenta praevia (Complete)
10. Perimortem
11. Maternal-foetal disproportion
12. Maternal
13. More than 1 previous Caesarean delivery
14. Contracted/limited pelvic cavity
15. Obstructive tumours
16. Active genital herpes virus
17. Elective caesarean section
18. Abdominal cerclage
19. Reconstructive vaginal surgery, e.g., fistula repair
20. Medical conditions, e.g. Cardiac (relative), pulmonary, thrombocytopenia…

(Gynecology and obstetrics clinical protocols & treatment guidelines, September 2012, Ministry of Health, P.O Box 84, Kigali. www.moh.gov.rw)

Appendix 6: Research Permit from NACOSTI

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **933045**

Date of Issue: **20/September/2019**

RESEARCH LICENSE

This is to Certify that Mr.. Evans Dzenis of Maseno University, has been licensed to conduct research in Siaya on the topic: Socio-cultural factors affecting utilization of Maternal and Child health by Nomiya Church Faithfuls in Alego-Usonga Sub-county, Kenya. for the period ending : 20/September/2020.

License No: **NACOSTI/P/19/593**

933045

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

Appendix 7: Maseno University Research Review Ethical Clearance

MASENO UNIVERSITY ETHICS REVIEW COMMITTEE

Tel: +254 057 351 622 Ext: 3050
Fax: +254 057 351 221
Private Bag – 40105, Maseno, Kenya
Email: muerc-secretariate@maseno.ac.ke

FROM: Secretary - MUERC

DATE: 14th May, 2019

TO: Evans Omondi Dzenis
PG/MPH/PH/00098/2014
Department of Public Health
School of Public Health and Community Development
Maseno University
P. O. Box, Private Bag, Maseno, Kenya

REF: MSU/DRPI/MUERC/00634/18

RE: Socio-Cultural Factors Affecting Utilization of Maternal and Child Health Care among Nomiya Church Faithfuls in Alego-Usonga Sub-County, Kenya. Proposal Reference Number MSU/DRPI/MUERC/00634/18

This is to inform you that the Maseno University Ethics Review Committee (MUERC) determined that the ethics issues raised at the initial review were adequately addressed in the revised proposal. Consequently, the study is granted approval for implementation effective this 14th day of May, 2019 for a period of one (1) year. This is subject to getting approvals from NACOSTI and other relevant authorities.

Please note that authorization to conduct this study will automatically expire on 13th May, 2020. If you plan to continue with the study beyond this date, please submit an application for continuation approval to the MUERC Secretariat by 15th April, 2020.

Approval for continuation of the study will be subject to successful submission of an annual progress report that is to reach the MUERC Secretariat by 15th April, 2020.

Please note that any unanticipated problems resulting from the conduct of this study must be reported to MUERC. You are required to submit any proposed changes to this study to MUERC for review and approval prior to initiation. Please advice MUERC when the study is completed or discontinued.

Thank you.

Dr. Bernard Guyah
Ag. Secretary,
Maseno University Ethics Review Committee

Cc: Chairman,
Maseno University Ethics Review Committee.

MASENO UNIVERSITY IS ISO 9001:2008 CERTIFIED

Appendix 8: Global map showing the Maternal Mortality Rates and the regional distribution burden by continent. Africa bears the heaviest burden at epidemic levels.