

EXPERIENCE OF POSTPARTUM CARE

Experiences of Nurses and Midwives Regarding Postpartum Care in Rural Kenyan
Communities: A Qualitative Focused Ethnography Study

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List of Acronyms

AIDS: Acquired Immunodeficiency Syndrome

AMPATH: Academic Model for Prevention and Treatment of HIV/AIDS

ART: Antiretroviral Therapy

CCF: Congestive Cardiac Failure

CE: Critical Ethnography

CINAHL: Cumulative Index to Nursing and Allied Health Literature

CME: Continuous Medical Education

CNO: Chief Nursing Officer

CPD: Continuous Professional Development

CT: Critical Theory

EBP: Evidence Based Practice

FBO: Faith Based Organizations

FE: Focused Ethnography

FMS: Free Maternity Services

FP: Family Planning

HIV: Human Immunodeficiency Virus

ICM: International Confederation of Midwives

IE: Institutional Ethnography

IEN: Internationally Educated Nurses

IOM: Institute of Medicine

IREC: Institutional Research and Ethics Committee

KCSE: Kenya Certificate of Secondary Education

KDHS: Kenyan Demographic Health Statistics

KHSSIP: Kenya Health Sector Strategic and Investment Plan

KNA: Kenya Nurses Association

MCH: Maternal Child Health

MNCH: Maternal, Newborn, and Child Health

MNH: Maternal and Newborn Health

MOH: Ministry of Health (Kenya)

NCK: Nursing Council of Kenya

NGO: Non-governmental Organizations

PEFA: Pentecostal Evangelical Fellowship of Africa

PHO: Public Health Officer

PMTCT: Prevention of Mother to Child Transmission

POC: Products of Conception

PPC: Postpartum Care

REB: Research Ethics Board

SAPs: Structural Adjustment Programs

SBA: Skilled Birth Attendant

SDG: Sustainable Development Goal

TBA: Traditional Birth Attendants

UN IGME: United Nations Inter-Agency Group for Infant Mortality

WHO: World Health Organization

Definitions of Concepts

Best Practice/ Evidence Based Practice (EBP): EBP is “the integration of best research evidence with clinical expertise and patient values to facilitate clinical decision making” (DiCenso, Guyatt, & Ciliska, 2005, p. 4). It is the conscientious, definitive, and good judgemental use of current best evidence with clinical expertise and patient values in making decisions about the care of patients (Sackett, 2000). Evidence-based nursing practice aims to improve the quality of healthcare, which would lead to best patient outcomes and cost reduction (Newhouse, Dearholt, Poe, Pugh, & White, 2007; Reigle et al., 2008). Hence, nurses and midwives providing postpartum care use clinical practices, treatments, and interventions that result in the best possible outcomes for the mother and infant during the postpartum period. For example, the Kenya National Guidelines for Quality Obstetric and Perinatal Care is an evidence-based practice intervention that is adapted from the World Health Organization’s best practices for postpartum care.

Clinical Officer (CO): A non-physician clinician who is authorized to practice general and specialized medical duties. The Kenyan CO cadre has two subgroups: general COs (RCOs), and specialist COs (SCOs are COs who have undertaken further specialist training in a medical discipline). COs are mostly administrators at the rural health centers (Mbindyo, Blaauw, & Mike, 2013).

Culturally Competent Postpartum Care: Margaret Leininger’s work on transcultural nursing introduced the concept of cultural competence in the nursing discipline (Garneau & Pepin, 2015). Cultural competence is a complex concept that needs to be known and understood by all individuals because it affects several realms of the person, including cognitive, emotional, behavioural, and environmental aspects (Garneau & Pepin, 2015). In the context of this study,

nurses and midwives provide postpartum care to diverse groups of women from different ethnic backgrounds with different social norms related to childbearing processes. Nurses and midwives should therefore possess cultural knowledge that enables them to recognize and reconcile cultural differences between themselves and the women they are caring for in order to have a more patient-centered approach to care (Teal & Street, 2009). Healthcare professionals including nurses and midwives should be encouraged to acknowledge that everyone has a culture that is value-laden. Thus, they need to recognize their own values and beliefs in order to eliminate barriers such as ethnic, racial, and cultural discrimination (Etowa, 2014).

Infant Mortality: Infant mortality is the number of infant deaths per 1000 live births (UN IGME, 2015).

Maternal Mortality: Maternal mortality is the proportion of women who die while pregnant or within 42 days of termination of pregnancy, regardless of the duration of pregnancy. Death could be from any cause related to or aggravated by the pregnancy, management of pregnancy or childbirth, but not from accidental or incidental causes (WHO, 2014a).

Midwife: A midwife is a professional who has successfully completed a midwifery education program that is duly recognized in the country where it is located and is based on the International Confederation of Midwives' (ICM) *Essential Competencies for Basic Midwifery Practice* and *Global Standards for Midwifery Education*; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title "midwife"; and who demonstrates competency in the practice of midwifery (Thomson & Van, 2011). Most midwives in Kenya undergo the basic nursing program. Midwives provide support to nurses on complicated postpartum cases as needed.

Nurse: A nurse is a trained professional who has successfully completed basic nursing training and has passed national nursing board examinations. Within the context of this study, nurses include Kenya Enrolled Community Health Nurses, Kenya Registered Community Health Nurses, and registered nurses who hold a bachelor's degree. Nurses' roles in postpartum care in Kenyan rural health facilities are intertwined with those of the midwives.

Postpartum Care: Postpartum care is used synonymously with postnatal care. Postpartum care is care provided to a woman and her baby by a skilled healthcare professional immediately following childbirth, up to six weeks postnatal (WHO, 2014b). Kenya has adapted the WHO's guidelines for postpartum care visits as follows: the first assessment should occur within 24-48 hours of the delivery of the baby, regardless of where the delivery happened. The subsequent assessments are: 1-2 weeks, 4-6 weeks, and 4-6 months at a maternal child health (MCH) clinic. In the context of this study, postpartum care refers to the period immediately following the birth of the baby up to six weeks post-delivery.

Rurality: These are geographic areas located outside cities, and where the population has limited access to quality healthcare services and skilled healthcare providers (El-Jardali et al., 2013). Health service providers in rural Kenya have limited resources for specialized services and therefore do not provide specialized treatments such as organ transplants, open heart surgeries, or neurosurgeries, among others. The main hospitals in rural areas are County and Sub-County hospitals, which provide basic and comprehensive obstetric services to the rural population that include: following up of mother during pregnancy, normal and assisted vaginal delivery, administration of antibiotic and uterotonic drugs, caesarean births, safe blood transfusions, and postpartum care services (KNBS, 2015).

Skilled Birth Attendants (SBAs): A skilled birth attendant is an accredited health professional

who has been educated and trained to provide proficient midwifery services including postpartum care. SBAs in Kenya include registered and enrolled nurses, registered and enrolled midwives, clinical officers, and medical doctors.

Summary of Thesis

Maternal, neonatal and infant mortality is still high globally, but worse in low-resourced countries such as Kenya. Progress in reducing maternal mortality in Kenya is slow, with an estimated maternal mortality ratio of 400 deaths per 100,000 live births. Similarly, the infant mortality rate is tabulated at 39 deaths per 1000 live births. Given the high prevalence of maternal and newborn mortality and morbidity in low-income countries such as Kenya, it is vital to maximize nurses' and midwives' capacity to contribute to the reduction of this burden of disease during the perinatal period. As the main healthcare providers in rural Kenyan facilities, nurses and midwives are best positioned to provide effective maternal, newborn, and infant health (MNH) services. They provide both health promotion and disease prevention care throughout pregnancy, labor and delivery, and the early postpartum period. One way of achieving this is through effective postpartum care, a period of perinatal care that is plagued with high rates of pregnancy-related complications.

A significant amount of research has been conducted on improving MNH in developing and low- to middle-income countries. However, there is a paucity of literature examining the experiences of nurses and midwives providing postpartum care in these settings. As is evident in the existing literature, nurses' and midwives' experiences and perspectives have not been explored to the fullest. This study, therefore, was guided by critical theory and Foucault's concepts of knowledge and power. Using focused ethnography (FE) as the research methodology, the study had four specific objectives: 1) To describe how the sociopolitical and cultural contexts of healthcare influence the provision of postpartum care by nurses and midwives; 2) To identify the facilitators influencing nurses' and midwives' ability to competently provide postpartum care; 3) To identify the barriers to nurses' and midwives' ability to competently provide postpartum care; and 4) To explicate nurses' and midwives' current knowledge regarding best practices in postpartum care.

As consistent with FE methods, this study employed individual in-depth interviews and focus groups to obtain data. Thematic analysis based on Braun and Clarke (2006) was used to analyze data. Credibility, transferability, dependability, and confirmability were used to ensure the trustworthiness of the research process. The analysis of data generated six themes: 1) Provider-Client Relationships; 2) Fostering a Healthy Work Environment; 3) Barriers to Postpartum Care; 4) Transcending Adversity; 5) Social Support Systems; and 6) Policies and Infrastructure Influencing Postpartum Care. The study findings demonstrated that nurses and midwives providing postpartum care in rural Kenya are the backbone of the healthcare system and greatly influence the health outcomes of the people they serve. Facilitators and barriers to the nurses' and midwives' work while providing postpartum care in this complex environment were identified. In this study, I have shown how gender, class, and power relations may be influencing the perinatal care that the nurses and midwives provide to postpartum women. The study also shines a light on how maternal and infant health may be influenced by power, politics, and policies. Therefore, I propose that use of an intersectionality lens to examine the experiences of nurses and midwives providing perinatal healthcare in rural Kenya could illuminate power dynamics within the healthcare sector. This study recommends relevant education, healthcare policies, and practice guidelines that support building the capacity of nurses and midwives through an inclusive, structured process, creating a robust environment in leadership, education, research, and nursing/midwifery practice.

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CHAPTER 1: Introduction

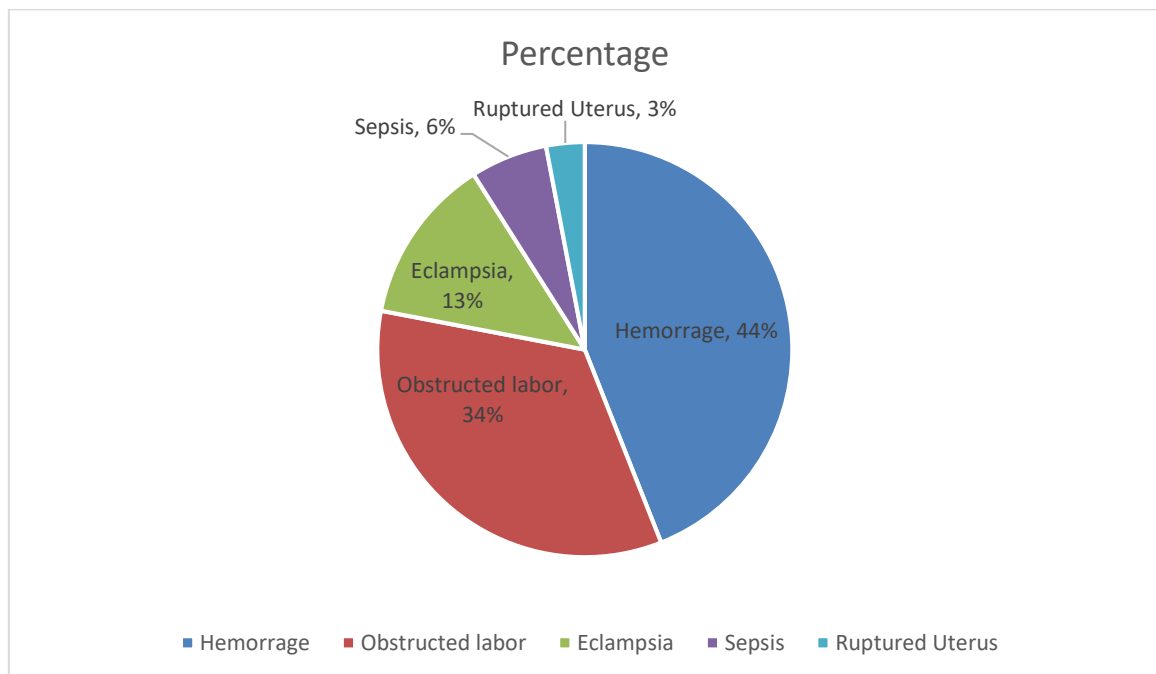
Maternal and infant death is still a major global concern. Each year, an estimated 289,000 maternal deaths occur worldwide (World Health Organization (WHO), 2014a). Approximately 99% of these deaths occur in low- and middle-income countries, with Sub-Saharan Africa accounting for 66% of them (WHO, 2014a). Correspondingly, progress in reducing maternal mortality in Kenya remains slow, with the most recent reports by the Kenyan National Bureau of Statistics and ICF Macro (KNBS), the Kenyan demographic and health survey (KDHS 2014), estimating an alarming maternal mortality ratio of 488 deaths per 100,000 live births (KNBS, 2015). Compared to developed countries, these rates are significantly higher. For example, Canada and the United States of America have 11 maternal deaths per 100,000 live births and 28 maternal deaths per 100,000 live births, respectively. A significant proportion of maternal deaths result from preventable causes such as postpartum bleeding, hypertensive disorders of pregnancy, and postpartum infections during the postpartum period (WHO, 2014a).

According to the United Nations Inter-Agency Group for Infant Mortality (UN IGME), the global neonatal mortality rate fell from 36 deaths per 1,000 live births in 1990 to 19 in 2015. However, almost 1 million neonatal deaths occur on the day of birth, while an estimated 2 million die in the first week of life (UN IGME, 2015). In Kenya, the infant mortality rate is tabulated at 39 deaths per 1000 live births (KNBS, 2015). The high rate of mortality is worrisome, given that most of the causes could be prevented by implementing best practices such as immunization, prevention of sepsis, and evidence-based education of the mothers during the postpartum period.

The postpartum period is an important component of the childbearing continuum, and almost 40% of women in Kenya experience complications during this period, with an estimated

15% of these complications being life threatening (KNBS, 2010). Mortality causes can be either direct or indirect. According to the Kenyan demographic health survey, the top five leading direct causes of maternal death in Kenya are: hemorrhage (44%), obstructed labor (34%), eclampsia (13%), sepsis (6%), and ruptured uterus (3%) (KNBS, 2015). Indirect causes of maternal death include illnesses that could be aggravated by pregnancy, such as HIV-AIDS, anemia, malaria, and cardiovascular diseases (WHO, 2014a). Hemorrhage, sepsis, ruptured uterus, complications from HIV-AIDS, and anemia are the direct and indirect causes of maternal death during the postpartum period.

Figure 1: Diagram Showing the Top Causes of Maternal Deaths in Kenya



Source: Kenyan Demographic Health Statistics, 2014 (KNBS, 2015)

The direct causes of death as depicted in Figure 1 above could be preventable with timely skilled interventions. Despite the disturbing rates from preventable causes, postpartum care is the least emphasized component of the infant-bearing cycle, and consequently, women and infants continue to face high risks of the physiological adverse effects of pregnancy that occur

during this period (Albers & Williams, 2002; Bashour et al., 2008). The limited attention given to postpartum care for women in Kenya is reflected in the women's use of postpartum services, which is 51% compared to 92% of women using antenatal care. The low rate of utilization of postpartum services poses a risk of poor health outcomes for both mothers and their newborns (Akunga, Kabue, & Menya, 2014; Beake, Rose, Bick, Weavers, & Wray, 2010).

The WHO (2014a) recommends that mothers and newborns receive four assessments from a skilled health provider during the postpartum period. It recommends that if birth occurred in a health facility, mothers and newborns should receive postnatal care in the facility immediately and for at least 24 hours after birth, and if the birth occurred outside of the health facility, mothers and newborns should receive postnatal care within 24 hours of the birth. Consecutive postpartum assessments should occur on the third day following the birth of the baby, between one to two weeks, and finally, at six weeks after birth (WHO, 2014a). This recommendation has been echoed by many countries, including Kenya. For example, the Ministry of Health (MOH) in Kenya has adapted these guidelines as follows: initial assessment within 24-48 hours, consecutive assessments in 1-2 weeks, 4-6 weeks, and 4-6 months after birth (MOH, 2014a). Since nurses and midwives are the main healthcare providers of postpartum services, the success of these postpartum guidelines in Kenya is dependent on these healthcare professionals implementing them (KNBS, 2015).

1.1 Statement of the Problem

In the "Three Delays" model, Thaddeaus and Maine (1994) identified barriers affecting access to skilled healthcare providers from the perspectives of childbearing women. These are: Group 1), delays in the decision to seek medical care; Group 2), delays in reaching care; and Group 3), delays in receiving adequate health care. All these delays have direct implications for

the quality of healthcare provided to childbearing women by nurses and midwives, especially for those working in rural communities. Group 3 delays point to the lack of provision of effective and efficient perinatal care by skilled healthcare providers.

Being the main healthcare providers in rural Kenyan facilities, nurses and midwives are best positioned to provide effective maternal and newborn health services (MNH). They provide preventive care during the perinatal period that leads to decreased numbers of complicated births and safer postpartum recovery. Skilled healthcare providers that include nurses and midwives aim to provide evidence-based intrapartum care that will ease childbirth and lower the rates of postpartum complications. Therefore, nurses and midwives have the responsibility of performing lifesaving observations and interventions during the postpartum period, which include monitoring both the mother's physiological recovery from the birth process and the newborn's health (Beake et al., 2010; Wakaba et al., 2014).

Although nurses and midwives are influential in the provision of postpartum care in low- and middle-income countries such as Kenya, several constraints prevent their involvement in the decision-making that affects health policy, as well as implementing the health policy (WHO, 2006; WHO, 2013). In the Gross et al. study (2001), nurses and midwives in rural areas of these countries are often faced with many challenges including a lack of necessary equipment to do the job, staff shortages, limited training of nurses and midwives, poor dissemination of maternal and infant health guidelines, and low wages.

The Kenya Health Sector Strategic and Investment Plan (KHSSIP) indicated that inappropriate staffing deployment to various regions of the country and poorly skilled staff providing maternal and infant health care, contribute to the slow improvement of MNH in Kenya (KHSSIP, 2013). Such contexts limit the quality of postpartum nursing care, which is to

provide competent and safe health services to women and their families and, ultimately, to prevent any complications after childbirth.

Importantly, nurses and midwives are the key educators of women on issues related to the health of mothers and their newborns, which include identifying signs and symptoms of postpartum complications such as sepsis and haemorrhage that could otherwise be fatal if not attended to in a timely manner (Beake et al., 2010; Gross et al., 2011; Klopper, 2013). They provide crucial information beneficial to both mothers and their newborns that includes breastfeeding support and development of confidence as a mother (Beake et al., 2010).

Regardless of their contribution in improving health outcomes for mothers and infants, nurses are not often identified as key stakeholders at the health policy table (WHO, 2010a). This can partly be attributed to the historical development of the nursing profession, where nurses were considered assistants to physicians (Meleis, 2012). Furthermore, their work in low- and middle-income countries like Kenya is further compounded by poor working conditions fueled by political, socioeconomic, and cultural forces shaping nursing care in this context (Fort, Kothari, & Abderrahim, 2006).

For nurses and midwives to execute their jobs and meet the goals of optimal maternal and infant health, they require supportive and enabling environments (WHO, 2013). Hence, for a better understanding of how nurses and midwives can contribute to better postpartum health outcomes of childbearing women and their newborns, it is important to understand the environment in which they work and the contextual factors that affect their work and them as individuals.

A significant amount of research has been conducted on improving MNH in developing and low- to middle-income countries (Bates, Chapotera, McKew, & Van Den Broek, 2008;

Kerber et al., 2007; Klopper, 2013; Thaddeus & Maine, 1994). However, there is a paucity of literature examining the experiences of nurses and midwives providing postpartum care in these settings. As is evident in the existing literature, nurses' and midwives' experiences and perspectives have not been explored to the fullest. This study therefore aimed to answer the following research question and objectives.

1.2 Research Question and Objectives

The research question for this study is as follows: *What are the experiences of nurses and midwives providing postpartum care in rural Kenya?*

This research question was used to illuminate how nurses and midwives provide maternal and newborn health services during the postpartum period, elucidating how the sociopolitical and cultural context of healthcare in rural Kenya influences the provision of evidence-based postpartum care by them. This study provided nurses and midwives with a voice to describe their experiences and their contribution to postpartum care in rural communities in Kenya.

Specific research objectives were:

1. To describe how the sociopolitical and cultural contexts of healthcare influence the provision of postpartum care by nurses and midwives.
2. To identify the facilitators influencing nurses' and midwives' ability to competently provide postpartum care.
3. To identify the barriers to nurses' and midwives' ability to competently provide postpartum care.
4. To explicate nurses' and midwives' current knowledge regarding best practices in postpartum care.

1.3 Situating the Researcher

My interest in maternal and infant health started while I was in my second year of nursing school when I heard a *scream*: a scream from my best friend calling for help, and a scream from a helpless woman by the roadside, trying to birth her baby. I have not forgotten the image of fear on this woman's face. She was emaciated and her uncertainty made her appear helpless.

Although I had just completed only my second year of nursing school, everyone with any health problems in the village looked up to me. My only experience with birthing babies had occurred during my clinical placement when I observed nurses and midwives assisting with births.

Regardless of my limited knowledge of midwifery, I knew that I had to try and assist this woman. There were no other better options, as I could see the baby's head crowning and the woman trying with great effort to push out the baby. Without further thought, my friend and I guided the woman to birth her baby, encouraging her to push with each contraction. Several minutes later, a baby boy was born.

This experience changed my perspective regarding childbirth and the role of the nurse and the midwife in this process. Childbirth is an important life event with long-lasting memories for women, and it should be a positive experience (Etowa, 2012), but this was not the case for this woman. Women in rural Kenya face many hurdles during the childbearing process. The woman that I assisted to give birth was just one of the few lucky ones as she managed to escape complications during and after delivery.

I am intrigued by some published literature about disrespect and abuse of childbearing women by nurses and midwives. As a student nurse in a rural health facility in Kenya, I watched nurses and midwives work exhaustively trying to assist the women through the birthing process. Due to a shortage of nursing staff at these facilities, nursing students were treated like qualified

staff and they were expected to have the same patient workload as the nurses working at the facility. My mentor was always in a rush to complete the day's tasks and little attention was paid to mothers who did not voice their concerns.

The essential supplies of gloves, syringes and needles, and medicine were limited. We did not have proper equipment like computers or even an internet connection to facilitate research, nor did we have the time to reflect on our practices at the end of the day. Nurses and midwives in these rural facilities seemed to be content with the status quo, having often worked for many years under challenging circumstances which had become part of their "normal" daily routines. The nurses and midwives did not have the courage to complain, for they feared being looked upon as a complainer by other nurses and midwives, or even losing their jobs.

My experiences working in rural Kenya and now as an internationally educated nurse in Canada have shaped my views on maternal and infant health. I believe that whether or not a person decides to act is strongly influenced by power relations in particular contexts. Nurses and midwives, who are the largest and most instrumental group of healthcare providers, should have the right tools and resources to analyze and provide culturally competent and evidence-based postpartum care services. Hence, I chose to use critical theory as a philosophical stand point and Foucault's concepts of knowledge and power in this study. These theories helped me to understand how the sociopolitical and cultural contexts of healthcare influence the provision of postpartum care by nurses and midwives, as well as the facilitators and barriers influencing their ability to competently provide that care in rural Kenya.

My belief is that reality has been shaped by many factors including social, political, cultural, and economic factors that are now being viewed as the norm. Therefore, knowledge as

truth is not discoverable, but is socially constructed, and reality is in the lived experiences of individuals.

1.4 Significance of the Study

In the 2016 WHO document entitled *Global Directions in Strengthening Nursing and Midwifery*, the Sustainable Development Goal (SDG) #3 is focused on reducing the global maternal mortality rate to less than 70 deaths per 100,000 births, with no country having a maternal mortality rate of more than twice the global average (WHO, 2016).

As the main healthcare providers of women's and infants' health services in Kenyan rural health facilities, nurses and midwives are valuable assets in ensuring the success of this SDG and in promoting positive maternal-infant health outcomes in these contexts. Thus, it is necessary for nurses and midwives to be involved in the decision-making process regarding health policies that affect postpartum care services in Kenya. This involvement is necessary for the nurses and midwives to advocate for the provision of people-centred perinatal healthcare in rural communities and to participate in the scaling up of national health systems to meet global goals and targets (WHO, 2013). However, nurses' and midwives' involvement in health policy processes in Kenya is limited despite them being the largest group of healthcare providers and bearing the largest burden for dealing with illness and disease (Juma, Edward, & Spitzer, 2014). Being shut out of policy dialogues disadvantages nurses and midwives since decisions affecting their work will be made by others without their input.

The continuum of perinatal care that includes antenatal care, skilled birth attendance, and postpartum care is necessary to enhance positive maternal, newborn, and infant health outcomes in rural communities. Conversely, limited access to skilled birth attendants and to postpartum care breaks this continuum, placing more women at risk of losing their lives because of

preventable causes (WHO, 2014b). Hence, to attain this continuum of health services and to reduce maternal and neonatal mortality through increased access to skilled healthcare, free maternity services were introduced in Kenya in 2013 (MOH, 2014a). Regardless of this milestone, there is still a need to address challenges to maternity services that include inadequate resources in terms of equipment and healthcare professionals in the rural areas (Wamalwa, 2015). These inadequacies contribute to a lack of access to quality maternal and neonatal health services including postnatal services in rural communities, leading potentially to maternal and infant mortalities.

Globally, only 24% of physicians and 38% of nurses work in rural areas, even though most of the population lives in these areas (Deller et al., 2015). This is regardless of the evidence that inadequate postpartum care services due to healthcare staff shortages in rural areas of low- and middle-income countries makes mothers and newborns vulnerable, further compounding complications that arise during birthing or in the postpartum period (WHO, 2014b).

Additionally, more than half of all postnatal maternal deaths occur during the first week after the baby is born, with the majority of deaths occurring among women living in rural areas and within the poorer communities (WHO, 2014a). Factors such as limited support for healthy home behaviors including breastfeeding can have on-going effects for infants in terms of malnutrition (WHO, 2007). Also, ineffective postpartum services contribute to frequent, poorly spaced pregnancies, which can contribute to mothers developing depression due to decreased emotional and psychological support (WHO, 2007).

Despite the reported critical shortages of nurses and other healthcare professionals, one WHO report (2006) indicates that there are nurses who are professionally qualified to practice but are unemployed because the national systems are unable to absorb them for lack of funds.

Although half of all nursing positions in Kenya are unfilled, a third of Kenyan nurses are unemployed (Dovlo, 2004; Volgvartz, 2005). Ghost workers [workers who are on pay-roll but do not exist] block access to healthcare worker positions. An estimated 5,000 ghost workers exist in Kenya (Dovlo, 2004). The few practicing nurses are then forced to take on different roles and responsibilities that could have been performed by other professionals, such as dispensing medications, which is primarily a pharmacist's job (Ugochukwu, Uys, Karani, Okoronkwo, & Diop, 2013).

Hence, the nurses' and midwives' knowledge and engagement with local communities while providing holistic family-centred and culturally appropriate postpartum care, is necessary in order to understand their experiences in providing postpartum care. Understanding their experiences informs future nursing and midwifery professional program development and the preparation of future nurse and midwife leaders and administrators, especially in rural communities. This in turn will enhance training and deployment of the healthcare workforce, fostering collaboration and a team approach, better use of communication technologies to disseminate best practices, and strategic planning and coordination of MNCH services (WHO, 2006).

1.5 Summary of the Chapter

In this chapter, I have explained the significance of nurses and midwives in maternal and infant health, especially during the postpartum period. This study aims to answer the research question, "What are the experiences of nurses and midwives providing postpartum care in rural Kenya?" Nurses and midwives were given an opportunity to express themselves and talk about their experiences. Research data were critically analyzed within the socio-cultural context of postpartum nursing care in Kenyan rural health facilities, exposing the facilitators and barriers

influencing nurses' and midwives' abilities to competently provide postpartum services. The study also exposed their current knowledge regarding best practices in postpartum care, which helped to understand their experiences and their current and potential contributions to maternal, newborn, and infant health outcomes in rural Kenyan communities.

In chapter two, I will present the literature review, in chapter three, I will discuss the theoretical perspectives guiding this study, in chapter four, I will present the research methodology used in this study, in chapter five, I will discuss the findings of the study, in chapter six, I will present the discussion, and finally, in chapter seven, I will discuss the implications of the study and present the conclusion.

CHAPTER 2: Literature Review

According to Creswell (2014), a literature review is important to research because it gives the researcher the opportunity to assess available knowledge and knowledge gaps, and it provides a benchmark to the study being undertaken by comparing the impacts on research from similar studies. Hence, the literature review builds a foundation for the study by identifying the important ideas that contribute to the advancement of knowledge in a study area and provides a reference point for the interpretation of findings (Merriam & Simpson, 2000).

2.1 Literature Search Strategy

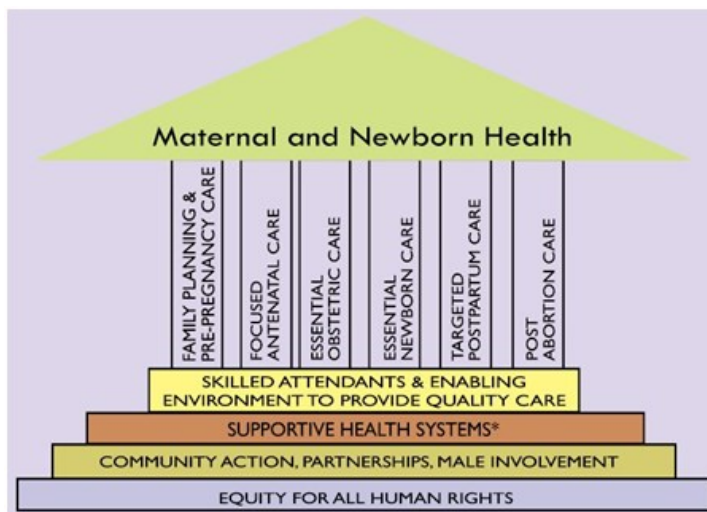
I conducted a literature search on the Cumulative Index to Nursing and Allied Health Literature (CINAHL), the Cochrane Library (OVID), and Pub Med (Medline). With the assistance of a librarian, keywords searched either individually or in combination included: “developing countries,” “evidence-based,” “low- to middle-income countries,” “maternal mortality,” “midwifery care,” “nursing care,” “postnatal,” “postpartum,” and “policy-making.” Abstracts were reviewed and articles that were relevant to answering the research question and objectives were included in the review. I also completed a manual search to identify individual studies on a reference list of relevant articles. None of the reviewed articles addressed the experiences of nurses and midwives providing postpartum care in rural Kenya. However, 15 publications were retained from this literature search.

I will present this under three sub-headings: 1) Maternal health services in Kenya; 2) Utilization of postpartum care; and 3) Nurses’ and midwives’ capacity in the provision of perinatal health services in Kenya. The chapter will conclude with a summary of the key messages from my appraisal and a synthesis of the literature.

2.2 Perinatal Health Services in Kenya

The Ministry of Health of Kenya (MOH) acknowledges that access to quality maternal and infant health services is a basic human right. Several maternal and infant health programs have been put in place with the aim of improving health outcomes for mothers and infants in Kenya. In 1987, the International Safe Motherhood Initiative was launched in Nairobi with the goal of reducing the maternal mortality ratio by 75% by the year 2000 (MOH, 2014a). Other programs implemented by the Kenyan government include: included the national Maternal and Newborn Health (MNH) Model in 2010 (See Figure 2), national guidelines for quality obstetrics and perinatal care in 2012, and the introduction of free access to maternal and infant health services in 2013.

Figure 2: The Kenya Maternal and Newborn Health Model



Source: Ministry of Public Health and Sanitation and Ministry of Medical Services (MOH, 2012)

The MNH aims to accelerate the reduction of maternal and newborn mortalities and morbidities to attain the Millennium Development Goals (MOH, 2012), which have now shifted to Sustainable Development Goals (SDG). The pillars of MNH are dependent on skilled attendants (including nurses and midwives) and an enabled environment to provide quality care.

All of these are dependent on a supportive health system that addresses health financing, health leadership, health products and technologies, health information, a health workforce, service delivery systems, and health infrastructure (MOH, 2012).

The six pillars of MNH in Kenya include: pre-conceptual care and family planning, focused antenatal care, essential obstetric care, essential newborn care, targeted postpartum care, and finally, post-abortion care. These services are strengthened through the foundation of skilled attendance and a supportive and functional health system, community action, and equity for all humans. The MNH model has employed key strategies such as improving availability of, access to, and utilization of, quality maternal and newborn healthcare. These strategies include utilizing healthcare workers such as nurses and midwives to expand access to good quality family planning (FP) options for women, men, and sexually active adolescents, as well as strengthening the referral system and advocating for increased commitment and resources for MNH and FP services (MOH, 2010). However, following the slow progress in the reduction of maternal and newborn morbidity and mortality in Kenya, the National Guidelines for Quality Obstetrics and Perinatal Care Reference Manual (Appendix 1) were developed by the Kenyan Ministry of Health in 2012 (MOH, 2014a). The development of this reference manual was in response to the need for emerging, updated evidence-based interventions that have proved successful when applied throughout the continuum of care of a woman's pre-conception, pregnancy, childbirth, and postpartum periods (MOH, 2014a). The manual describes in great detail obstetrical and medical conditions and the management of complications that can affect a woman during the childbearing process. The success of these guidelines is partly dependent on training and deployment of healthcare providers that include nurses and midwives. Using this manual, nurses

and midwives should be able to refer a woman early when necessary and conduct deliveries in her home if unable to transfer her to the local health facility.

Free maternity services were introduced in Kenya in 2013 with the goal of improving accessibility and utilization of quality maternal, newborn, and infant healthcare, as well as facilitating access to these services for disadvantaged communities. However, there is no evidence of nurses' or midwives' involvement in this monumental decision. Free maternity services were meant to remove financial barriers to these services (KNBS, 2015). Following their introduction in 2013, the number of women utilizing these services increased immediately (KNBS, 2015). However, a qualitative study on the healthcare providers' perspectives on this free service policy in Kenya showed that its introduction diluted the quality of care due to high patient volume amidst a shortage of staff (Lang 'At & Mwanri, 2015). Nurses and midwives were forced to deal with high patient volumes, uncompensated loss in fee revenue, shortages of essential drugs and supplies, and an increased workload due to few available staff (Lang 'At & Mwanri, 2015). Subsequently, this study also indicated that women's experiences of the resulting poor quality of maternity services have led to a decrease in their utilization of maternal health services and potentially, to further decreases in maternal, newborn, and general health outcomes in Kenya (Lang 'At & Mwanri, 2015).

Despite some progress in the reduction of maternal mortality, the overall target has not been achieved by Kenya and many other low- to middle-income countries. The struggle will continue, supported by the United Nation's SDGs, of which Goal Three is to ensure healthy lives and promote well-being to all regardless of age (United Nations, 2015). All of the 17 SDGs developed by the United Nations Assembly focus on eradicating poverty and ensuring human development, thus improving health and well-being (Hanson, Pupilampu, & Korbla, 2017).

Progress towards ending maternal mortality due to preventable causes is dependent on improving the quality of care during childbirth and in the immediate postpartum period, and this improvement requires addressing healthcare strategies, including strengthening the healthcare workforce (KNBS, 2015; KHSSIP, 2013). Nurses and midwives play a major role in maternal and infant health services in Kenya. At the organizational level, senior executive nurses and midwives can contribute to strategic directions through their participation in senior level decision-making, influencing how nursing is practiced and valued (Wong, Laschinger, Cummings, Vincent, & O'Connor, 2010). Therefore, it is necessary to have a structured system that supports nurses and midwives to perform to their full capacity.

2.3 Utilization of Postpartum Care

Essential obstetric care is important in ensuring that essential care for women experiencing high-risk pregnancies and complications is made available to all women who require these services (MOH, 2014a). Despite numerous campaigns for skilled perinatal care in Kenya, only 62% of births in Kenya are conducted by skilled providers, and only 61% of those are carried out in healthcare facilities (KNBS, 2015).

Postpartum care is generally composed of a physical and psychological examination of the mother and baby, immunization, the provision of health education, and discussions on family planning. As little as 51% of women in Kenya receive a postpartum check-up in the first two days of birth, with an even lower percentage (43%) being reported in rural areas (KNBS, 2015). In order to alleviate this shortfall in developing countries, postpartum packages were created to support the implementation of the recommended postpartum assessments by the WHO. Postpartum packages are a context-specific set of postpartum interventions designed to improve postpartum care in resource challenged countries (Warren, Mwangi, Oweya, Kamunya, &

Koskei, 2010). As one of the six pillars of maternal and newborn health in Kenya, targeted postpartum care focuses on supporting and maintaining maternal and newborn/infant wellbeing throughout the postnatal period (MOH, 2010). Targeted postpartum care is a goal-oriented program that entails four personalized visits or assessments after the birth to at least six months later (MOH, 2010). The timing of postpartum care services is based on evidence that there are crucial moments immediately following childbirth when both mother and infant should be assessed by a skilled attendant (Mazia et al. 2009; Warren et al., 2010). Hence, by using targeted postpartum care, nurses and midwives are instrumental in the holistic assessment of mothers and in uncovering some of the risk factors that could potentially compromise their health during the postpartum period.

In their study on improving postpartum care in Kenya, Warren and his colleagues indicated that although postpartum package have been in use in Kenya since 2007, there have been insignificant changes in maternal and newborn health outcomes (Warren et al., 2010). This could be due to a lack of a strong skill component for managing maternal and newborn complications through postpartum care package mechanisms. The study of Warren et al. also demonstrated a lack of consistently measured indicators of the effectiveness of postpartum care due to little systemic implementation of postnatal packages. The authors suggested that some of the mechanisms to ensure the success of such programs are to involve key actors who provide support with pre-service training institutions and professional bodies to ensure the institutionalization and standardization of targeted postpartum care.

Enhancements to postpartum care services through existing services could improve the delivery of postpartum care. Studies indicate that targeting the most vulnerable women (rural populations and people living in poverty) is essential for substantial progress in reducing

maternal mortality. For example, a study compared postnatal quality in facilities participating in a maternal health voucher program versus non-voucher facilities in Kenya (Warren et al., 2015). The study indicated that in those facilities that utilized vouchers, 80% more women and their newborns were seen within 48 hours of giving birth than those in non-voucher facilities. This study also concluded that patients were satisfied with the care and wait times in both facilities.

Kenya has employed this model, and focused antenatal care serves as a platform to strengthen a continuity of care that includes integrating existing services with the Prevention of Mother to Infant Transmission of HIV/AIDS (PMTCT). This is particularly important since a recent review indicated that Kenyan women from low-wealth categories have continued to underutilize postpartum services despite the introduction of a voucher program aimed at encouraging them to seek skilled care (Warren et al., 2015). This same review concluded that initiating the discussion of postpartum care with mothers during antenatal visits could help promote their use of postpartum services.

Maternal health policy changes could have diverse consequences for both mothers and staff. In Kenya, the integration of PMTCT into primary health centers has increased access to postpartum care services by HIV positive mothers and has enabled expanding practice capacity for nurses and midwives (KNBS, 2015). Simultaneously, the integration of services has increased the workload of nurses working at these facilities since the staffing ratio has remained unchanged (Turan et al., 2012). The integration has created task shifting among healthcare professionals in Kenya, since nurses and midwives are asked to undertake such procedures as blood testing for HIV, which was originally done only by doctors (KNBS, 2015). Task shifting is built on the assumption that less specialized health workers can take on some of the responsibilities of more specialized healthcare workers in a cost-effective manner without

compromising quality of care (Dawson, Buchan, Duffield, Homer, & Wijewardena, 2014; Deller et al., 2015). However, nurses and midwives are disadvantaged by task shifting because they end up taking on more work from the obstetricians while retaining their current roles; hence, there is an increased workload for the nurses and midwives. With task shifting, nurse-patient contact time has decreased due to the increased workload, posing a challenge to the provision of necessary services, for example, counseling patients before and after testing for HIV (Delva et al., 2012).

A needs assessment conducted in Kenya, Burkina Faso, Malawi, and Mozambique on improving postpartum care indicated that there are limited specific postpartum care policies, and there was little evidence that the policies currently existing had been implemented (Duysburgh et al., 2015). The study also pointed out that there were no clear instructions for the healthcare professionals on how to implement the postpartum care guidelines. Also noted was that while the pattern of postpartum mortality is clear, there has been less attention paid to using postpartum care guidelines as a strategy to improve maternal health and infant care (Duysburgh et al., 2015). Barriers to implementation of recommended perinatal policies could be affected by the attitudes and beliefs of staff. This includes, the staff's reception to new training and knowledge (Pettersen, et al., 2006).

Beside the underutilization of postpartum guidelines, physical access barriers to health facilities, including the lack of an adequate transportation infrastructure, contribute to delays for women in reaching health facilities (Abuya et al., 2015). Poor road conditions in areas of Kenya are one of the main causes of delay as most of the rural roads are inaccessible, especially during the rainy seasons. Also, healthcare facilities are often more than five kilometres from many local communities. This makes it difficult for women to travel promptly to the facilities, especially

with limited public transportation. The poor access to healthcare facilities deters women from choosing to receive skilled postpartum services, especially because the birth process is often perceived as “normal.”

Other factors, such as the attitude of healthcare professionals, influences women’s decisions to utilize postpartum care (Abuya et al., 2015; Gebrehiwot, San Sebastian, Edin, & Goicolea, 2014; Mwangome, Holding, Songola, & Bomu, 2012; Warren et al., 2013). In their study of childbirth in Kenya, Abuya et al. (2015) concluded that disrespect and abuse during the perinatal period adversely affects a woman’s decision to utilize postpartum care. They also noted that lack of knowledge, heavy workloads, and lack of enough staffing could also be contributing factors to disrespect and abuse by nurses and midwives. The study suggested that working with policy-makers to encourage training on respectful maternity care and strengthening the linkages between facility and community for accountability and governance, are important factors for understanding and breaking the current culture of disrespect and abuse by nurses and midwives in healthcare facilities (Abuya et al., 2015). Nurses and midwives must examine their own cultural beliefs and values in order to eliminate biases, prejudice, and stereotypes they may direct to their patients. Disrespect and abuse during childbirth dehumanizes women and decreases the chances of them utilizing postpartum care.

According to the 2008/2009 Kenya Demographic Health Survey report (KNBS, 2015), accessing postpartum care services is dependent on several factors. First, women who deliver in a healthcare facility are more likely to utilize postpartum services than women who deliver outside of it. Second, the level of maternal education plays a major role; women with a secondary level of education or higher are more likely to utilize postpartum services. Finally, women who have had at least four visits for antenatal care and who delivered at a health facility

with the assistance of a skilled healthcare provider are more likely to access postpartum services. Specifically, women who delivered without assistance from a skilled healthcare provider were 81% less likely to utilize postpartum services except for cases where observable complications required follow up (KNBS, 2015).

It is therefore necessary to have supportive perinatal programs in the healthcare system that enable women to utilize perinatal services in order to improve health outcomes during the childbearing process. Understanding the continuum of maternal and infant healthcare is very important for positive health outcomes of mothers and their newborns (Warren et al., 2010). Nurses and midwives in rural Kenya play an important role in this continuum of care by identifying potential complications during pregnancy, such as anemia and malaria that could further complicate outcomes during the perinatal period (Warren et al., 2010). A successful program resulting in a better uptake of services by mothers would allow nurses and midwives to effectively manage complications that may arise during the postpartum period.

2.4 Nurses' and Midwives' Capacity in Provision of Perinatal Health Services in Kenya

Progress towards ending maternal mortality due to preventable causes is dependent on improving the quality of care during childbirth and in the immediate postpartum period, with an emphasis on addressing healthcare strategies, including strengthening the healthcare workforce (KNBS, 2015; KHSSIP, 2013). In reviewing the capacity of nurses and midwives to provide maternal health services, three factors influencing their work were identified: nursing and midwifery education and registration, the Kenyan healthcare system, and finally, the significance of nurses and midwives in the provision of maternal health services.

2.4.1 Nursing and midwifery education in Kenya.

Nursing education in Kenya was introduced by the British Colonialists. Healthcare

assistants (enrolled nurses) were trained to assist professional nurses, who were primarily from the United Kingdom (Ndirangu, 1982). The training of registered nurses in Kenya began in 1952 at the King George Hospital in Nairobi (now known as Kenyatta National Hospital), while community health nurse training commenced in 1966 at the Nyanza hospital, Kisumu (Ndirangu, 1985).

The Nursing Council of Kenya (NCK) is the national regulatory body for nurses' training and practice in Kenya. The NCK has approved three levels of basic training for nurses (cadres): 1) Certificate (Kenya Enrolled Community Health Nurse); 2) Diploma (Kenya Registered Community Health Nurse, Kenya Registered Nurse, and Registered Midwife); and 3) Degree, (Bachelor of Science in Nursing). The entry level for nurse education in Kenya was certificate and diploma until the late 1980s when the degree program was initiated at the University of Eastern Africa, Baraton. Each level has prescribed minimum entry grades obtained in the Kenya Certificate of Secondary Education (KCSE). A decision was made to terminate training of the certificate level nurses and to expand the diploma level in 2000 (Rakuom, 2010). Some institutions offer upgrade courses, where, for example, an outstanding diploma holder can enroll in the degree program, or a certificate holder can enroll in the diploma program.

All community health nurses are generalists and undergo basic training that combines nursing, midwifery, and community health nursing. This means that nurses' and midwives' roles are inter-changeable at the basic level, depending on their competencies and experiences. Post-basic training is normally a one-year course with a specialization in a particular nursing field, for example, critical care, midwifery, neonatal care, and most recently, palliative care. Basic nursing training as well as the post-basic training provide nurses with the opportunity to practice in all levels of healthcare facilities in Kenya. Each level of training entails classroom teaching, skills

laboratories, and laboratory practical, as well as clinical placements. The Masters and Doctorate degrees in nursing are offered in few universities in Kenya, and they are recognized as special qualifications (Rakuom, 2010).

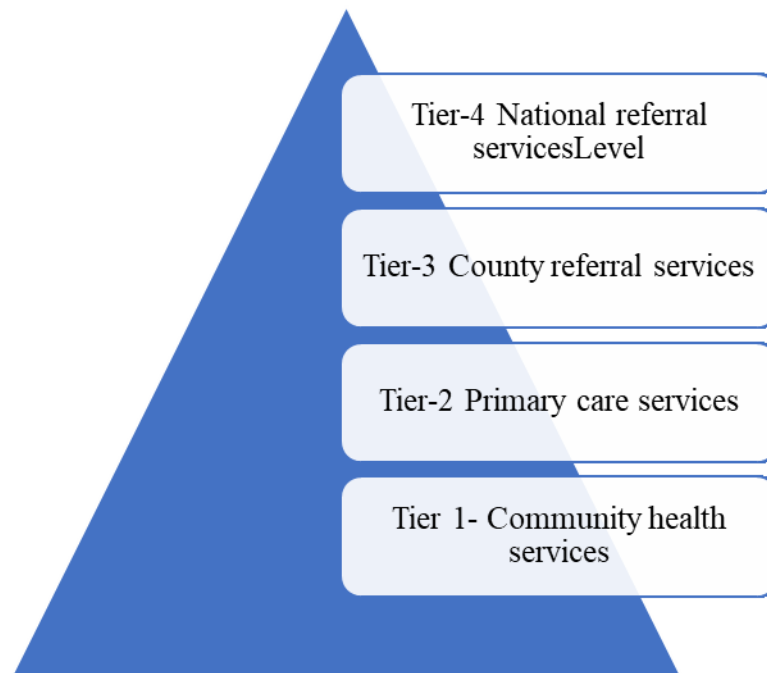
All nurses and midwives are required to register with the NCK and thereafter renew their practice licenses every three years. To renew their licenses, nurses and midwives are required to provide their personal information and proof of completion of required continuous professional development (CPD). Nurses and midwives in Kenya are required to complete 20 hours of CPD per year in order to retain their licensure (NCK, 2012). This learning is self-funded and does not require nurses to receive education specific to their area of specialty. However, employers are required to provide nurses 40 hours per year to support their participation in these professional development activities. CPD can be earned through attending health conferences, publishing research, or completing appropriate courses from an accredited training school. The NCK also approves and accredits all nursing training institutions and determines what nurses can or cannot do based on their competencies, skills, and experiences.

2.4.2 The Kenyan healthcare system.

The Kenyan health sector is divided primarily into three systems: The Public Sector, the Private Sector, and Non-governmental Organizations (NGO) or Faith Based Organizations (FBO). The public sector has the most healthcare facilities, followed by the private sector. According to the *State of the Health Referral System in Kenya* report (MOH, 2013), the current Kenyan healthcare system is organized into a four-level tier system of care that is also a referrals system based on the complexity of care required: tier 1, Community health services; tier 2, Primary care services; tier 3, County referral services; and tier 4, National referral services (See Figure 3).

Tier-1 is run by community health workers, who are volunteers supervised by the community health extension workers employed by the Ministry of Health. Tier-2 facilities are run by nurses and clinical officers and they provide basic inpatient services, including antenatal care, delivery services, and postpartum care. Tier-3 facilities include County referral hospitals, and they provide both outpatient and inpatient services as well as training centers for nurses and clinical officers. Tier-4 facilities provide highly specialized care and also act as training and support for healthcare research. The Chief Nursing Officer (CNO) is the head of all nursing services in Kenya (Rakuom, 2010). The office of the CNO is responsible for nursing policy directions and the environment of practice in Kenya.

Figure 3: The Four Levels of the Kenyan Health System Delivery (MOH, 2013)



Following the Kenyan devolution of the eight regions in 2010, 47 counties were restructured. This introduced a two-tier governance system in 2013 with health service delivery being transferred to counties, while the national government retained the function of leadership

in policy development, management of national referral facilities, and capacity development. This devolution has had a significant socio-economic impact on nurses and midwives. For example, counties are responsible for the salaries of healthcare workers, including nurses and midwives, who were grandfathered from the national government. Because the human resource files for these workers remain with the national government, it is difficult to manage workers and attend to their issues related to training needs, promotions, and retirement (Williamson & Mulaki, 2015). Under such an arrangement, frequent delays in salary payments have been reported, and healthcare workers have gone on strike because of a lack of available and supportive avenues to dialogue with the County leaders (Williamson & Mulaki, 2015).

2.5 Perinatal health services and the status of nursing and midwifery in low middle-income countries

Given that the highest mortality and morbidity for mothers and infants occur during the postpartum period, many studies to identify the barriers and facilitators of perinatal services have been conducted in LMIC. Health facilities in LMIC face acute shortages of human and material resources. As the main healthcare providers in LMIC, nurses and midwives are well-positioned to present evidence-based information to all patients while respecting women's natural physiological processes of pregnancy, childbirth, and afterward (WHO, 2016). This means that nurses and midwives must possess good customer service skills and public relations to provide culturally appropriate perinatal care and instill confidence in using skilled healthcare services. First, I will present the perinatal health services in low middle-income countries, followed by the status of nursing and midwifery in these contexts.

2.5.1 Perinatal health in low middle-income countries

Utilization of skilled perinatal services is still a challenge in low middle-income countries (LMIC). The low use of utilization has been linked to socioeconomic status such as the education of the woman and spouse, history of previous complications from pregnancy, financial status, limited access to the healthcare facilities, among others (Maxwell, Mikolajczyk, Dhafer, & Kramer, 2008). In Malawi, a study on causes of maternal mortality using the Three Delays conceptual framework indicated that the decision to seek skilled health services during the perinatal period is influenced by sociocultural practices such as dependence on male partners for finances or information required to care for the mothers. This prevented mothers from receiving timely and appropriate postpartum care (Thorsen & Sundby, 2012). Similarly, engaging men in perinatal services has been associated with improved skilled health service utilization, such as antenatal care, skilled birth attendance, and postpartum care (Rahman et al., 2018). As well, this engagement increased women's autonomy as it promoted a joint-decision making between the women and their husbands.

In their study on barriers to the utilization of formal emergency obstetrical care services in two Nairobi slums, Essendi, Mills, and Fotso (2011) concluded that ineffective decision-making at the home level as well as poor transportation systems discourage women from utilizing skilled postpartum care services. Of importance, they also noted that poor logistical planning within the healthcare system that leads to cumbersome procedures and long wait times at health care facilities also deter women from utilizing formal postpartum care services, and instead they turn to traditional birth attendants (TBAs). The study recommended enhanced education for the community, including TBAs, on the complications related to pregnancy, with timely referral to health facilities.

Women living in rural areas are less likely to access skilled perinatal health services compared to women living in urban areas. This could be due to geographical locations of the health facilities, making the transportation to these facilities difficult, poor organization of postpartum services, and poor quality of care that the women receive at the health facilities (Duysburgh et al., 2015). This indicates the need for health policies and process that improve accessibility and quality of care within healthcare facilities to promote the use of perinatal services.

Maternal and infant mortality is still very high in low-income countries. Therefore, strengthening the utilization, accessibility, and quality of postpartum care could improve the health outcomes of the mothers and infants and reduce maternal and infant mortality.

2.5.2 Status of nurses and midwives in low middle-income countries

Nurses and midwives in low middle-income countries such as Kenya are influential in the promotion of positive health outcomes, the prevention of diseases, the early identification and treatment of communicable and non-communicable diseases, the management of chronic diseases, and the innovative healthcare practices in their practice contexts (WHO, 2016). Therefore, nurses and midwives play a unique role in collaborating with other healthcare workers to improve health outcomes for individuals and entire communities by providing competent, culturally sensitive, evidence-based nursing and midwifery services (Asuquo et al., 2013; WHO, 2010a).

The Institute of Medicine (IOM) report (2010) on reforming nursing acknowledged that nurses and midwives are yet to realize their full potential of becoming equal partners along with other health professionals (e.g. physicians) in the redesign and policy decisions of the healthcare system. The report recommended that: 1) nurses should practice to the full extent of their

education and training; 2) nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression; 3) nurses should be full partners, with physicians and other healthcare professionals, in redesigning healthcare in the United States; and 4) effective workforce planning and policy making require better data collection and information infrastructure. These recommendations should also apply to nurses and midwives in LMIC countries because they are the core to healthcare outcomes for the patients in these contexts.

Achievement of the goals above will allow nurses to lead and conduct research that will improve practice environments and healthcare systems (IOM, 2010, p. 29). Such practical evidence is important for nursing as a profession because it enables nurses and midwives to recognize that power is relational and having knowledge on how to protect the health of the population, they serve is important in order to overcome any inequities and barriers throughout their practice.

Professional and personal barriers have been identified to negatively affect the nurses and midwives in LMIC, negatively affecting the health outcomes during perinatal period. These includes limited education, training, licensure and regulation of professionals, social inequality and inequity, family issues, financial issues such as inadequate remuneration, and unsafe working conditions (Filby, McConville, & Portela, 2016). The leadership capacity of nurses and midwives could be hampered if they do not receive adequate education to support them in these roles.

The WHO Nursing and Midwifery report of 2008-2012 (WHO, 2013) elaborates that nurses and midwives must have an evidence-based education that will support them in meeting changing healthcare needs while working individually or with other healthcare team members

throughout the continuum of care. The report continues by stating that the work of nurses and midwives needs to be analytically evaluated for its efficiency and effectiveness, and nurses themselves need to be involved in decision making for health policy throughout their educational program (WHO, 2013). However, lack of opportunities to learn through practice, unsupportive environment, and limited interactions of healthcare providers with the women during perinatal services were identified as barriers to quality perinatal services in most low-resourced countries such as in Mexico (DeMaria, Campero, Vidler, & Walker, 2012), and Mozambique (Pettersson, Johansson, Pelembe, Dgedge, & Christensson, 2006). This could diminish the nurses' and midwives' knowledge, promoting their subjugation by other dominant professions such as medical doctors, as well as contributes to poor perinatal care outcomes.

Strengthening the capacity of nurses and midwives in LMIC through education that strengthens their position in healthcare system could bridge the gap in healthcare workforce between developed and developing countries (Njie-Carr, Adeyeye, Marong, Sarr, 2016). Similarly, nurses and midwives require adequate basic training to the profession as well as continuous professional development. This knowledge is necessary for them to transform the healthcare system to meet the demand for safe, quality, and affordable care for the patients. For example, Warren et al (2015) suggest that health programs could succeed by closing the gap between policy and care provision. This involves critical use of evidence-based training for healthcare professionals that promotes updated training, followed by a period of supervision.

Pre-service and continuous professional development is crucial in ensuring quality perinatal services, as well as promotion of use of these services. A study in Vietnam conducted by Graner, Mogren, Duong, Krantz, and Klingberg (2010) indicated that a well-trained staff will manage perinatal complications adequately. Hence the need for continuous skills update of the

healthcare professionals, which is supported by policies that enable the culture of funding for staff education. Further, few nurses in LMIC have academic degree (Njie-Carr, et al., 2016). These low numbers could be attributed to the lack of country policies that support the training of nurses, low motivation of staff to advance their careers, and unfavorable work environments, leading to staff dissatisfaction.

There is also a need to strengthen involvement of nurses and midwives in research in LMIC. Building research capacity increases the competence of healthcare staff that is critically needed to support sustainable global health and research initiatives that build new programs and strengthen those already existing (Cooke, 2005). Promoting an “all inclusive” culture of conducting health research provides a voice for marginalized populations such as women and nurses and midwives (Anderson, 2000). Therefore, enabled nurses and midwives could lead and participate in their own research.

Positive patient perception of nursing care enhances a hospital’s image and increases the marketability of its maternity programs, thus attracting more women to utilize postpartum care (Cottrell & Grubbs, 1994). Patient satisfaction with nursing care (determined by technical-professional attitudes, trusting relationships including communication fostering good patient-nurse interaction, and educational factors) is generally one of the indicators for quality patient care in healthcare facilities (Cottrell & Grubbs, 1994). Nurses and midwives and other healthcare providers promote patient rights by eliminating negative actions such as superior attitudes towards patients and ignoring patient concerns. Such negative behaviors by healthcare providers have been attributed to many reasons. For example, in their descriptive study on factors influencing job satisfaction of nurses in Kenya, Ojwang and his colleagues elucidated that there is a relationship between physical exhaustion and the attitudes and interaction patterns in nurses’

responses to their work (Ojwang, Ogutu, and Matu, 2010). The study concluded that when nurses were strained with too much work, their attitude changed, and was manifested with negative verbal and non-verbal acts. These actions in turn created dissatisfaction among the patients. However, the authors clarified that not all nurses demonstrated this kind of behavior as some were observed to express humaneness and to maintain client-centered services regardless of the strain at work.

Similarly, studies from developed countries such as Canada have also shown a strong correlation between provider attitude and satisfaction of nursing care. For example, a study addressing adolescent mothers' satisfaction of postpartum nursing care indicated that their satisfaction was influenced by how nurses related to them (Peterson, Sword, Charles, & Dicenso, 2007). This study also suggested that women's positive experiences with nursing care are dependent on the nurses' job satisfaction. It concluded that women perceived nursing care to be satisfactory when nurses shared information about themselves, had a calm approach, and demonstrated confidence in mothers; however, when care was too serious and limited to job requirements, it was perceived as unsatisfactory. These are important factors to be considered by nurses and midwives who provide postpartum care services.

Shortages of healthcare professionals is a global problem, while nurses and midwives make up over 80 percent of these professionals (WHO, 2016). Shortages of healthcare staff in rural health care facilities negatively influence provision of perinatal services (Graner et al., 2010). The shortage could be due to poor recruitment processes, unavailability of staff willing to work in rural areas, poor working conditions in rural areas, as well as low salaries (Graner et al., 2010). The shortage causes increased workloads, which could jeopardize the care the mothers and infant receive during perinatal period. In another study, shortages of staff undermined the

quality of care, decreased patient centered care, and increases delays in initiating emergency measures, leading to poor patient outcomes (Bradley et al., 2015). Experiences of burnouts and dissatisfaction, that could lead to increased errors, mortality, and morbidity of the patients, have been reported by nurses working in developed countries (Aiken et al., 2013). Therefore, implementation of policies and processes that will support the nurses and midwives and promote a favorable work environment could enable nurses and midwives to positively influence health and health outcomes for the clients they serve.

2.6 Summary of the Chapter

There is a vital need for more context-specific studies on the prevention of maternal mortality, as the role of nurses and midwives in postpartum care has not been clearly established within many rural health facilities in Kenya and in many other developing countries. The strengthening of the nursing and midwifery workforce should focus on creating policies that promote nurse training, retention, and sustainable recruitment processes. Nurses and midwives should possess appropriate knowledge and skills that will enable them to execute both their everyday work and such emergency clinical situations as postpartum hemorrhages in Kenyan rural primary health facilities. Enabling them is vital in ensuring successful implementation of postpartum services in the rural health facilities of Kenya.

There is a gap in the continuum of care for mothers and babies due to decreased access to postpartum services, leading to their under-utilization by mothers. The lack of health system resources is a contributing factor to this decreased access. Nurses and midwives would benefit from additional training in clinical skills for managing maternal and newborn complications during the critical period following childbirth. Policies on implementation and management of postpartum care in Kenya are still largely unclear, hence affecting nurses' and midwives' work

in rural Kenya. Lack of reliable training that was exacerbated by the roll-out of postpartum guidelines created inconsistencies in measuring effectiveness of postpartum care.

In order to enhance maternal and infant health outcomes and to reduce maternal mortality, nurses and midwives must be empowered and kept up-to-date on the prevention and prompt management of postpartum complications. This could be attained by examining the experiences of nurses and midwives providing postpartum care in rural Kenya.

CHAPTER 3: Theoretical Perspectives

Knowledge generation in social science is guided by philosophical assumptions (paradigms) that are established with shared beliefs about the nature of reality and how knowledge is constructed (Guba & Lincoln, 1994; Weaver & Olson, 2006). The philosophical assumptions, according to Guba and Lincoln (1994), are beliefs about *ontology* (the nature of reality), *epistemology* (what counts as knowledge), and *methodology* (the process of research). These beliefs shape how the researcher views the world and acts on complex problems and social issues (Denzin & Lincoln, 2005). Philosophical assumptions are embedded within interpretive frameworks used in qualitative research, thus they inform the researcher's choice of important issues that need to be examined, as well as guide the research process that includes formation of the research problem, development of research questions, and provision of a framework for data analysis (Creswell, 2013).

According to Crotty (1998), these philosophical assumptions inform each other and hence the researcher must describe these assumptions as specifically as possible when identifying and justifying the research process. *Theoretical perspective* is the philosophical stance that lies behind the *methodology*, therefore, the researcher must state clearly what these assumptions are and how they are reflected in the methodology (Crotty, 1998).

For this study, critical theory and Foucault's concepts of knowledge and power are the theoretical perspectives that guided the methodology. Nurses' and midwives' work in rural Kenya are influenced by several complex contextual factors such as availability of essential resources to do their work, staffing ratios, and sociopolitical influences, among many others. Hence, using critical theory and Foucault's concepts of knowledge and power in examining nurses' and midwives' experiences in rural Kenya provided a strong understanding on how these

contextual factors affect their work. Moreover, because nurses and midwives are charged with providing equitable nursing care and allocating resources (WHO, 2006), their work is therefore a product of societal values and influences. Hence, it is important to critically examine their work.

This chapter will address the philosophical perspectives guiding this study, that is, *critical theory and Foucault's concepts of knowledge and power*. Critical theory as a philosophical perspective will be discussed, then Foucault's concepts of knowledge and power, and finally, the relationship between critical theory and Foucault's knowledge and power will be discussed within the context of postpartum care in rural healthcare facilities in Kenya.

3.1 Critical Theory (CT)

Critical Theory (CT) evolved to address effects of domination and oppression beyond economic and class struggles (Kim & Holter, 1995). CT originated from the theoretical tradition of the Frankfurt School in Germany in the 1920s (Stevens, 1989). The three leading thinkers of the Frankfurt School were Max Horkheimer (1895-1973), Theodor Adorno (1903-1969), and Herbert Marcuse (1898-1979) (Morrow & Brown, 1994). According to Morrow and Brown (1994), early CT

Proposed that an alternative conception of social science was required, one that could grasp the nature of society as a historical totality, rather than as an aggregate of mechanical determinants or abstract functions. Further, it was argued that such analysis could not take the form of an indifferent, value-free contemplation of social reality, but should be engaged consciously with the process of its transformation. (p.14)

Hence, CT examines the complex modes of social domination and the possibilities for social change within these contexts (Morrow, 1994). CT assumes that the reality of individuals, groups, and society is affected by socio-economic, political, and cultural factors surrounding them and that there is a possibility of liberating them from the oppressive powers that are embedded in societal structures (Stevens, 1989). According to Guba and Lincoln (1994), the

ontological stance of CT thinkers is that a comprehensive reality has been shaped by socio-economic, political, and cultural factors that are now being considered as real, with the reality constructed by those in power at points in history.

The epistemological stance of CT, according to Guba and Lincoln (1994), is that knowledge is “transactional and subjective, hence the researcher and participants are assumed to be interactively linked and their values jointly influencing the inquiry” (p.110). Knowledge as truth in CT is not discoverable, but is socially constructed, and reality is in the lived experiences of persons whose interpretations of their experiences are grounded in language (Weaver & Olson, 2006). Because perceptions are immensely influenced by past experiences, CT research generates knowledge that examines the influence of the distribution of power resources with the attempt to explain how things could be and not just how they are (Kendall, 1992; Maguire, 1987).

With CT, reality could be changed through knowledge construction (Creswell, 2013; Morrow & Brown, 1994). Therefore, CT allowed an examination in this study of socio-cultural and political factors in order to identify barriers that oppress nurses and midwives in rural areas of Kenya. According to Freire (1970), initiatives aimed to alleviate identified barriers can be advocated for and implemented in order to eliminate constraints. An analysis of the study findings through a CT lens allowed this researcher to come up with discussion topics that could encourage nurses and midwives to perceive social, political, and economic inconsistencies in the general healthcare system that affect the delivery of postpartum care in rural Kenya. Unearthing these inconsistencies could set the stage for a conscious collective action to change oppressive constraints to the provision of postpartum care in Kenya.

Since CT is built in a relationship between social analysis and critique (Maggs-Rapport,

2001), it allowed the researcher to detect and analyze how nurses and midwives recognized and acted on key adverse determinants of health such as poverty, unemployment, and inadequate nutrition. For nurses and midwives to give humanistic care, they must become aware of the environments that they work in order to participate in measures that focus on improving patient quality care. Therefore, CT highlighted the nurses' and midwives' capacity to address issues related to power inequalities as identified in the literature review (Chapter 2): shortages of nurses and midwives, limited professional development opportunities, and minimal involvement in policy development. Everyday power dynamics were uncovered, providing nurses and midwives with a voice in relation to their work providing postpartum care in rural Kenya. CT enabled the researcher to analyze how power imbalances within socio-economic, political, and cultural sectors affected these nurses and midwives as individuals, professionals, and as part of a greater healthcare system.

The concept of power has been defined in many ways by many theorists. For example, in his theory of power and domination, Weber (1978) views power as the chance that one or more individuals within a social relationship can assert their will despite the opposition of others. To Weber, power can be manipulated; it can be used to benefit particular groups, but it can also be imposed on the masses (Weber, 1978). According to Weber, a gain in power for one party must come at the expense of another (Albrow, 1990). Striving for power is determined by the heightened social honour or reputation that it brings although not all kinds of power bring such honour (Waters et al., 2010). Others see power as one's ability to obtain his or her needs, activate resources, and achieve one's goals in order to succeed and act (Kanter, 1977). Kanter (1977) states that organizations do not prohibit or provide power, but that it is generated by each individual through his or her own personal actions.

Michel Foucault, a French historian and philosopher, conceptualizes power as not being an entity but something present everywhere (Foucault, 1980). Given the contexts of nurses' and midwives' work in Kenyan rural health facilities, Foucault's concepts of power/knowledge provided an enhanced analysis of power. A detailed account of these concepts will be provided below.

3.2 Foucault's Concepts of Power and Knowledge

Foucault understood power relations in terms of struggle and resistance and how human beings are made subjects of the modern world (McHoul & Grace, 1993). Power relations are therefore rooted in the system of social networks; hence, power can be understood in terms of the systems through which it is implemented (McHoul & Grace, 1993). The history of these systems is distinct and defines the authority within which power relations function (McHoul & Grace, 1993). For Foucault, power is not an entity; instead, power is everywhere and is exercised only over free subjects who are faced with a field of possibilities (Foucault, 1980). Foucault's conception of power is that "it reaches into the very grain of individuals, touches their bodies, and inserts itself into their actions and attitudes, their discourses, learning processes, and everyday lives" (Foucault, 1980, p. 39). His belief is that what we are today is not necessarily what we ought to be by virtue of any historical or political influences (McHoul & Grace, 1993).

Foucault stresses the productive nature of the current exercise of power: "We must cease once and for all to describe the effects of power in negative terms: it 'excludes,' it 'represses,' it 'censors'... it 'conceals.' In fact, power produces; it produces reality; it produces domains of objects and rituals of truth" (McHoul & Grace, 1993, p. 64). Therefore, to Foucault, power can be productive, and he explains that there could be ways to exercise power that generate minimal or no conflict and frustration (Holmes & Gestaldo, 2002).

Foucault also understands that power is not produced by individuals, but rather power produces facts, with individuals being vessels of knowledge production (Foucault, 1980). Therefore, no individual entity controls power. In this case, power is not viewed as dominance from one side; instead, it is relational in the sense that while individual subjects are placed in relations of production and of signification, they are equally placed in complex power relations (Foucault, 1980). Foucault discusses how the mechanisms of power and governance work in particular spaces (Satka & Skehill, 2012). Spaces emerge as a result of long-term practices and as the fields in which those practices operate (Dreyfus & Rabinow, 1982). As Foucault elaborates, subjects emerge in these spaces, and they battle in these spaces alone causing endless circles of domination (Foucault, 1980).

As an example, in my study, relations of power could be visible between the nurses and midwives and the women seeking postpartum care services. The nurses and midwives possess knowledge, in their own space, regarding best practices in postpartum care, and at the same time, the women in their own space possess cultural knowledge about postpartum care. Hence, nurses and midwives provide interventions and education that they believe will promote positive health outcomes for the women and their newborns while, at the same time, they need to consider the cultural factors that influence the uptake of their services by the women. In this case, both parties have choices and opportunities to collaborate with each other. The process of participation in decision making allows nurses and midwives to be robust and enables them to meet the changes in healthcare needs while working both individually and with other healthcare professionals along the continuum of health and illness (WHO, 2013). As well, the implementation of evidence-based nursing practices enables the generation of knowledge among the nurses and midwives as well as their clients.

Foucault insists that “one needs to investigate historically, and beginning from the lowest level of society, how mechanisms of power have been able to function” (McHoul & Grace, 1993 p. 9). He examines how the mechanisms of power have been invested in and utilized leading to those types of social domination that we can readily identify with (McHoul & Grace, 1993). For example, nurses’ and midwives’ limited visibility in political arenas has led to a lack of involvement in the development of healthcare policy, which could be attributed to their lack of power and their domination by other disciplines in the healthcare system. Thus, the nursing profession has had only a limited ability to have a significant impact on the health and wellbeing of the public.

In this vein, Foucault recommends the investigation of subsidiaries that have their own functional procedures independent of central institutions in order to illuminate the particular formations of power relations that they depend on (McHoul & Grace (1993). As such, the exercise of power transcends the influence and direction of central control while its effectiveness is as significant as the central controls (McHoul & Grace, 1993). Foucault stressed that

We are forced to produce the truth of power that our society demands, of which it has need, in order to function: We *must* speak the truth ... Power never ceases its interrogation, its inquisition, its registration of truth: it institutionalises, professionalises and rewards its pursuit. (Foucault, 1980, p. 93).

3.2.1 Knowledge development.

Although the phrase “knowledge is power” is casually used by many, there is a complex relationship between power and knowledge. These concepts are closely interwoven so that powerful individuals and groups can use their knowledge to manipulate others to accept things in their favor (Foucault, 1994). In discussing knowledge production, Foucault (1980) states that for some statements to be deemed true or factual, other equally credible statements must be deemed

false or denied. According to Foucault, knowledge is a conjunction of power relations and it is not possible to exercise power without knowledge (Mills, 2003). Therefore, in order to understand the question of development of knowledge, it is important to understand the two distinct modes of analysis that Foucault utilizes: archeological investigation and genealogical analysis (McHoul & Grace, 1993).

3.2.1.1 Archeological investigation. Archeological investigation speaks to the unconscious formulations which regulate the emergence of discourse in the human sciences such as perceptions in medicine. It constitutes a way of doing historical analysis of systems of thought or discourse (Smart, 2002). According to Foucault (1972), archeological investigation describes the history of ideas that continually determine relations. It describes conflicts between old and new ideas, the resistance to acquired ideas, and the repression of what has not yet been said. In other words, it is the construction of discourse as a strategy. It seeks to describe the archive. Hence, in his writings on the archeology of knowledge, Foucault maintains that discourse must be treated as practices (Foucault, 1980). This is because discourses assist in the creation of various practices and they at the same time play an essential role in the continuation and reinforcement of patterns and practices (Yuginovich, 2000).

Foucault explains the archive as a general system of the formation and transformation of statements that exist at a particular period in a particular society. Archeology describes discourses as practices as specified in the element of the archive (Foucault, 1980). Archives, however, according to Foucault, are not meant to reveal hidden meanings or truth, but to document its conditions of existence and the practical field in which it is deployed (Smart, 2002). Therefore, archeological investigations are meant to unearth the subjugated knowledge of those groups who have been historically and politically silenced (O'Neil, 1986). For this study,

Foucault's concepts allowed the researcher to examine and explore what was said by the nurses and midwives during data collection, hence making visible a neglected domain of objects and statements (Kendall & Wickham, 2004; Smart, 2002).

3.2.1.2 Genealogical analysis. Genealogical analysis reveals the emergence of the human sciences, including the conditions of existence and relations with particular technologies of power embodied in social practices (Smart, 2002). According to Foucault, the relationship between archeology and genealogy is at the core in terms of constructing the present (Foucault, 1980). For example, genealogy could reveal relations and interactions between the political, social, cultural, and institutional discourses that have emerged from the nursing and midwifery disciplines as well as from those of other healthcare professions, such as medicine and the education of clinical officers. According to Dreyfus and Rabinow (1982), Foucault introduced genealogy as a "method of diagnosing and grasping the significance of social practices from within them" (p.103). Within this analysis, theory is one of the essential components through which organizing practices operate (Dreyfus & Rabinow, 1982). For example, as nurses and midwives provide postpartum care services in rural healthcare facilities, the need to adapt and improvise procedures to provide the best possible care has allowed for the emergence of a common culture on how a practice is best provided. However, the fact that these practices work in these particular healthcare facilities does not guarantee that they will work in other healthcare facilities if a direct transfer is made. Using a genealogical analysis, the factors affecting nurses and midwives in rural Kenya were examined, leading to an understanding of their spaces and the knowledge they have acquired related to postpartum care services.

Foucault conceptualizes discourse as whatever constrains or enables the production of knowledge within a specific historical time period (McHoul & Grace, 1993). Therefore,

discourses can either be treated separately (within an historical period), or as part of their contribution to the current overall view of the world (McHoul & Grace, 1993). In the case of my study, much of the literature indicates that nurses' and midwives' everyday reality is generally affected by political, socio-economic, and cultural factors (Abuya et al., 2015; Moyer et al., 2014; Wamalwa, 2015). An analysis of the various perspectives of just how such factors affect the work of nurses and midwives was relevant in order to remedy them. Since nursing is a practice science, it has social and moral scientific mandates to promote nurses and midwives to seek and to foster healing, health, and wellbeing (Bishop & Scudder, 1997). As such, theoretical understanding of discourses in nursing science will help promote knowledge creation, which in turn will enable the greater social good and promote positive health outcomes for the population served.

Mills (2003) indicates that discourse should be perceived as a structure that illuminates the way we perceive reality. Similarly, Foucault (1977) argues that any element in a discipline is defined and identified by "the place it occupies in a series, and by the gap that separates it from the others" (p. 145). This suggests that disciplinary organizations create complex spaces, with hierarchical divisions that are meant to bring order within the discipline. According to the World Health Organization (WHO), 70% of healthcare providers are nurses and midwives and 70% of these are female (WHO, 2006). Therefore, Foucault's concepts of power/knowledge helped this researcher to understand how gender influenced the work of nurses and midwives in rural Kenya. For example, nurses and midwives, despite their large numbers, have been perceived by many as an oppressed group within the healthcare system (Farrel, 2001; Kuokkunen et al., 2014; Trossman, 2003).

Therefore, Foucault's concepts of power and knowledge enabled the researcher to unearth the different levels of organizational power influencing nurses and midwives in rural Kenya. As Manojlovic (2007) stated, in order to provide effective and efficient postpartum care in rural areas, nurses and midwives must understand the dynamics of power at work in their environments in order to take control of the content and context of their practice. Knowledge is an exercise of power while power is a function of knowledge (Foucault, 1980). Therefore, Foucault's stance on knowledge production is that knowledge is not a pure search after "truth," and that there is a great influence of power in the processing of information that will be labelled as "fact" through a thorough process of ratification by those who are in authority (Mills, 2003). In this case, knowledge is therefore conceptualized as multiple truths (Foucault, 1980). Foucault conceptualizes that knowledge resides not only in what is known at a particular point of time, but also in what is known about the processes that lead to certain facts being privileged above others (Mills, 2003). In other words, for Foucault, history is contingent and is used to expose the taken for granted (Kendall & Wickham, 2004).

Foucault notes that the production of knowledge often leaves out the marginalized, creating a power imbalance that maintains them in marginalized positions (Mills, 2003). For instance, in an effort to strengthen nursing and midwifery services across the globe, the WHO (2013) as an authority for health and wellbeing, provided guidelines and recommendations that would help countries in dealing with factors such as staffing ratios, salaries, poor working conditions, shortages of healthcare workers in remote and rural areas even in high income countries, poor communication strategies, as well as a lack of high quality educational programs. These recommendations were reached by considering evidence-based practices that had been proven to work in other countries. Each country was expected to apply the WHO

recommendations based on the capacity of their health systems, so that, it was believed, best possible practices were being implemented. For these recommendations to be successful, however, nurses and midwives should have participated in this decision making since they are the ones on the front lines working with mothers and their newborns in the provision of postpartum care services.

As Foucault notes, knowledge production, and its reproduction and practice, could be advantageous to the marginalized if information is produced by the marginalized themselves (Mills, 2003). Nurses and midwives participating in regular professional development opportunities may well increase both their knowledge base and confidence in their practice, and as well would be able to disseminate information and provide feedback to their clients and other healthcare professionals. Developing evidence-based practices based on their own knowledge would allow the nurses and midwives to improve health outcomes for individuals and their families by providing culturally competent nursing and midwifery services, including postpartum care (WHO, 2013).

3.3 Relationship between Critical Theory and Foucault's Concepts of Power/ Knowledge

Critical theory (CT) and Foucault's concepts of power/knowledge have allowed for a better understanding and analysis of how nurses and midwives have experienced postpartum nursing care in rural Kenyan communities. Current nursing and midwifery care including postpartum care in Kenyan rural areas is typically carried out in "value-laden" political contexts. Such contexts challenge nurses' and midwives' understanding of their caring mission (Aasgaard, Borg, & Bengt, 2012). Hence, it is important to systematically examine, through a critical theoretical lens, the social, cultural, economic, and political factors that influence the experiences of the nurses and midwives in rural Kenyan facilities. Given the minimal involvement of nurses

and midwives in the development of policies that affect their work, it is clear that there are unequal relationships of power in healthcare, and these hierarchical power relations are both historical and current. Therefore, in the case of my study, both CT and Foucault's conceptualization of knowledge and power serve as a magnifying glass for me to closely examine the power dynamics in perinatal healthcare in Kenya, including some of the facilitators and barriers affecting nurses' and midwives' work.

I would argue that nurses and midwives do have some power by virtue of their professional knowledge and position within the healthcare system (Oudshoorn, 2005). By imparting their knowledge to mothers and decision makers in rural Kenyan health facilities, nurses and midwives have the potential to promote positive health outcomes for mothers and their newborns during the postpartum period.

Nursing knowledge and skills are important for the success of programs and the attainment of organizational goals (King, 1981). Nursing as a discipline produces knowledge and therefore nurses and midwives need to continually examine the process of knowledge production and how discourses are disseminated and implemented in their nursing practice. Discourses about cultural competence encompass the use of evidence-based practices and provide the capacity to identify, understand, and respect the values and beliefs of others (Chippis et al., 2008). For instance, nurses and midwives in Kenyan rural health facilities are tasked with promoting the health and well-being of the postpartum mother and baby, and to do so, need to be cognizant of their interactions with their clients to avoid any form of marginalization.

The nurses and midwives are knowledgeable about the social determinants of health as well as the processes that bring patients to the healthcare system (Etowa, 2014). Evidence-based practices guide their work and they are able to effectively collaborate with physicians, other

healthcare professionals, and amongst themselves. A greater understanding of the organizational influences affecting their work would allow nurses and midwives to more efficiently incorporate several strategies, such as practice guideline protocols and teamwork and training that would positively influence the management of postpartum care in rural Kenya, and hence improve overall health outcomes for women.

The use of CT and Foucault's concepts of knowledge and power help to explain how nurses and midwives in rural Kenya confront oppression and repression arising from societal relationships by engaging in collaborative relationships with other healthcare professionals, elected political officials, and their clients – making their voices heard. A greater theoretical understanding can also aid in involving nursing leadership in decision making on matters related to the work of the nurses and midwives. Critical theory exposes the domination of discourses and practices that have reduced the chances of the nurses and midwives to make their voices heard.

The use of CT uncovered those hidden social, political, cultural, economic, ethnic, and gender structures that constrain and exploit nurses and midwives providing postpartum care in rural Kenya, while Foucault's conceptualization of knowledge and power enabled the researcher to embrace the idea of power during data analysis as a positive force. This allowed the researcher to intellectualize how nurses and midwives could engage in collaborative relationships with elected officials and other stakeholders, making their voices heard. The use of CT and Foucault's perspectives on knowledge and power in this research enhanced production of new knowledge that facilitated better understanding of the contextual factors affecting the nurses' and midwives' day-to-day work.

3.4 Summary of the Chapter

The nurses and midwives are faced with factors that both enable and constrain their

efforts to be involved in the management of postpartum care in rural Kenya. In order to provide optimal care to their clients they must take control of their clinical practice by speaking about important issues such as empowerment, inequality, and alienation. Power in CT is viewed as a basic component of human existence that is seen in every activity of the human tradition, rendering all humans as either empowered or under-empowered. Since power is conceived as being everywhere, nurses and midwives perceive the potential resistance and change instituted by power in every area of their work.

The constraints that nurses and midwives face in their workplace could be individual, social, political, economic, or cultural exercises of power. The tenets of CT and Foucault's concepts of knowledge and power can promote the understanding of how socio-cultural, economic, and political factors reflect certain realities of the nurses' and midwives' work. They can also help understand the power imbalances created from these variables, along with gender, that interact with the professional status of nurses and midwives in Kenya. These theories have provided a solid guide for implementing this research, and for analyzing and interpreting the stories of these nurses and midwives.

CHAPTER 4: Research Methodology

This study uses a qualitative research design informed by the traditions of Focused Ethnography (FE), and the guiding tenets of critical theory and Foucault's concepts of knowledge and power, as presented in the previous chapter. Qualitative inquiry employs distinct methodological traditions such as FE to explore a social human problem like the experiences of nurses and midwives in rural healthcare facilities in Kenya. This inquiry is primarily conducted in a natural setting, with data analysis being both inductive and deductive, and the final written report includes the voices of the participants, the reflections of the researcher, and the interpretation of the problem (Creswell, 2013; Mayan, 2009). Congruency between theoretical perspectives, which encompass the personal philosophy (worldview) of the researcher, and research strategies or approaches (methodology), is necessary for any research study (Creswell, 2013). Qualitative research is used: 1) when a problem needs to be explored; 2) when there is a need for a complex detailed understanding of a problem; 3) when the researcher wants to empower the participants to share their stories; 4) when the context of the problem needs to be understood; and 5) when it is necessary to develop theories when partial or inadequate theories exist (Creswell, 2013).

In this chapter, I will present a brief description of ethnography, followed by a discussion of focused ethnography, including the rationale for choosing focused ethnography as a study methodology. I will also undertake a comparative analysis of focused ethnography and other forms of ethnographies. The chapter will also show how focused ethnography aligns with critical theory and Foucault's concepts of knowledge and power to inform this research. The study setting, research participants, ethical considerations, sampling, data collection, and data analysis methods will be presented. The chapter will conclude with a discussion of the strategies

that were employed to establish the trustworthiness of the research findings.

4.1 Ethnography

Ethnography is one of the oldest qualitative research methods that originated from 19th century anthropology (Mayan, 2009). Ethnography is widely used by researchers to understand descriptions and patterns of behaviour of individuals and groups of people within a culture (Roper & Shapira, 2000). I did not consider phenomenology for this study because ethnography focuses on the collective experiences of a community whereas phenomenology focuses on the individual experiences and meaning of a phenomenon. Phenomenology is based on the idea that there may be multiple ways of experiencing and interpreting a given phenomenon while ethnographers are more interested in uncovering knowledge about the culture of a group (Patton, 2002). In this study, I needed to analyze the culture of the nurses and midwives working in rural Kenya in order to determine their experiences. Cultural understanding can be acquired from a variety of data (Chambers, 1987). Culture is essential to ethnographic studies, and understanding culture requires a holistic perspective that includes understanding the beliefs, knowledge, and activities of the group being studied (Chesnay, 2015). Ethnography provides an in-depth and holistic inductive research approach that considers the perspectives of the participants rather than those of the researcher (Morse, 2012). Thus, ethnographic research is holistic, contextual, and reflexive (Boyle, 1994, in Morse & Field, 1995).

Roper and Shapira (2000) observed that ethnographic research mirrors the nursing process. New fields of study with new kinds of questions for undertaking ethnographic studies in nursing have emerged, and with these, the traditional ethnographic method has been adapted to include critical ethnography, institutional ethnography, and focused ethnography (Mayan, 2009; Wall, 2015). These types of ethnography are presented below to illuminate the choice of

focused ethnography.

Critical Ethnography (CE) is an ethnographic method that engages in cultural critique by examining broader political, social, and economic issues that focus on oppression, conflict, struggle, power, and praxis (Thomas, 1993). It is a type of reflection that examines culture, knowledge, and action, leading to emancipation of the individuals or groups researched (Richard & Morse, 2013; Thomas, 1993). In CE, culture is viewed as a complex entity that is heterogeneous, conflictual, negotiated, and evolving (Thomas, 1993). According to Germain (2001), critical ethnography is distinguished from other ethnographies because of its focus on issues of social oppression and inequity. LeCompte and Preissle (1993) explain further that critical ethnography explores the experiences of the oppressed and uncovers underlying social practices of everyday life, contributing to the emancipation of oppressed individuals or groups. My study of postpartum care (PPC) in rural Kenya focused distinctly on the experiences of nurses and midwives themselves.

Institutional Ethnography (IE) was developed by Canadian sociologist and feminist Dorothy Smith, who believed that the social world and everyday activities in it are controlled and coordinated textually and discursively by the institution or ruling relations of society (Smith 2005). The central belief of IE is that knowledge is socially organized and what is known is dependent on one's location in the specific subject position in institutional practices (Smith, 2005). These institutions refer to a complex of ruling relations that include multiple activities of individuals, administration, management, professional authorities, and of intellectual and cultural discourse (Smith, 2005). The researcher in IE examines the role of knowledge and power in people's everyday lives and how it shapes what they do (Mayan, 2009). The work of nurses and midwives in rural Kenya is affected by several factors beyond the institutions that they work in.

Therefore, this form of ethnography would not allow me to provide a full comprehensive picture of the experiences of these nurses and midwives.

4.2 Focused Ethnography (FE)

Focused ethnography (FE) is “a more targeted form of ethnography and is led by a specific research question, conducted within a particular context or organization among a small group of people to inform decision-making regarding a distinct problem” (Mayan, 2009, p. 39). While traditional ethnography seeks to explore and acquire knowledge from the entire society, FE seeks to acquire knowledge by focusing on small elements of a person’s society (Muecke, 1994; Roper & Shapira, 2000). FE not only explores aspects of meanings as with traditional ethnography, but it also generates knowledge that is specific to the context and that can be used to address specific problems such as health and clinical problems (Higginbottom, Pillay, & Boadu, 2013). Since there were no studies focusing on the experiences of nurses and midwives providing postpartum care in Kenyan rural health facilities, FE was the preferred methodology as it centres on a specific topic among a distinct group of persons or community (Roper & Shapira, 2000). FE allowed an intimate examination of how individual, political, socio-economic, and cultural factors influence nurses’ and midwives’ current and potential contributions to maternal newborn and infant health. FE, as a qualitative inquiry, uses multiple methods to gather data such as semi-structured in-depth interviews, participant observation, and focus group discussions (Mayan, 2009).

FE can be useful for nurse researchers in rural health facilities of low- to middle-income countries such as Kenya to understand and address socio-cultural factors affecting postpartum nursing care in such rural settings. FE can facilitate knowledge production by nurses and midwives on how to prevent maternal and infant mortality and promote good maternal infant

health outcomes in rural areas of Kenya. As such, knowledge obtained from FE research can be used to inform health policies related to maternal and infant health in order to improve health outcomes of the mother and infant.

The characteristics of FE as described by Muecke (1994) and illustrated by Higginbottom et al. (2013, p. 3) are:

1. Focus is on a discrete community or organization or social phenomena
2. A limited number of participants is involved
3. Research is problem-focused and context-specific
4. Participants usually hold specific knowledge
5. Uses episodic participant observation
6. Used in academia as well as for development in healthcare services

According to Roper and Shapira (2000), FE can be used to inform nursing research in several ways: for example, to understand the health practices of diverse cultures and how these practices are integrated into their lives; to study practices of nursing and midwifery as a cultural phenomenon; to understand how specific community settings as sites of supportive activities are assigned meanings by members of a cultural or sub-cultural group; and to answer questions important to nurses and midwives, exploring issues and phenomena familiar with or experienced by them.

4.3 Justification of Focused Ethnography for this Study

Focused ethnography was useful to this study because it enabled the researcher to understand descriptions and patterns of behaviours of nurses and midwives in rural health facilities in Kenya by considering the participants' insider view (emic) while considering the researcher's outsider view (etic) from the perspective of the researcher's framework (Fetterman,

1998; Roper & Shapira, 2000). Acknowledging the multiple realities of participants and researchers contributes to the development of knowledge in nursing research (Roper & Shapira, 2000). The use of FE is particularly important in investigating specific beliefs and practices of illnesses or healthcare processes (Higginbottom et al., 2013). In this study, it helped to explicate the structural, socio-economic, and political factors contributing to the current contexts of the experiences of nurses and midwives providing postpartum care in rural Kenyan communities. The goal of FE in nursing is to study specific phenomena grounded in a particular culture, with the researcher ideally having a background knowledge of the culture being studied (Higginbottom et al., 2013; Knoblauch, 2005). Hence, using FE for this study is appropriate because as the principal researcher, I grew up and practiced as a nurse and midwife in rural Kenya, and thus I have extensive knowledge of the culture of rural health facilities. I understand the language, the processes, and the expectations of nurses and midwives in rural Kenya.

Although FE is more time-limited, and its use of technical equipment may affect the researcher's participation (Knoblauch, 2005), I was able to invest more time in in-depth individual interviewing, hence retrieving background knowledge from the participants. Also, as explained by Knoblauch, FE is problem-focused (postpartum care) and context specific (rural Kenya); hence, the findings generated from the study will be meaningful and the application of the recommendations will be related to the practice setting as well as to diverse other settings (Knoblauch, 2005).

The complex nature of the social and moral mandates in nursing calls for the use of multiple modes of inquiry to a phenomenon (Browne, 2000). FE provides this avenue through the multiple data collection strategies used in the study such as in-depth individual interviews, participant observation, and focus groups (Cruz & Higginbottom, 2013; Mayan, 2009). FE

allowed an examination of the collective work culture of nurses and midwives working in rural health facilities in Kenya. The use of these multiple methods enhanced and uncovered the tacit skills, complexities, and discretion in nurses' and midwives' jobs that may have been perceived as routine. Critical theory and Foucault's knowledge and power concepts revealed the power interplays between the nurses and midwives and other healthcare professionals and political decision-makers within the postpartum care settings in rural health facilities of Kenya.

As a naturalistic inquiry, FE enhanced and elicited the nurses' and midwives' experiences in a comprehensive manner within the context of rural Kenya (Higginbottom et al., 2013), explicating the socio-cultural context of their postpartum nursing care. These experiences were critically analyzed in relation to the natural settings of rural healthcare facilities. FE facilitated an in-depth examination of the discrete community of nurses and midwives in rural health facilities in order to understand the facilitators and barriers influencing their ability to competently provide postpartum care. CT and Foucault's knowledge and power concepts provided a critical lens to examine these contexts. This methodology suited this study because with FE, participants hold specific knowledge and they do not need to know each other (Muecke, 1994). Nurses and midwives working in rural Kenya are often isolated from their colleagues due to the nature of the facility setting and the shortages of healthcare staff they experience, hence setting a platform of a discrete community within a rural setup.

As is consistent with FE, a specific set of questions were identified with the intent of systematically explaining how socio-cultural factors affect nurses and midwives providing postpartum nursing care in rural Kenya (see the attached interview guide in Appendix VI). The researcher is well conversant with both the type of work and the location.

FE has been found to be suitable for nursing and healthcare research since it does not

require prolonged observation in the field. Financial and time constraints make it a better fit than other forms of ethnographies such as traditional ethnography, critical ethnography, or institutional ethnography, that require extensive field observation (Higginbottom et al., 2013). This study emphasized the experiences of nurses and midwives as individual entities as well as located them within the healthcare professional group. Power dynamics were analyzed keeping in mind that all individuals have different levels of assigned authority, and that they have different levels of knowledge and power in relation to others within their work environment and the healthcare system in general. The multiple data generation strategy used in this study illuminated the problem from different points of view, generating dialogue that could move towards emancipation and empowerment of the nurses and midwives.

4.4 Study Setting

The study was conducted with nurses and midwives working in nine health centers and the County Hospital in Nandi County, Kenya (see County location in Appendix II). In general, the healthcare facilities in Nandi County include 1 County hospital, 1 sub-County hospital, 9 healthcare centers, and 45 dispensaries.

Nandi County was strategically chosen for this study because it has a high number of maternal deaths (KNBS, 2015). The County's rural geographical location and socio-cultural conditions contribute to preventing women from accessing skilled healthcare. Nandi County also has a significant shortage of nurses with a ratio of the active nursing workforce at 38 nurses to 100,000 population, compared to the national ratio of 55 nurses per 100,000 population.

Nandi is a 2,884 square-kilometer County located in the west Rift-Valley province of Kenya, with an estimated population of 752,965 people (KNBS, 2010). The County's primary mode of transportation is by road (automotive and walking), with most roads being highly

inaccessible during the rainy seasons between March and June and between October and November. Very few people own cars, with most utilizing public transportation. The majority of people in Nandi County are *Nandi*, a sub-group of the Kalenjin tribe. The Nandi are culturally rich in most aspects of their daily lives and believe in a supreme deity known as *Cheptalel/Asis*, who is symbolized by the sun. Some Nandi communities idolize spirits (*Oyik*) that are believed to control human beings' behavior. However, many people have converted to Christianity, and a few to Islam.

4.5 Ethical Considerations

During the study, I completed the Tri-Council Policy Statement: Ethical Contact for Research involving Humans Course on Research Ethics (TCPS2: CORE) and obtained a certificate of completion (See Appendix XVIII). Ethics approval was obtained from the University of Ottawa Research Ethics Board (REB) and the Institutional Research and Ethics Committee (IREC) in Kenya. A letter of approval from the Kapsabet County Referral Hospital Medical Superintendent and the Nandi County Director of Health were also obtained (See Appendices XIV, XV, XVI, and XVII for details). The IREC oversees research conducted in the western part of Kenya, where my research setting is geographically located. The research process adhered to the ethical guidelines and protocols from these institutions. The research proposal and declaration of the researcher's interest to conduct research in Nandi County were submitted to the IREC, who provided approval to visit the research site. An information letter (Appendix III) was provided to nurses and midwives working at the study sites. Written informed consent to participate in an individual interview (Appendix IV) and/or focus group discussion (FGD) were obtained from the participants before initiating data collection. The consents included permission to tape or digitally record the interview and focus group sessions.

Participants were also assured of confidentiality, and each participant was assigned a research code instead of using his or her name.

Research objectives were articulated both verbally and in writing to the participants to enable a better understanding of the process (See Appendix III for Letter of Information). Confidentiality was maintained throughout, and names of the nurses and midwives who agreed to be participants were not released to their supervisors. The time of the interview sessions was agreed upon by the researcher and the participants. Interviews took place away from the health facility, in a private setting as agreed to by the participant and the researcher in order to maintain confidentiality.

4.6 Sampling and Participant Recruitment

Before entering the research field, written permission was obtained from the Kapsabet County Referral Hospital Medical Superintendent and the Nandi County Director of Health. Although I had indicated in my proposal that I would obtain written permission from the nursing officer in charge of each health center, I was informed by the County Medical Superintendent that this was not necessary. It is important to note that during data collection, the nursing staff were participating in a national strike over pay and job evaluation. Although the nurses and midwives were not at work, recruitment posters (Appendix VII) and focus group invitations for nurses/midwives in-charge (Appendix VIII) were visibly posted at these facilities' bulletin boards, for transparency of the research.

My personal networks as a nurse facilitated collaboration with key people at the Kapsabet County Hospital and with the Kenya Nurses Association (KNA) representative for Nandi County. The KNA representative provided me with contact information for some potential participants from both the Kapsabet County Hospital and health centers in Nandi County. This

process formed the basis for data collection and the snowball technique advanced the data collection further. The invitation for study participation (See Appendix III for invitation for study participation) was provided to all the nurses and midwives prior to commencement of the data collection. The nurses and midwives were provided an opportunity to accept or decline participation. For those who agreed to participate, written consent was obtained.

Purposeful sampling was used for this study since it allowed me to obtain information from participants who are noted to be particularly knowledgeable about postpartum care in rural Kenya. Purposeful sampling is a non-probability sampling method in which the researcher selects participants based on personal judgment about who will be the most informative (Patton, 2002). In this case, collaboration with the nurse leader from the region fostered the purposeful sampling. Selecting information-rich cases is essential for purposive sampling to appropriately answer the questions and maximize knowledge concerning the central issue of the study (Patton, 2002; Roper & Shapira, 2000). Snowballing occurred when participants referred other nurses and midwives who met the inclusion criteria for participation in the study.

The process of initially inviting all nurses and midwives providing postpartum care services in Nandi County to participate enabled open access to the study population. I ensured that all participants spoke and wrote English legibly. Maximum variation sampling was used in participant selection. Participants were chosen deliberately by comparing similarities and differences in their experience with postpartum care; for example, some provided postpartum care in the County hospital only, while others worked in both health centers and the County hospital. Comparison is important to optimize variation in the sample, and for deeper understanding of the phenomenon and concepts (Patton, 2002).

The sample sizes for qualitative research are much smaller than those of quantitative research because qualitative research is concerned with meanings and not making generalized hypothesis statements (Mason, 2010). Nandi County has approximately 419 nurses and midwives serving at all levels of healthcare facilities. The sample is usually determined by the methodology employed in qualitative studies (Higginbottom, 2004). With focused ethnography, the number of participants cannot be pre-determined, and data are collected until there is no new information or no new themes are generated from the data (Higginbottom et al., 2013; Roper & Shapira, 2000).

Thirty nurses and midwives were approached and 28 of them accepted to participate in the study. However, data saturation was reached after in-depth individual interviews and participant observation of 23 participants. I contacted the other five individuals who had agreed to participate in the study and informed them that I would not be interviewing them because I had enough data for my study. I thanked them, however, for agreeing to participate. Data saturation is reached when no new or significant information related to the research question is emerging from the data (Mayan, 2009).

The final sample of this study consisted of 10 nurses and midwives from the Kapsabet County hospital and 13 nurses and midwives from all the 9 health centers. Table 1 below shows the summary of participant demographics. The participants' years of experience working as a nurse/midwife ranged from 2 to 35 years, and the participants' ages ranged from 25 to 59 years old. The participant sample in this study was consistent with samples from other focused ethnography studies (See Table 2). For instance, Higginbottom (2011) used purposive sampling of 23 internationally educated nurses (IENs) to understand IENs' transitioning experiences on relocation to Canada. The study used semi-structured interviews with IENs.

Table 1: Participant Demographics and Distribution

Variable	Frequency	Percentage
Sex		
Female	20	87
Male	3	13
Age Range (Years)		
25-35	6	26
36-45	8	35
46-55	4	17
>55	5	22
Years of Clinical Experience		
2-10	7	30
11-20	7	30
21-30	7	30
>31	2	10
Facility		
Health Center	13	57
County Hospital	10	43

It revealed that IENs reported negative experiences with respect to their work contract and support, which was mostly caused by a lack of communication. Plaza del Pino, Soriano, and Higginbottom (2013) studied 32 nurses to ascertain how they perceived their inter-cultural communication with Moroccan patients and what barriers were evident which might be preventing effective communication and care. Gerrish, Naisby, and Ismail (2013) employed a purposive sample of 14 Somali patients and 18 healthcare professionals to explore the experiences of the diagnosis and management of tuberculosis from the perspective of both the patients and the professionals involved in their care.

Table 2: Examples of FE Studies in Nursing

Author	Research Aim	Setting/Participants	Data Collection and Analysis Method	Conclusion of Study
Gerrish, Naisby and Ismail (2013)	Explore experiences of the diagnosis and management of tuberculosis from perspectives of Somali patients and healthcare professionals involved in their care	Established Somali community in the United Kingdom. Purposive sample of 14 Somali patients and 18 healthcare professionals	Individual semi-structured interviews Framework approach to qualitative analysis	Nurses have a role in promoting early presentation, timely diagnosis and treatment adherence through supporting Somali patients and raising awareness of the disease among their care practice
Higginbottom (2011)	Understand IENs' transitioning experiences on relocation to Canada.	Purposive sampling of 23 internationally educated nurses (IENs) who were recently recruited by one of Western Canada's health authorities.	Semi-structured interviews with IENs. Analysis followed Roper and Shapira's framework for ethnographic data analysis with the help of Atlas.ti software.	Negative experiences were reported by IENs with respect to their work contract and support. Communication, or its absence, was a contributory factor in the reported discontent among IENs. Failure to provide IENs with appropriate orientation opportunities affect their ability to transition to the workplace.
Plaza del Pino, Soriano and Higginbottom (2013)	Ascertain how nurses perceived their intercultural communication with Moroccan patients and what barriers are evident which may be preventing effective communication and care	3 public hospitals in Southern Spain. Purposive sample of 32 nurses	Semi-structured interviews AQUAD.6 qualitative data analysis software	The language barrier might compromise nursing care delivery and could be readily overcome by implementation of professional interpretation within hospital settings. It is essential to educate nurses in provision of culturally appropriate and sensitive care
Spiers and Wood (2010)	Explore perceptions and actions of community mental health nurses in building a therapeutic alliance in the context of brief therapy and the factors that helped or impeded its development.	Convenience and theoretical sampling of community mental health nurses providing brief therapy (ten sessions or less) or consulting practice for three or more years in Alberta, Canada.	Three focus groups, individual interview, verification interview and methodological journal. Thematic content analysis	Building an alliance consisted of three overlapping phases: establishing mutuality, finding the fit in reciprocal exchange and activating the power of the client. Factors inhibiting alliances were related to patient history, environment (for example, workload) and experience. Recommendations are made to enhance intentional alliances.

4.6.1 Inclusion and Exclusion Criteria.

All nurses and midwives who had provided postpartum care in Nandi County health centers and County Hospital for a minimum of two years were eligible to participate in the study. This ensured that the study participants had good knowledge of the particular work setting and postpartum care guidelines. Nurses and midwives who were not currently working in Nandi County, who had worked fewer than two years in postpartum care settings, or who had not managed postpartum care, were excluded from the study. All nurses and midwives who expressed interest in participating met the inclusion criteria.

4.7 Data Collection

Data were collected for a period of nine months (July 2017 to February 2018). In keeping with the principles of focused ethnography methods, individual in-depth interviews, and focus group discussions were used to obtain data (Higginbottom, 2011). Participant observation levels are placed on a continuum, ranging from complete participant, where the researcher is more actively involved with the participants, to complete observer, where the researcher is fully involved only in observation of the participants' activities (Mayan, 2009; Roper & Shapira, 2000). With focused ethnography, participant observations are conducted at specific times or events (Mayan, 2009). For this study, the non-verbal communication of the nurses and midwives, were observed during the interview sessions and focus group discussions. I documented these observations as field notes, which were prepared immediately after each interview session. Field notes describing the demographics of the participants, location and duration of the interview, key comments from the participants, and any other items atypical to the interview or participants were kept. As suggested by Mayan (2009), the field notes described the researcher's feelings, ideas, and reflections on what was observed during the individual in-depth interviews and focus

group discussions. Observation is a method consistent with ethnographic research (Roper & Shapira, 2000). This information informed the coding and data analysis of the individual interviews.

4.7.1 Individual interviews.

The aim of ethnography is to obtain information from participants and to interpret what the researcher sees from his or her own perspective (Roper & Shapira, 2000). Individual semi-structured interviews were the primary source of data generation in the study. Interviews explain and put into larger context what the researcher is trying to explain, hence the interview is one of the important ways of eliciting descriptions of the phenomena under study (Fetterman, 1998). A total of 23 interviews were conducted for this study. The use of an interview guide (Appendix XI) facilitated comprehensive data collection of the stories of these nurses and midwives. The semi-structured interviews employed open-ended questions, allowing the interview process to take its own shape as it progressed (Wolcott, 1999). The interview guide was developed based on the information from the literature review, with the aim of answering the research question (Roper & Shapira, 2000). They captured the multiple areas of the literature reviewed and target the research objectives. While developing the interview guide, I acknowledged suggestions from the thesis advisory committee. I also interviewed one Canadian nurse who have previously worked in Kenya, to check for the clarity of the guide. The guide was divided into four sections as per the study objectives aiming to answer the research questions. A total of 17 open-ended questions with probes were devised. However, I did not have to ask all questions during the interview because the guide was used flexibly during the individual interviews (Mayan, 2009). For example, the participants were asked the following questions: *“How would you describe the general population of mothers seeking postpartum care in your facility?”* *“As a nurse and a*

midwife how would you describe the care mothers and their families receive from you during the postpartum period?”

In eliciting views and opinions from the participants, the interview guide helped me to avoid becoming prescriptive, and aided consistency by maintaining focus on the research topic (Creswell, 2014; Patton, 2002). Each participant was provided with the Individual Interview Consent Form (Appendix IV) and Confidentiality Agreement Form (Appendix XII) prior to the commencement of the interview. A demographic questionnaire (see Appendix V for details) was also administered prior to the beginning of each individual interview.

All interviews were audio-taped with permission from the participants. This allowed me to concentrate on the discussion and it provided easy access to the data at the end of the discussion. Rubin and Rubin's (2012) interview stages were used as a guide in this study: that is, I introduced myself and the topic to the participant. I asked easy questions first while showing empathy, then followed by asking more specific questions or introducing sensitive topics. I then toned down the emotional level, and finally finished the interview by thanking participants and acknowledging their positive contribution (Mayan, 2009).

One in-depth individual interview session was held with each participant. Each individual interview session took place in a private venue suggested by the participant. Most interviews were conducted in the participants' homes while a few were carried out in private rooms in several cottage restaurants in Kapsabet town. Most of the participants indicated to me that they were not comfortable being seen around the health facilities because of the on-going, nationwide nurses' strike. Therefore, this setting ensured confidentiality and comfort for the participants. The interview sessions ranged from 35 to 60 minutes. At the end of each interview, participants were invited to a focus group discussion where they would meet with other

participants. Participants were informed that participation in the focus group discussion was voluntary.

Following each interview session, I transcribed the data verbatim and analyzed the results using the Braun and Clarke (2006) six-step data analysis process for identification of themes (Mayan, 2009). As a novice researcher, I chose this form of analysis because of its flexibility. Each participant was assigned a file number in order to maintain anonymity. An honorary fee of 500 Kenyan Shillings (the equivalent of \$7 Canadian) was given to each participant at the beginning of each interview session. An honorarium receipt (See Appendix VIII for details) was completed and a copy was provided to each participant.

4.7.2 Focus group discussion

Two focus groups were conducted after completion of the interviews with the nurses and midwives: one focus group was with the participants themselves, while a second one involved administrative staff. For the first focus group, each participant was provided with an opportunity to participate to allow for member checking and to seek participants' input to advance data analysis and interpretation, as suggested by Creswell (2014). An interview guide for the focus group (Appendix XI) was used to probe participants. I developed this guide based on the interview guide questions, acknowledging suggestions from the thesis advisory committee. Examples of questions asked during the focus group were: *"In general, how would you describe the current postpartum care service in rural Kenyan facilities?"* *"Do you feel that you are providing adequate postpartum care to the mothers and the infants? Please explain"*. Although I had originally intended to conduct three focus group discussions with smaller groups of participants, it was not possible due to the national nurses' strike that was going on at the time. I decided to conduct only one focus group in order to accommodate most participants and to have

a meaningful discussion among them. Only the participants were invited to the first focus group discussion. Of those participants who had been individually interviewed, 22 out of the 23 attended.

At the beginning of the focus group discussion, each participant was given a Focus Group Consent Form (Appendix X) to complete prior to the commencement of the discussion. Participants were informed that since the focus group involved several participants, confidentiality could not be absolutely guaranteed. They were informed that confidentiality is kept only when all the participants agree to keep everything that is shared in the room confidential and not share any of this information with anyone outside of the group discussion. To protect their confidentiality, participants were encouraged to think through and decide what they would and would not share in a group setting. To protect everyone's privacy, participants were asked to sign the agreement of confidentiality at the bottom of the Focus Group Consent form. To enhance their privacy, participants were also encouraged to use a made-up name while taking part in the consultation meeting.

During the focus group discussion, I clarified the information collected from the interviews and gave the participants an opportunity to provide me with feedback or challenge my interpretation. With permission from the participants, focus group discussions were audio-taped. The focus group lasted about 90 minutes, with each participant given equal opportunity to participate.

For the second focus group, a total of eight participants were involved: six County nurse managers, one County medical director, and one County administrator. These are the participants who had responded to the focus group invitation for nurses/midwives in-charge (Appendix XIII). The invitation was extended to nurses and midwives in-charge as well as any other healthcare

professionals who were in a charge position. An invitation poster was put up at the healthcare facilities with directions for those who wanted to participate to contact the researcher by telephone. Each participant was given a Focus Group Consent Form (Appendix X) to sign prior to commencement of the discussion. This focus group was solely intended to provide the County officials with preliminary results from the study and to hear their views related to current postpartum care in Nandi County. Information gathered from this group was not integrated into the study.

An honorary fee of 500 Kenyan Shillings (the equivalent of \$7 Canadian) was given to each participant at the beginning of each focus group session. An honorarium receipt (See Appendix VIII for details) was completed and a copy was provided to each participant.

4.8 Data Analysis

As is the tradition in qualitative studies, data collection and analysis occurred concurrently. The analysis of interviews, field notes, and information from the focus groups began concurrently with the data collection (Roper & Shapira, 2000). Thematic analysis, as elaborated by Braun and Clarke (2006), was used to analyze data. This form of analysis was chosen because it is flexible and provides a rich, detailed, and complex dataset. Thematic analysis is a method for analyzing and reporting patterns in the data. It is minimally organized but described in rich detail, facilitating the interpreting of various aspects of the research topic (Braun & Clarke, 2006). Themes capture some important commonalities within the data in relation to the research question and represent a level of patterned response or meaning within the data set (Braun & Clarke, 2006; Boyatzis, 1998).

Braun and Clarke suggest six steps of data analysis. The first is to familiarize yourself with your data, which entails transcribing data, reading, and noting initial ideas. This allows the

researcher to discover cultural themes and identify recurrent patterns (Streubert & Carpenter, 2007). The second is to generate initial codes, coding interesting features of the data in a systematic fashion across the entire data set and collating data relevant to each code. The third step involves searching for themes: in this stage, the researcher collates codes into potential themes, gathering all data relevant to each potential theme. The fourth is reviewing themes, when the researcher checks to see if the themes work in relation to the coded extracts and to the entire data set, generating a thematic “map” of the analysis. The fifth step involves defining and naming themes: in this stage, ongoing analysis refines the specifics of each theme and the overall story the analysis tells, generating clear definitions and names for each theme. The sixth and final step is producing a scholarly report. It is the final opportunity for analysis and involves selecting vivid, compelling extract examples, providing a final analysis of these selected extracts, and relating them back to the research question and literature.

With the guidance of critical theory perspectives and Foucault’s concepts of knowledge and power, Braun and Clarke’s (2006) six-step process guided this study’s data analysis. Several coding and data analysis meetings were held with my thesis supervisor. Following each interview, data were transcribed, read, and initial ideas were noted. By reading and re-reading the data, I discovered themes by identifying recurrent patterns. This allowed me to generate codes from the data.

According to Mayan (2009), coding is the first step in being able to say something and make comparisons about pieces of data and the phenomenon. My thesis supervisor assisted me with the initial coding of the data. After coding four transcripts line-by-line, a code table was generated and sent to my supervisor. She revised the code table and more codes were generated. I then collated the codes into potential themes and gathered all the data relevant to each potential

theme. With my supervisor's guidance, themes were then reviewed against the codes to ensure congruency, while identifying sub-themes and putting names to each of the themes.

During my analysis, CT lens and my extensive nursing experiences in the study setting and North America helped me to see beyond the statements that the nurses were making. For example, when participants stated that they were short-staff and overworked, I could see that these are systemic issues of power manifesting in limited resource allocation and subsequent workload distribution. Therefore, when I was listening to the transcript and looking back to the interview sessions through my field notes, I could see that there were issues of power embedded in the day to day work of the nurses. My interviews were guided conversations, where I listened attentively to the participants and probed for uncompleted sentences. I wanted to learn more from the nurses and midwives themselves about their experiences, in their own words. My experience as a nurse who has worked in such context and in the Canadian context played a big role in my critical analysis. I am a nursing manager in a Canadian facility, therefore, I could relate with what the participants were telling me. I can see how nurses struggle daily especially when they are working short-staffed, because the organization's policies expect nurses to complete all their required duties during the shift, not factoring in the shortage of staff.

From the data I extracted some compelling examples and analyzed them. I produced the final report as the findings chapter (see Chapter Five).

4.9 Rigor / Trustworthiness

The aspects of trustworthiness, as outlined by Lincoln and Guba (1985), were used to ensure the trustworthiness of the research process. These are credibility, transferability, dependability, and confirmability.

Credibility refers to the assessment of research findings to ensure accurate representation of participant data, and to reflect on how believable the research results are (Lincoln & Guba, 1985). In this study, member checking and triangulation of data from the individual interviews, field notes, and focus group discussion were used to ensure credibility. Triangulation validates and enhances findings (Lincoln & Guba, 2000; Patton, 2002), and is used to corroborate evidence from different sources to illuminate a theme or perspective (Creswell, 2013; Fetterman, 1998). Triangulation enabled me to portray the perspectives of the participants as clearly as possible (Morse & Field, 1995). Transparency enables credibility: when the interpretation of the data is supported by direct quotes from the participants, readers can follow the research process and can draw similar conclusions. At the end of each in-depth interview, participants were given a verbal summary of the interpretation of their responses and were asked to confirm if the interpretation represented their views. I also kept a journal in which I recorded my interactions with the participants, which allowed me to self-reflect after the individual in-depth interviews (Koch, 2006).

Transferability involved thick description of the settings and participants as a means of assessing the applicability of the research findings to other settings (Guba & Lincoln, 1985). The details provided about the research site, the participants, the experience of data collection, and the researcher's thought processes throughout the research allow for clarity for the reader (Burns & Grove, 2001).

Consistency ensured *dependability* of data and findings (Guba & Lincoln, 1985). Findings in this study have been presented in a way that the experience of the participants can be replicated in a similar context, keeping in mind the uniqueness of the nurses' and midwives' current working environments. According to Koch,

A study and its findings are auditable when another researcher can clearly follow the decision trail used by the investigator in the study. In addition, another researcher could arrive at the same or comparable but not contradictory conclusions given the researcher's data, perspective and situation. (Koch, 2006, p.92, quoting Sandeloski, 1986)

Presentation of the findings in this study includes direct quotations from the participants, hence providing consistency in the representation of the participants.

Confirmability was assured through the process of the researcher's reflections (Guba & Lincoln, 1985). Personal memos to elicit self-reflection created an honest narrative of the research findings (Creswell, 2014). During the research process, I reflected on my own beliefs in the same manner as I examined the nurses' and midwives' beliefs. I ensured that I was not imposing my feelings onto the interpretation of the data. I read and re-read the participants' quotes to confirm that I was looking into the deeper meaning of the interpretation. Hence, confirmability in this study was reached when credibility, dependability, and transferability were achieved (Koch, 2006).

4.10 Reflexivity

Reflexivity is the process of researchers' continual self-evaluation and internal dialogue on their position as well as acknowledgment of how their position could affect the research process and outcome (Stronach et al., 2007). Hence, reflexivity is a thoughtful, conscious awareness of the researcher in the process of research. It includes the development of transparency in decision making in the research process at personal, methodological, theoretical, and epistemological levels (Engward & Davis, 2015).

According to Foucault, knowledge can be produced through reflection (Smith, 2005). As power is linked to discourse, to the accumulation and proliferation of knowledge, Foucault insists that the responsibility for truth and knowledge is double-edged. Researchers must continuously reflect and be diligent in recognizing their actions throughout the research process

in order to avoid agents that marginalize voices (Bierema, 2015). Since Foucault (1980) concedes that knowledge production could be advantageous to the marginalized if the information is produced by the marginalized themselves, it is imperative that the researcher is cautious about his or her own voice, watching for the influences of anonymous rules that are unknowingly or knowingly applied, to avoid the possibility of misrepresentation, or rather, the consequence of “interested representation” (Bierema, 2015). Hence, as Madison (2011) explains, researchers must acknowledge their own power, participate in discourse, and use theory to interpret social action.

Being the main instrument for data collection, I was aware that I could consciously or unconsciously influence both how the data was collected and its interpretation. Thus, reflexivity was crucial in all phases of the research process for my study. It allowed me to be critical of how I interviewed and how I interpreted what I heard during the interviews and focus group discussion. Similarly, through reflexivity, I acknowledged my role in the creation of knowledge and the impact that my personal experiences could have on the interpretation of the research. For example, prior to beginning the individual in-depth interviews, I was upfront with the participants in informing them of my background, including my work experiences.

I grew up in rural Nandi County, and obtained my nursing degree in a university located there. Therefore, I had a background knowledge of the healthcare system in Kenya as well as practical experience as a nurse. This made it easier to collect the data because I understood the terminologies used by the participants. I completed my community practical placement, including postpartum care experience, as a nursing student in several Nandi County health centres. Following my qualification as a registered nurse midwife, I worked in a medical unit at a private hospital for one year, and then spent two years in the Intensive Care Unit (ICU) at a

national referral hospital before I left the country. During my tenure at the national referral hospital, I was also assigned to a management rotation schedule where I was responsible for supervising assigned units at the hospital. One of the units that I supervised was the maternal and child health unit. This provided me with the experience of interacting with the nurses and midwives providing postpartum care, as well as the mothers.

Sharing my experience with the participants was helpful during the data collection phase of my study because the participants were receptive to sharing their experiences with me. Some of them indicated how excited they were that I could represent them in voicing their concerns. They opened up to me during the individual interviews and focus group discussion since I could relate to their current work experiences. Similarly, my past experiences put me at ease visiting the homes of the participants for the individual interviews because I understood their cultural practices.

With this backdrop, I was careful not to impose my feelings during the interviews and focus group sessions as well as during the interpretation of data. Reflexivity allowed me to determine the extent to which I needed to emphasize certain points during the participant interviews, as well as it made me aware of my potential influence during data analysis. Jootun, McGhee, and Marland (2009) posit that reflexive research acknowledges that the findings are a product of the researcher's interpretation.

4.11 Summary of the Chapter

This chapter has provided details of the research methodology for this study, with a particular focus on Focused Ethnography (FE) as the chosen research method. Different kinds of ethnographies were described, and justification of the use of FE was presented. The study setting has been discussed in detail and ethical consideration explained. The use of individual in-depth

interviews, participant observation, and focus group discussions produced a wealth of captivating data for my study. Thematic analysis, as explained by Braun and Clarke (2006), with the guidance of critical theory and Foucault's concepts of knowledge and power, enabled me to analyze and report patterns within the data that were interpreted in relation to various aspects of my research question and objectives. The four aspects of trustworthiness (credibility, transferability, dependability, and confirmability) as outlined by Lincoln and Guba (1985) were used to ensure the trustworthiness of the research process.

CHAPTER 5: Findings

This chapter presents the findings of this research, which examined the experiences of nurses and midwives providing postpartum care in rural Kenyan communities. The analysis of the participants' data was guided by critical theory and Foucault's concepts of knowledge and power. This analysis generated six themes: 1) Provider-Client Relationships; 2) Fostering a Healthy Work Environment; 3) Barriers to Postpartum Care; 4) Transcending Adversity; 5) Social Support Systems; and 6) Policies and Infrastructure Influencing Postpartum Care. An outline of these themes and their sub-themes is presented below in Table 3.

Table 3: Outline of Research Findings Themes and Sub-themes

	Themes	Sub-themes
1	Provider-Client Relationships	1.1 Gaining client's trust and acceptance 1.2 Supporting the mothers 1.3 Fostering mother-baby bonding
2	Fostering a Healthy Work Environment	2.1 Professional collaboration 2.2 Continuing professional knowledge and skills development 2.3 Creating an empowered environment through knowledge translation
3	Barriers to Postpartum Care	3.1 Staffing shortages 3.2 Limited essential supplies and equipment 3.3 Increased workload related to caring for special needs of the mother and baby
4	Transcending Adversity	4.1 Powerlessness 4.2 Limited leadership roles 4.3 Resilience
5	Social Support System	5.1 Family as a social support 5.2 Support from friends and other community members 5.3 Support from community health workers 5.4 Cultural context of postpartum care
6	Policies and Infrastructure Influencing Postpartum Care	6.1 Free maternity services 6.2 Adherence to perinatal care guidelines 6.3 Recruitment and retention of nurses and midwives

5.1 Provider-Client Relationship

This theme describes how nurses and midwives accepted the responsibility of building and nurturing a trusting and respectful relationship with new mothers and their families. It highlights how nurses and midwives promoted their clients' health outcomes during the postpartum period by enabling a positive environment for the mothers and their newborns. Although faced with several challenges such as lack of time and limited essential supplies to care for mothers and newborns, nurses and midwives strove to promote a good nurse-client relationship. They endeavored to create a positive environment that promoted trust between themselves and their clients. Nurses and midwives understood that women's perception of their care during the perinatal period could have an impact on their future use of these services. Thus, the nurses and midwives made every effort to foster an environment where the women felt confident to take charge as new mothers. This theme is comprised of three sub-themes: gaining clients' trust and acceptance, support for mothers, and fostering mother-baby bonding.

5.1.1 Gaining clients' trust and acceptance.

This sub-theme refers to the strategies nurses and midwives employed to build trust in a nurse-client relationship. They acknowledged that the experience of childbirth is unique to every woman, and each woman may adjust to the process of motherhood differently. Therefore, participants in this study acknowledged that the building of a trusting relationship was necessary for a smooth transition from pregnancy to becoming a mother.

Nurses and midwives in this study managed expectations of their clients during the postpartum period by promoting an environment where their clients felt safe. Client safety and trust were paramount to the success of their accepting perinatal services. Participants indicated that with trust, there was better communication between the nurses/midwives and their clients.

They stated that they had to maintain a good relationship with the mothers in order to encourage them to adhere to the perinatal care regime. Participants indicated that their work rotation entailed caring for women during all stages of the perinatal period (antenatal, birth, and postnatal). They explained that trusting relationships between the nurses/midwives and the mothers began at various stages of the childbearing continuum. As explained by one participant,

You know, we see some of these mothers from when they are pregnant, during the antenatal clinics ... Others come only to deliver ... How we treat these mothers when we see them is important because if they are not happy with us, they will not come back to deliver the baby at the hospital ... So, we get to know them, and they get to know us. We get to understand these women during the process. We even conduct the deliveries, and then take care of them during postpartum period. We understand them, and because they know us, it is easy for us to care [for] them because they open up to us. They know we are here to help them, and they can ask us anything. (P004)

In addition to knowing the mothers and anticipating their expectations, nurses and midwives fostered trust by demonstrating an understanding of the new mother's journey while providing supportive postpartum care services to her. Most participants indicated that the point of initial assessment is crucial in forming these relationships because most women are anxious about themselves and their ability to care for their baby. Participants explained that new mothers require a lot of reassurance, listening, and empathy during the immediate postpartum care period. During the initial assessment is when the nurse and midwife determine the health vulnerability of the mother and her newborn and start teaching her about her postpartum responsibilities. One participant elaborated on this point:

After delivery, the mothers are normally anxious, and some do not know what to do. During assessment, we encourage them. We listen to them. We explain the procedures that we are doing to them before we begin. We educate them and encourage them to ask questions. This way, when we ask them to come back after six weeks for postnatal care of the baby and for themselves, they come back because we provide good care. (P008)

Similarly, others commented that nurses and midwives promoted trusting relationships with the mothers through listening and demonstrated understanding and caring attitudes during

the initial assessments. The nurses and midwives allowed the mothers to participate during these assessments by providing them with the opportunity to ask questions related to these assessments. Nurses and midwives also used this occasion to advise mothers on watching for abnormal signs and symptoms during the postpartum period. One of the participants explained that the mothers and their newborns underwent assessment and observation, and a plan was devised for them based on that assessment that would optimize their care during the postpartum period.

We have to take good care of these mothers. They depend on us. After the baby is delivered, we take the mothers and their newborns to the postnatal wards. At the postnatal wards, we manage our mothers in the third stage of labour. We assess and observe if they have any bleeding, any diversion from normal. We also give them advice on the bleeding, to check the amount of blood in the pad, check vital signs – blood pressure, pulse and temperature – we make sure that the mother is comfortable and that they understand what we are telling them to watch. Our mothers appreciate the care that we give because we listen to them. (P010)

As well, the nurses and midwives built trust and confidence by providing physical comfort to the mother and the newborn. They keep the newborn warm to prevent neonatal complications like respiratory distress, and they are alert for any excessive bleeding caused by poor ligation of the cord. In addition, nurses and midwives acknowledged that the mothers depended on them to ensure safe treatment in a timely manner when faced with complications such as postpartum hemorrhage. Nurses and midwives also instilled trust and confidence in their clients through engaging the relatives who accompanied the women to the health facility. One participant explained that when a client arrives at the health facility with life-threatening complications, the client trusts the nurses and midwives to assist her and save her from risks or complications. As she explains,

Sometimes the mother arrives with postpartum hemorrhage, and maybe the baby was born at home. In addition to the bleeding of this mother, the baby could be bleeding too because the cord has not been ligated well. Maybe the baby is cold due to lack of warm clothing.

Fine, what do we do? We have to take care of this mother and the baby. They are depending on us. They know that we will help them ... But remember, this mother wouldn't come alone, and she has her relative. Reassure the relative also, so they know that you are helping this mother and baby. Reassure the mother too. (P007)

In addition, upholding of these trusting relationships through respectful communication between the nurses and midwives and their clients was important in facilitating meaningful discussion about the mother's care. The majority of the participants indicated that clear communication between the nurses/midwives and the mothers built confidence and relieved anxiety for the mothers. However, nurses and midwives were distraught when they did not have time to communicate their actions during the assessment procedures. For instance, the following quote from a nurse indicated that the women and their families could be better informed of the care that they receive by explaining procedures and providing them with an opportunity to consent for care. This nurse stated that informed care is compromised by inadequate staffing because the nurses/midwives have to rush through their work, leaving them with feelings of being overwhelmed.

It is quite overwhelming, even when you know you are doing the right thing, you feel like something wrong might happen ... You feel like you are letting down the mothers and their families because you don't have time to communicate to them what you are doing. These mothers have confidence in us when they know the procedures being done to them and they really need to consent to them you know. But when we don't have enough staff, we are just rushing to finish up with everyone waiting for us to see. (P012)

The nurses and midwives expressed dissatisfaction with their work when they felt that they did not have the time to engage women in meaningful discussions about their care, especially as it related to clearly explaining procedures to ensure informed care. As the main healthcare providers for postpartum care services in rural Kenyan health facilities, participants in this study stated that the nature of the relationship between the nurses and midwives and the

mothers could determine the overall perception of care by the mothers during the postpartum period.

5.1.2 Support for the mothers.

This sub-theme describes how the nurses and midwives endeavored to address the psychological and emotional needs of the new mothers and their families during the postpartum period. Participants understood that throughout the perinatal period, mothers' bodies and minds undergo a kind of metamorphosis in accommodating the newborn. The childbearing process can be stressful and unpredictable for the mother and her family. Participants indicated that the extent to which mothers can tolerate the perinatal process is greatly dependent on their own will as well as the environment that they are exposed to. These participants therefore stated that they provided the mothers, as well as their families, with physical and emotional support during the postpartum period as a means of eliminating emotional distress.

The nurses and midwives explained that mothers are vulnerable to mental illness conditions during the postpartum period, which can negatively affect their safety as well as that of their newborns and their immediate family members. Participants stated that new mothers can easily plunge into postpartum depression if their psychological needs are not met. I could see how important the idea of support to mothers meant to one participant when she explained how she supported two generations of mothers for the sake of their wellbeing and that of their newborns.

The mothers are supposed to have a good and comfortable delivery of the baby. We reassure the mothers especially the younger mothers and also the mothers of these younger mothers. We listen to them. We talk to both the younger mother and their mothers on how to care for the baby and clarify any questions they might have. Because if the mother is unstable, she can easily fall into [a] postpartum depression state and this can affect the wellbeing of the newborn and the immediate family members. We also encourage the younger mothers to continue their education while nursing the baby at home. We tell them to seek help if they feel depressed. (P001)

In addition, through listening and caring attitudes, nurses and midwives expressed emotional support by empowering mothers to explore their concerns with healthcare providers during the perinatal period. Empowering the mothers facilitates appropriate care that is often obtained through referrals. One participant explains, “We listen to them. Sometimes, we do not have anything to offer to solve their problems, but we sit and listen to what they are telling us. Then we advise or refer as necessary” (P019).

Some participants indicated that they provided emotional support through mental health assessments and treatments. They assessed how the mother responded to the newborn and obtained other relevant information from family members that could assist in determining the mother’s mental status during the postpartum period. For example, one participant indicated that she determined the mother’s need for emotional support based on the degree of emotion she demonstrates to her newborn. If the mother is withdrawn from her newborn, or if she appears sad and depressed, it could be an indication that the mother is mentally unstable and requires emotional support or even a referral to a psychiatrist.

We ask the mother about the baby, and then you try to determine the mood of the mother depending on how she responds. A mother who has given birth is generally a happy mother. So if you find otherwise, then you probe ... You can also obtain the history from the relatives. Some will also tell you this mother is like this when she gives birth. Like we have one that we already know that she breaks into depression when she gives birth. But the husband is so supportive, and he brings her for assessment and treatment. Sometimes we have to refer the mothers to the psychiatrist if we determine they need more help than we can offer. (P016)

Some participants pointed out that they supported the mothers emotionally by maintaining their dignity and showing respect by involving their partners or relatives in their care and enabling them to participate in decisions about referral if needed.

You look at the general condition of the mother, and you will know if the mother has psychiatric signs, or not. We advise them to the best of ability and manage them as best as

we can, then refer them to the psychiatric clinic at the County Referral Hospital. Once we determine the patient has a problem and we are unable to assist them at our facility, we take the relatives aside and discuss with them the patient's condition ... We advise them to take the patient to the psychiatric clinic. (P021)

Likewise, nurses and midwives supported the mothers through counselling them regarding their new role of motherhood. The participants acknowledged that they provided extra support to younger and single mothers in order to prevent psychological problems that could arise from failure to cope with being a mother. For example, one participant explained that she offered counselling to the mothers regardless of their experience with childbearing, age, or marital status. She understood that she needed to advocate for all mothers, but mostly the vulnerable women who could have conceived their babies through unconventional means such as rape. This participant explained how she provides emotional support to the mothers, as well as to their immediate family members.

I provide them with counselling so that they can be at ease in accepting the role of motherhood. Especially when I see school age students, [and when] I find out that their parents are aggressive and upset with them for having the baby while still in school, I make sure I also counsel their parents. These young mothers undergo psychological problems because you find that sometimes they could be innocent because they were raped. (P001)

One participant expressed how nurses and midwives provided support through empathy and the use of medications for pain relief. She recalled how, during postpartum care, she would "bring her [Client] to the unit, just to give her analgesic for pain, so that when you will be ruling out all these impossibilities, she may not feel that pain" (P007). Another participant stated that she anticipated the mother's discomfort from pain and alleviated it so that she could focus on her healing. "You give treatment for pain so that they can concentrate on taking care of themselves and the baby" (P001).

Other participants indicated support for mothers by providing advice on good nourishment and affordable food ideas. They indicated the importance of replenishing lost fluids and other nutrients during the childbearing process, as explained by the following participant.

For the mothers in our care, we teach them on general care of themselves. We really stress on food and good nutrition because it is important for their health and the health of their baby ... Sometimes the mothers tell us that they cannot afford to buy the foods that we had advised them to buy. We normally support them on food choices. We also give them education on nutritious and the cheapest food that they can take. (P019)

It is necessary to provide support for the mother during the postpartum period because it promotes positive health outcomes for the mother as well as the newborn. Healthy mothers grow healthy babies. If the mother is not healthy, they will not be able to focus on providing good care of their newborns. For example, if the mother is in physiological distress due to pain, their bodies will not adjust well to produce breast milk, which is crucial for the newborn's nourishment and survival.

5.1.3 Fostering mother-baby Bonding.

This sub-theme emerged when most of the participants spoke about techniques that fostered bonding between mothers and their newborns through such measures as rooming-in, breastfeeding support, and in general, the building of caregiving skills. Although some of the techniques such as rooming-in came naturally due to the lack of space in the maternity wards, the participants believed that promoting the mother-baby bonding was a key part of early postpartum care. Nurses and midwives encouraged mothers to hold their newborns and initiate breastfeeding as soon as possible. Mothers are also encouraged to provide hygiene care to their newborns and are supported through the process. I will discuss how each of these techniques facilitated mother-baby bonding.

Rooming-in and building caregiving skills. Most participants indicated that whenever possible during the immediate postpartum period, mothers were encouraged to share the same bed with their babies in order to promote bonding. They described this as “rooming-in.” Although the participants indicated that they encouraged the mothers to do this, it seemed that rooming-in was not a choice but a default option because of lack of space for a nursery. However, nurses and midwives were still tasked with preparing mothers emotionally for rooming-in and encouraged them to practice skin-to-skin contact with their babies. Skin-to-skin contact promotes bonding and produces positive emotions for the mother. As the following participant elaborates, “We encourage rooming-in with the baby, and skin-to-skin baby and mother contact. This is important because it promotes bonding of the mother and the baby. You can see how happy the mother is when they hold their baby” (P022).

There were exceptions where rooming-in was not possible, for example, if the newborn was critically ill and needed to stay in the newborn unit for treatment or closer observations, or if the mother was experiencing postpartum complications and was unable to take care of her newborn. Otherwise, participants acclaimed rooming-in for enabling an empowered environment for the mothers and increasing their confidence in taking care of their babies. It was evident from the discussion that the mothers received advice on watching for signs and symptoms that would indicate the newborn was in danger and required immediate medical attention. The danger signs for the baby frequently mentioned include fever, difficulty feeding and breathing, and discharge from the umbilical cord, among others. Participants also indicated that the mothers were given a chance to ask questions relating to caring for their babies, hence boosting self-assurance in their mothering abilities. As explained by one participant,

During this time, we educate the mothers about rooming in. We also show them how to care for their baby, like hygiene, observing critical signs like shortness of breath, baby

color change, temperature. I find that it makes the mothers feel good when they take care of their babies. They ask many questions about their babies. (P001)

Another participant explained that rooming-in enabled prevention, early identification, and treatment of neonatal complications, especially when the mother was aware of the signs to watch for. Therefore, rooming-in was noted to be critical to the survival of the newborn during the immediate postpartum period. One participant explains that:

We educate these mothers on general care of the newborn, the danger signs of the baby, for example, if the baby is not breastfeeding, having discharge from the cord, difficulty breathing, or fever. Because the mother is rooming-in with the baby, it is easier for her to identify these problems. We encourage the mother to bring the baby to the nearest health facility as soon as possible when they observe any of the danger signs. When a mother knows what to watch for, it brings her close to her baby because now, they pay more attention to the baby. (P017)

Similarly, other participants indicated that rooming-in promoted better communication between mothers and nurses and midwives. While acknowledging the difficulties of parenting, some participants explained how rooming-in facilitated mothering skills because mothers were able to demonstrate back skills taught by the nurses and midwives. As one participant explains, “The mothers stay with their babies in the same bed, so it is easy to teach them how to care for their babies and watch for danger signs because they do it as we teach” (P010). Hence the return demonstration promoted a better communication strategy between the mothers and the nurses and midwives.

Conversely, participants were concerned that lack of space in the postpartum care units forced mothers to share beds with other mothers; a mother with a newborn shares a bed with another mother with her newborn. Participants were concerned that sharing of the beds posed risks to contracting nosocomial infection for both the mother and newborn. As explained by the following participant, “The problem now arises when the mothers have to share the beds with

other mothers and their babies. There is a big chance of the babies contracting infections from other patients” (P023).

Of more concern was a situation where a mother who has suffered loss, for example, who had a still-birth or neonatal death, was forced to share the same bed or room with other mothers with their newborns. This situation caused distress to both mothers as well as to the nurse/midwife taking care of them.

It is hard for all when you have a mother with her infant sharing a bed with another mother who [has lost her] infant. This is really difficult for me as a nurse and I can imagine how difficult it is for the mothers. But there is nothing I can do since I have to accommodate all of them in the same room because that is all I have. (P013)

In general, rooming-in was preferred by nurses and midwives because of the mother-baby bonding effect. Although there was no indication that the women were provided with a choice between rooming-in and having their newborn taken to the nursery unit, none of the participants indicated mothers raised concerns about rooming-in.

Breastfeeding support. The sub-theme of breastfeeding support arose because all participants commented on promoting breastfeeding practices immediately following the birth of the baby. In accordance with the World Health Organization’s guidelines on promoting and supporting breastfeeding practices in facilities offering maternal and newborn care (WHO, 2017), nurses and midwives promoted breastfeeding within one hour of the baby being born, and advocated breastfeeding exclusively for six months following birth. It was evident from the discussion with the nurses and midwives that they all believed breastfeeding was natural and they encouraged the mothers to initiate breastfeeding at birth. They also encouraged the mothers to breastfeed exclusively for at least six months because of the benefits to the newborn such as

the prevention of infections. They also indicated that they supported mothers to establish early breastfeeding, as elaborated by the following participant.

In fact, we tell them [the mothers] to initiate the baby on breastfeeding immediately and continue with exclusive breastfeeding for at least six months. Breast milk is beneficial to the baby as it provides the baby with immunity from infections. We also encourage the midwives to initiate breastfeeding immediately following delivery because some mothers might not be aware that they need to breastfeed their baby immediately after delivery. (P002)

Further to the nutritional advantage of breast milk, breastfeeding was deemed integral in forming the mother-baby bonding because of the close attention that the mother provides to the baby while breastfeeding, as the following participant explained.

Breastfeeding is important because it brings the mother and baby close. Because when a mother is breastfeeding, they are looking at the infant and that eye contact is very important to the infant. This is the time when they [mother and newborn] get to know each other. In addition, the mother is able to detect abnormalities in her breast when they breastfeed. (P014)

Other participants suggested that mothers who breastfed their newborns paid more attention to their newborns than those who did not, because they needed to watch the baby as they breastfed. With such close observation, mothers could detect any abnormalities with their newborns faster and could act much more quickly to prevent any complications.

We teach them the importance of exclusive breastfeeding. We tell them that breastfeeding is necessary for the baby's nutrition and also, that it is helpful for bonding and because they get to learn the baby, it is easier for the mothers to detect any abnormalities with the baby when they breastfeed than when they don't breastfeed. (021)

Participants indicated that the bonding of mother-baby was promoted by strongly encouraging the mothers to breastfeed their newborns except in circumstances where the mother was unable to due to health complications. Breastfeeding is the most preferred way of nourishing the newborn because breast milk has all the nutrients that the newborn requires, without any extra preparation of another form of milk. One participant explained that she supported the

mothers by advising them on exclusive breastfeeding and encouraging them to return to the health facility if the baby was not feeding well. She stated that given the tough economic status of most women, she encourages exclusive breastfeeding because sometimes it can be difficult for the mother to obtain supplemental food for the baby due to poverty.

We make sure they breastfeed the baby within one hour after delivery, then continuous breastfeeding as the baby demands ... we tell them to breastfeed exclusively for six months. Because of poverty, we don't discuss other options of feeding during discharge because the mother cannot afford. We tell them to come back if the baby is not breastfeeding well. Then we now look at other options. (P004)

To some participants, breastfeeding was not a choice that the mother could make, it was an expectation. Nurses and midwives insisted on breastfeeding for the safety of the newborn. For example, one participant talked about mothers feeding their newborns with improperly diluted cow's milk. She explained that even though most of them were homemakers, they did not understand how to properly dilute cow's milk for newborns, and thus, breastfeeding exclusively was the only option.

Most of our patients are homemakers. Therefore, if you give them the options, maybe they will feed the baby cow's milk and they do not know how to dilute it. At least most of them they are doing it [breastfeeding]... we do not give them an option. (P008)

However, there were some circumstances for which nurses and midwives did provide mothers with options around breastfeeding, for example, mothers with HIV infections. Although exclusive breastfeeding was encouraged even for these mothers, those who were HIV positive and who were on Antiretroviral Therapy (ART) were given the option of either breastfeeding exclusively or using only supplements. Mixed feeding interfered with the newborn's immunity status, as one participant explained.

Yes, we give a choice to the mothers who are HIV positive. If they choose to breastfeed, they should breastfeed continuously and if they cannot, they should use supplements only. They cannot mix-feed. They should just give the supplement and stop breastfeeding because the baby's immunity will be affected if they mix the feeding methods. (P017)

Mothers with HIV infections, who chose not to breastfeed, were still advised to maintain skin-to-skin contact with their infants, as well as to place the infant in the breastfeeding position when feeding them with the formula so that they could benefit from the bonding effect.

We also encourage them to keep the baby in the breastfeeding position when they are feeding them with supplements so that they can still enjoy the eye-contact just like the ones who breastfeed. (P017)

In support of the early breastfeeding initiative, nurses and midwives educated mothers on how to properly attach their infant to the breast. They enlisted help from the nutritionist who provided education to the mothers and encouraged them to seek help from healthcare professionals if they had problems with breastfeeding their infants at home.

We encourage them to breastfeed. We even have a nutritionist who comes to educate on how to attach the baby on the breast. At least so they know what to do and if they have any difficulty they should be able to come back to the hospital for intervention. (P005)

Although most participants understood the significance of building and maintaining nurse-client relationships, a major challenge was lack of time. All the participants commented on how a lack of time hindered their relationship with the mothers because they felt “rushed.” Participants explained that the time they spent with their clients was limited due to high patient ratios, compounded by poor staffing ratios in their facilities. They stated that the limited time they had to spend with the mothers negatively affected the quality of care they provided.

You know, we are supposed to provide care as per the postpartum care guidelines, but we don't have enough time to take care of all the women that come to us. They are too many and we don't have enough staff to take care of them. We are rushing so much that sometimes we miss to educate the women on how to take care of their infants and prevent complications at home. (P011)

It was obvious from the interviews that nurses and midwives strove for personalized, safe, and respectful postpartum care services, despite the challenges that they faced while providing these services. The theme “Anchoring Provider-Client Relationships” describes how

nurses and midwives accepted the responsibility of building and nurturing a trusting and respectful relationship with new mothers and their families. Within this theme, the strategies nurses and midwives employed to build trust and a positive nurse-client relationship, as well as the techniques they used that fostered bonding between the mothers and their newborns, were identified.

5.2 Fostering a Healthy Work Environment

The theme of “fostering a healthy work environment” highlights those facilitators that created a positive work environment for the nurses and hence made them feel valued. A healthy work environment allowed the nurses and midwives to do their work without feeling like victims of a failed health system. Nurses and midwives were the frontline providers in the rural health care facilities, hence, they coordinated client services throughout the healthcare facility. The nurses and midwives, therefore, had an opportunity to set a culture that nurtured a healthy work environment by creating a sense of community amongst themselves and with both other healthcare professionals and external stakeholders. Thus, a healthy work environment optimized healthcare provision by the nurses and midwives. Participants (nurses and midwives) acknowledged that the care they provided to their clients was augmented by the availability of essential supplies, availability of equipment necessary for them to complete the procedures as needed, teamwork amongst the nurses and midwives, as well as with other healthcare professionals, continued skills development, and supervisor support, among others. This theme has three sub-themes: 1) Professional collaboration, 2) Continuing professional knowledge and skills development, and 3) Creating an empowered environment through knowledge translation. Each of these sub-themes will be discussed below.

5.2.1 Professional collaboration.

Professional collaboration explains how the nurses and midwives worked together with other healthcare providers within their facilities as well as community partners to improve the quality of care for their clients and achieve healthcare goals, such as the reduction of maternal and infant mortality. Collaboration allowed the nurses and midwives access to information and resources necessary for them to provide care for their clients, hence, bringing satisfaction with their work. This sub-theme will be discussed under the following two topics: collaboration and teamwork with other healthcare professionals, and collaboration with community partners and stakeholders.

Collaboration and teamwork with other healthcare professionals. Most participants used the term “teamwork” when talking about collaboration. Nurses and midwives collaborated with other healthcare professionals, such as doctors, clinical officers, and laboratory technicians, to contribute their expertise and enable a common plan of care for clients. They acknowledged that with good communication through collaboration, lives of mothers and their newborns were saved. Collaboration promoted a shared workload among healthcare professionals that in turn improved the patients’ health outcomes. As explained by the following participant,

I think teamwork is the best thing. When there is teamwork, everything goes well. Everybody is there for the mother ... for example, if blood is needed for a patient, you get the blood from the lab technician, the doctors and nurses are also there doing their parts, so when we work as a team life becomes very easy and the patient survives ... Yah we work in association with the doctors when there is a complication, we work as team. (P023)

Support from management was an important aspect of collaboration. Managers could assist the nurses and midwives to obtain the necessary support required for them to do their work, such as staff, equipment, and basic supplies. Nurses and midwives considered this support good teamwork. The following excerpt from one of the participants explains how management support

as well as teamwork with other healthcare professionals such as doctors were critical in preventing postpartum complications.

Okay, actually we have our managers who are always very supportive and at the same time the teamwork as I had said before is very good ... teamwork is the most useful, because you can't work alone especially now when you are observing a mother after delivery. You need to have somebody to support you as you do the work and be that second eye to prevent unnecessary complications to the mother. It could be another nurse, midwife, or even a doctor. (P020)

Participants explained the importance of teamwork among nurses and midwives with various skill, educational, and experience levels. For example, collaboration between nurses and midwives who had only basic training and those with advanced training in emergency obstetric care was deemed necessary for the safety of the mother and newborn. Nurses and midwives stated that this teamwork enhanced support during care, improved learning experiences, promoted safety of practice, and increased confidence when tackling obstetric emergencies. As explained by one participant,

What I find to be more useful to me is having those nurses that have been specifically trained in obstetric emergencies ... they have saved lives. I have seen it firsthand ... because I have not received training in that area. I know that they are available to assist me with caring for the mothers and babies whenever there is a complication. This gives me confidence to do my job and I learn from them. (P012)

Another participant indicated that the spirit of teamwork facilitated team cohesiveness and a common understanding of coping with shortages of staff in the facilities. Although not always a solution to the shortages of staff, participants indicated that they reached out to their colleagues who were off from work to come and assist whenever the workload was unbearable. As explained by the following participant,

Teamwork is important because when you are two, it is easier to tackle a problem faster than when you are alone. When the workload is too big for us, and maybe you are alone, we call other nurses who are off to come and assist us (P021).

Collaboration with community partners and stakeholders. Community partners and stakeholders were the external organizations that provided additional support for perinatal care services. These included non-governmental organizations such as the Academic Model for Prevention and Treatment of HIV/AIDS (AMPATH), which is a partnership between Moi University, and Moi Teaching and Referral Hospital, and a consortium of the North American Academic Health Centers led by Indiana University working with the government of Kenya; Pentecostal Evangelical Fellowship of Africa (PEFA); and Marie Stopes, Kenya. The stakeholders are mostly influential in HIV/AIDS care, Prevention of Mother to Infant Transmission (PMTCT) programs, and Family Planning programs.

The AMPATH centers in the rural communities followed up specifically with mothers and infants who were infected with HIV/AIDS. Although this organization has its own nursing staff who care for the mothers and their infants immediately after the infant is born, nurses and midwives collaborated with them by ensuring that the clients' care at the health facilities followed the plan devised for them at the community centers. Participants explained that on some occasions, nurses who were employed by AMPATH accompanied their clients to the health facilities. They also stated that they benefited from occasional training that was provided by AMPATH, as well as from the provision of extra resources required to care for the HIV mothers and newborns. Nurses and midwives therefore worked in collaboration with the AMPATH nurses to ensure the best health outcomes for these clients. As explained by one participant,

Yeah, we have also the AMPATH center in [Health Centre]. Most of their clients come to us for perinatal services including postpartum care. They have their own nurses [AMPATH]. They have trained their own nurses and they train us occasionally. That is a big help to us. They chip in with resources to care for their clients when they follow up with them. They make sure they get the medication on time. The AMPATH nurses take over with newborn care immediately following birth. Sometimes we don't have to take

care of the AMPATH infant because the AMPATH nurses take over from that point to make sure they get the first prophylaxis treatment. (P012)

Nurses and midwives also collaborated with the Marie Stopes Kenya staff in providing postpartum family planning. Family planning was considered important in preventing unwanted pregnancies as well as in promoting healthy spacing of infant bearing. Most of the participants indicated that the health centers provided all methods of family planning except the permanent methods. Therefore, Marie Stopes Kenya filled this gap by sending their mobile clinics to the health centers to conduct tubal ligations for women and vasectomies for men who were interested in these permanent methods of family planning. Hence, nurses and midwives coordinated with the Marie Stopes Kenya team in bringing free family planning services closer to their clients. One participant stated that:

We provide all family planning methods except for the permanent methods. We have an arrangement with Marie Stopes in Kenya where they come and give free family planning services. They [Marie Stopes] normally come and do mass family planning for tubal ligation and vasectomy. Our role is to organize with the patients who require these services and let Marie Stopes know. (P006)

The PEFA organization was helpful in following up on infant immunization and family planning for those mothers who were unable to obtain these services at the health facilities. PEFA provided transportation for the nurses and midwives so they were able to reach their clients in the community and provide them with these services. Other participants indicated that PEFA provided training to the nurses on good documenting of client care as well as writing reports following community visits. The following participant explained that:

We usually have mothers who attend care only once and do not follow up with their appointments as required. So, the manager from PEFA will help us to follow up with those mothers so that we can give immunization to the babies and also family planning for the mother. They provide us with transportation to the community and we walk from door-to-door in the community together as we offer the services to the mothers in their homes. Then they also come to the facility for quality management to see how we

document in the registers and report writing. They train us on how to document and report well. They usually don't victimize us if we are not doing it well. (P017)

Some participants explained how they took advantage of the school health programs and the community meetings that were held by the Chiefs (Chief's Baraza). Citizens were sensitized to pertinent health issues such as using skilled birth attendants, obtaining skilled postpartum care, immunizing their infants, and adhering to treatment regimens. They were also told about the importance of screening for tuberculosis and HIV. Similarly, nurses and midwives encouraged students to use good hygiene and develop good health habits with the hope that they would relay the information to their family members. The following excerpt from a participant explains how nurses and midwives collaborated with the community leaders, school leaders, and community volunteers to promote healthy habits in the community.

We have community mobilization program in our health center. With this program, we utilize the public health officers (PHOs) to go to the rural communities and sensitize the mothers on the importance of hospital deliveries. During the school health programs, we teach students about good health habits and we encourage them to relay the information to their parents. We also liaise with the community leaders who will inform us of the Chief's Baraza. We send a nurse or a PHO to Chief's Baraza to sensitize them on the importance of hospital delivery, postpartum care and immunization of babies, and screening for other conditions like TB and cancer of cervix. We also utilize the community health volunteers in sensitization of the communities and we ask them to refer clients to the health facility as needed. (P022)

As noted, community partners and stakeholders were instrumental in collaborating with the nurses and midwives, transforming their work through training and dissemination of best practices. Nurses and midwives benefited by developing skills through the learning sessions offered by the stakeholders within their communities. These stakeholders also provided the health centers with essential medical and pharmacological supplies that enabled the nurses and midwives to do their work.

5.2.2 Continuing professional knowledge and skills development.

The theme of “Continuing professional knowledge and skills development” illuminates how the new knowledge obtained by the nurses and midwives promotes evidence-based care for their clients. Formal nursing and midwifery education in Kenya emphasize primarily care during the uncomplicated perinatal period. However, complications during the perinatal period, particularly in the postpartum period, contribute to high mortality and morbidity rates for mothers and their neonates. Nurses and midwives thus require regular skill updates in order to deal with perinatal complications. Professional skills development is undertaken in different ways through course training, classroom education, post-incident huddles or debriefings, pamphlets, or as a life exercise. Continuing professional education created a healthy work environment for the nurses and midwives, and the knowledge allowed them to adequately provide care to the mothers and their infants.

Participants explained that most of the mothers who deliver at home would normally not seek skilled healthcare unless there was a complication to either the mother or the newborn. Knowing the necessary skills therefore creates an empowered environment for the nurses and midwives to deal with the life-threatening complications during the postpartum period. One participant explained how confident the nurses and midwives were when treating these complications after they had received training on emergency obstetric complications.

We receive referral cases from Sub-counties. Most of the referrals have life threatening complications like postpartum hemorrhage. Some of us have been given some training on dealing with these cases. Therefore, when we receive them, we take the initiative to find out the cause of the hemorrhage ... And if we determine that she has a ruptured uterus, that is when we call the doctor and we prepare the patient for theatre to repair the uterus. We can do more if we have the education you know. (P009)

Similarly, participants conveyed feeling confident in providing care to the mothers after completion of a continuous medical education (CME) course in obstetric care. CME is on-the-

job training that the nurses and midwives and other healthcare professionals receive periodically to enhance their knowledge in the current competencies required to deliver quality acceptable healthcare services. CME training can be either structured (classroom settings) or unstructured (huddle meetings). Participants indicated that when nurses and midwives are prepared to handle obstetric complications, the delay in receiving care at the health facility is minimized. Regardless of the means of knowledge delivery, participants emphasized the importance of the nurses and midwives being prepared to meet these postpartum emergency demands. As explained by one participant,

Most of the nurses and midwives working with mothers have received some basic knowledge on how to deal with obstetric emergencies through some non-governmental organizations, but a few nurses and midwives have been trained in dealing with complicated obstetric emergencies. It is better when we have more nurses trained in dealing with emergency obstetrics so that when we get a complication, we do not have to call and wait for the doctors to come, we want to start helping the mothers as soon as possible while the doctor is arriving. (P002)

Similarly, in some facilities, there was an education management committee that coordinated weekly topics to be discussed during CME sessions. The participants found these education sessions helpful especially when they were working alone at the health centers. The education committee also conducted training as huddles following management of any rare complication so that nurses and midwives were prepared when faced with similar situations in the future. The following participant explained that:

Okay, a management committee that coordinates the CME topics. Also, as a group, we suggest to this committee the subjects that we wish discussed. Anybody can come with a suggestion on the topic to discuss especially when we have a difficult case like a rare case like cord prolapse, we discuss. Sometimes when you are in a health center, you feel like you are isolated and you work without a doctor. So when we find such difficult cases we discuss so that we gain more knowledge. Because it is better to know how to deal with a case so that when you are alone, you know what to do. (P020)

Most of the nurses and midwives indicated that they took part in CME at least once a month in the form of case management discussions with their colleagues, or by receiving updates from the reproductive health coordinators.

The good thing is that we have CME every month. That helps keep us up-to-date when we are dealing with obstetric complications. We also have case managements within the facility itself, where when we get a case that is difficult to manage, we discuss it with the rest of the team so that we can improve on the management of these cases next time. (P004)

Participants indicated that they occasionally had structured CMEs, mostly to be introduced to any new maternal health policy or policy revision. These CMEs are held in a central area and nurses and midwives from all health facilities within the County are invited to attend. The attendees of the structured meetings received compensation for their transportation and as well a per-diem amount. The expectation was that the nurses and midwives who attended these CMEs would disseminate the new knowledge to the other nurses and midwives who did not attend the training. As explained by these participants,

We normally have CME when there is a new policy being rolled out. At least one nurse from each health center attends and they must give feedback to the rest of us when they return. We normally hold a meeting where they provide us with this feedback. Then they also provide us with training about the new policy (P005).

They are adequate because mostly whenever there are revised protocols and guidelines, we are expected to attend CME first so that we can be trained on the guidelines and the protocols before we can implement in our facility (P011).

As well, participants indicated that they took advantage of the monthly meetings to exchange ideas during the facility's Progress Report Submission. Each health facility is required to submit data on selected quality indicators such as the numbers of infants immunized, clients in family planning, hospital births, and mortalities, among others. In these meetings, participants stated that the nursing leaders took the initiative to network and to share best practices used in their facilities.

Sometimes when we submit our monthly facility progress reports at the County office, we exchange ideas. For example, if someone had difficulty in dealing with a problem, we discuss amongst each other on how to solve it. At these meetings, we also have CME to update on any new or revised postpartum management policies and practices. (P015)

Conversely, while some participants stated that they received equitable opportunities to attend the CME or other seminars on postpartum care, others expressed concerns with the irregularly distributed training opportunities amongst the nurses and midwives. Participants from both health centers and the referral hospital indicated that the training opportunities did not encapsulate all staff who required the training. For example, the following explanation from one of the participants indicated inequitable distribution of the training opportunities for the nurses and midwives in their facility and lack of transparency in the process of selection of staff who attended the training. The participant stated that because the training sessions came with other monetary incentives, it was likely that other healthcare professionals who did not provide postpartum services and did not require the training had priority to attend the training regardless of its usefulness. This participant stated that:

From my experience, I don't find it to be an equal opportunity as such [training opportunities]. I think the seniors take the opportunities and then if there are any other opportunities left, the new employees now may be considered We have the people in position ... the matrons, in-charges. Therefore, if they need two people to attend, then we can be sure that those of us working in the ward will not get it because they will be distributed to the administration first ... (Laughs) Yeah, like 90% of the time. You can find the people who are not using it, as in those who are doing administrative duties, attending a training on family planning or doing a training on newborn resuscitation, yet they are not in labor ward. The problem around here, these training [sessions] come with money. Yeah, that's what it is. So, if you go there, it's not about the knowledge. OK, knowledge is there, you will get the knowledge definitely (laughs) but at the end of the training, you get some per diem and some small money which adds up actually and becomes big money let's say at the end of two weeks, or sometimes six weeks. Yeah. (P012)

The study found that there was no standardized procedure on how the CME was offered to healthcare professionals in the County. From the participants' stories, it appeared that besides

the occasional educational meetings held by the County health leaders and with some external stakeholders, each facility conducted its education training differently. Moreover, the power imbalance created by the lack of a clear process in the distribution of on-the-job training opportunities did create a disempowered environment for the nurses and midwives. Participants indicated that staff that legitimately required the training could miss the opportunity to be trained, and as well, there was potential misuse of the already scarce resources. Nurses and midwives require empowerment in order to provide an empowered environment to their clients.

5.2.3 Creating an empowered environment through knowledge Translation.

The sub-theme “creating an empowered environment through knowledge translation” refers to the crucial moments when the nurses and midwives fostered an empowering environment for the mothers at their health facilities through health education and promotion. Nurses and midwives provided health education to their clients and other people who influenced the health of their clients. Participants in this study indicated that they were involved in the comprehensive education of mothers and their families during the postpartum period. They expressed pride in providing postpartum teaching to the mothers, especially on breastfeeding, hygiene, counseling, infection prevention, immunization, and family planning. Nurses and midwives took control of their practice by providing advocacy through their knowledge expertise. As explained by one participant,

Health talks [are] a big part of postpartum care. You educated these mothers on infant care, the danger signs of the baby for example, if the baby is not breastfeeding, having discharge from the cord, fever and any other thing that the baby might develop after discharge, urinal pain, discharge in eyes, not feeding well, so that is about baby care and the danger signs of the baby. Now, the health talk on the side of the mother, you educated the mother on nutrition, family planning, when to resume sexual intercourse, and the danger signs, for example, if the mother develops fever, if the mother develops lower abdominal pain, monitor vaginal discharge, that is the lochia. If the mother had a tear or an episiotomy, you educate on the care of the episiotomy ... we invite a counselor to come and encourage the mothers to do what they like to do most. For example, staying

with people, because our goal is for those people to know the changes happening with the mother. For example, a mother might not know when they are depressed, but others will know. So we encourage the mother not to stay alone. (P017)

Postpartum teaching entailed both individual and group sessions. Individual sessions provided the one-on-one teaching of specific tasks for particular mothers while the group sessions were used to teach mothers about general expectations during the postpartum period. Mothers received comprehensive teaching based on national postpartum care guidelines that focused on caring for themselves as well as their newborns. The comprehensive postpartum teachings began immediately following the birth of the baby. At these teachings, mothers were advised on how to watch for the danger signs for both their newborn and themselves. One participant explains that:

Immediately after delivery, we educate them on personal hygiene, if there is a tear or episiotomy, how to take care of it. How to watch for danger signs. We educate them on how to breastfeed the baby, how to latch, how many times to breastfeed the infant, how to do exclusive breast feeding not including water, unless it's only in medicine. We also give them information on family planning. We give them immunization information for the baby, and also what danger signs to watch for on herself and the baby and when to return to the hospital. (P012)

Family planning was understood to be an important component of postpartum care, and most participants were well conversant with methods of family planning that are offered in their health facilities. Although their insights on the timing of initial family planning following the birth of the newborn were not consistent, participants stated that they made every effort to ensure that there were no missed opportunities in providing these services to the mothers. As explained by the following participant,

For the postpartum mother, we usually have this method of “if this mother breastfeeds exclusively, she will be safe for 6 months,” then others we usually ask them to come to the clinic the day they start their monthly period, so that we can initiate family planning. For most of them, we usually tell them, after six weeks, you come for family planning. (P017)

Some participants explained that they initiated family planning based on their perceived needs of the mothers for these services. If the nurse and midwife determined that the mother was at risk of having another pregnancy sooner, they encouraged the mother to initiate family planning as soon as possible following the birth of the baby. In taking this step, nurses' and midwives' interventions advocated for and protected the mothers from unwanted pregnancies.

One participant stated that:

There are those we give immediate family planning and those we give at six weeks ... It depends on the vulnerability of the mother and the family ... if the mother agrees you initiate family planning methods immediately. (P004)

Other participants indicated that they provided knowledge to the mothers on family planning and empowered them to make informed decisions related to when to initiate these services. The following participant explained how knowledge on family planning methods having increases the mothers' confidence in choosing their preferred method.

During the postpartum period at the hospital, we give them talks on family planning and by the time the mother decides to start family planning, they are well educated on the different methods and will be making an informed choice. (P017)

Despite the efforts of the nurses and midwives in ensuring the success of the family planning program, limited availability of essential resources in health facilities, especially at the health center level, created missed opportunities for such crucial programs. Participants indicated that on some occasions, they referred women to the next level health facility for family planning due to a lack of essential resources to provide the services in their facility. Participants were also concerned that the unnecessary referrals could create missed opportunities with the use of family planning because their clients did not have the means to reach the next level health facility. Nurses and midwives also underused their skills due to the lack of essential supplies in the facilities that they worked in. As the following participant explains,

We can insert here [the Intrauterine Device for family planning] – like all of us have gone for the training, but we don't have insertion sets. This sometimes creates those missed opportunities because some mothers don't have the ability to travel to the referral hospital and so they end up being pregnant again sooner than they wanted to. (P011)

In order to limit the missed opportunities on the use of postpartum care services, participants went beyond the walls of their health facilities to provide these services for the mothers in the community with the support of the management in their facilities, “We normally walk to the community and we offer the services to the mothers in their homes” (P017).

A healthy work environment was crucial for the success of the nurses and midwives in Nandi County. When nurses and midwives were enabled, they provided pertinent postpartum services to their clients and prevented unnecessary postpartum complications and maternal, infant, and infant mortalities. Participants valued their essential supplies and equipment, their educational opportunities for professional development, as well as their ability to educate their clients on pertinent health issues. Thus, facilitators that created a positive work environment for the nurses as well as optimized health care provision were: availability of resources, professional intra-collaboration, professional knowledge and skills development, as well as knowledge translation.

5.3 Barriers to Postpartum Care

This theme describes the challenges that created an unfavorable working environment for the nurses and midwives. The participants believed that these barriers inhibited their ability to provide competent and evidence-based postpartum care to their clients. The barriers identified were either individual or structural. Examples of individual barriers were insufficient knowledge and skills to manage and prevent postpartum complications, and lack of individual professional development. Structural factors included inadequate staffing, inadequate physical space within the facilities, inconsistent availability of basic supplies and equipment, poor access to essential

drugs, lack of supervisor/management support, unclear healthcare policies, inequitable distribution of staff, lack of time, and undependable transport to the health facility due to poor geographic terrain. This theme has three sub-themes; 1) Staffing shortages, 2) Limited essential supplies and equipment, and 3) Increased workload related to caring for special needs of the mother and baby. Each sub-theme will be discussed below.

5.3.1 Staffing shortage.

Typically, the health facilities are understaffed with nurses and midwives and the shortage of staff was commented on by all participants. All were concerned about the inadequate numbers of nursing and midwifery staff and the subsequent poor staffing ratios in their facilities especially during the night shift. Participants indicated that this level of staffing is hampering the government efforts on universal health for all. They also indicated that staff shortages hinder the effectiveness of the postpartum services in rural facilities because of the limited contact of nurses and midwives with their clients. The following participant explained that:

Staffing is more challenging. We have very few nurses attending to so many mothers. We don't even have enough time to provide the education required to the mothers before they are discharged home because we are rushing to the next mother who has just delivered. (P002)

One participant was apprehensive because nurses and midwives were not able to attend on-the-job training for their continuing professional development due to staff shortages. This participant explained that since the healthcare sector is dynamic, lack of regular skills updates due to inadequate training could reflect negatively on the quality and safety of their practice. She states that:

First, for postpartum service to be effective, they have to improve on staffing. They have to improve on supplies, then also they have to do the on-job training and updates because the world is dynamic and there is always changes. So they should be taking nurses for training on the updates of the current management of mothers and the baby. But because we don't have enough staff to rotate, we miss these training opportunities. (P010)

Another participant explained that due to insufficient staffing, nurses and midwives were forced to take on the roles of other healthcare practitioners because they might be the only healthcare provider present at the health centers. In taking on these extra roles, participants indicated that they were not able to adequately perform their primary roles as per the postpartum guidelines. This participant stated that by taking on multiple roles that were beyond their capacity, the nurses and midwives exposed their clients to risks of preventable complications, as well as increased the chances of errors.

Being in the health center or dispensary, you are doctor, you are the nurse, you are the subordinate, you are the everything ... It affects one in such a way that you cannot do what you are supposed to do, like the observation in hourly or half hourly as per the guideline. Because if there is long line of mothers waiting for you on the other side, all you do is tell the mother who has just given birth to relax and rest and [you] will see her in another two hours. If the mother or infant develops a complication in between, you will not notice on time. So, this makes our work really hard! It is easy to make a mistake when you are overworked. (P004)

Similarly, another participant expressed that low nursing ratios lowered the quality of nursing care received by the clients and prevented nurses and midwives from performing to their full capacity. She indicated that clients would receive safe and better quality of care if the staffing ratios were adequate,

It is not adequate [staffing] because we have two categories of patients, acute, and the recovering ones. And you can have about 10 in each group. So for one nurse to manage about 20 patients, it is way [below] the WHO standards ... But now you cannot give such expectations where there is only one nurse managing such many patients. If the staffing is improved, then we can give the maximum care as per our training and experiences. (P010)

Fatigue and burnout in the nurses and midwives due to staff shortages. Besides compromising the quality of care, an insufficient staffing ratio brought about physical and emotional exhaustion of the nurses and midwives, “As a nurse, you know sometimes when you are overworked, you are exhausted, you have that burnout” (P011). Nurses and midwives were

fatigued because they were expected to work in various roles and be in several spaces at the same time during the shift assignment. Furthermore, they were required to work long hours to cover the staff shortages, as described by one participant.

In our facility, we have maternity and the other patients. We have children, women, and male wards all together and only two nurses on duty. And when there is a mother in active labour or 2nd stage of labour, you cannot have one nurse, you must have both nurses there in case anything happens. So, it means the other patients are left alone and in case of an emergency with the other patient, or an incoming patient that needs to be seen by a nurse, it means they will have to be neglected or someone has to stop to attend the mother in 2nd stage of labour and rush out to check out on the other patient. This is very stressful to the nurse and so, I don't feel staffing is adequate and safe. I feel like if we had three on the minimum or four that would be probably the best. (P012)

Findings also revealed that the nurses' and midwives' personal lives were destabilized by being irregularly and frequently on-call. The following participant explained how the shortage of staffing has forced task shifting for the nurses as well as taking a toll on their personal lives.

The issue of staffing is distressing. We had proposed to the County to be given more nurses in the rural set-up. Most of the time we usually do our local arrangements amongst ourselves so that if someone was off-duty and there is a lot of work in the maternity, we can request him or her to come and assist, then we can give them another day off. So the staffing should be restructured so that we can also have our lives back. (P021)

5.3.2 Limited essential supplies and equipment.

Participants acknowledged that improving the health of the mothers and their babies is a priority in Kenya. However, they indicated that there are limited resources allocated to address this priority. Participants were concerned that the lack of essential resources, such as drugs, wound dressing supplies, equipment for taking vital signs, running water and electricity, among others, negatively affected their response to their clients' needs at the healthcare facilities. One participant explains that:

Some other barriers are the lack of supplies eh, like non-pharm, like, for example, the gloves, these other things like branulas, some other drugs which may help you during postpartum like oxytocin, you find that it is really hard to work when they are out of stock. (P013)

In addition to insufficient supplies, some participants talked about unsafe organizational practices such as the rationing of essential supplies, making their work difficult and unreliable. One participant elaborated that in their facility, they were provided with limited daily ratios of essential supplies such as gloves. This participant also complained that lack of running water was challenging to their practice as they spent a lot of time trying to fetch water from the tank reservoirs located outside of the facility.

I can say lack of supplies ... Sometimes we are just given two boxes of gloves and we are supposed to miraculously use them for three days before going back to the supply store to get more. So supplies sometimes are a challenge. Like I told you before, many times, we run out of some important drugs like oxytocin. You know how important that drug is for a mother immediately following birth. We also have the water problem in [name of health facility]. We do not have a constant supply of water, the pump is down, like more than 50% of the time. So, in those instances ... we have to get it from a small well outside and a few tanks outside that we have for reservoir ... We need tap water, running water, you know, when fetching water with a jug (laughs), you don't feel it's enough hygiene especially if you have to clean up the place after delivery ... Yeah. It is quite a challenge. (P012)

With the same sentiments, participants voiced that shortage of essential supplies such as gloves created unsafe working conditions and placed the nurses and midwives in a vulnerable position for infections such as hepatitis and HIV/AIDS. This also compromised the safety of the mothers and their newborns as they were unnecessarily exposed to these potential life-threatening infections.

Sometimes we don't have enough supplies like gloves. This is very risky because of the infections that we can catch. It is also bad for the mothers and infants because they can also be exposed to infectious diseases. Sometimes the AMPATH partners chip in but most of the time we don't have any. So, we have to improvise, or they have to buy. (P008)

Other participants indicated that the lack of essential resources could be attributed to poor procurement and management of supplies in the health facilities. As expressed by one participant,

At times they give us a good supply of drugs and other supplies, but other times when you request for supplies, you are informed that the supplies are not available because they have not received any from the County so you are left wondering what to do with the clients. They should order these supplies on time so that we don't lack them when we need them (P002).

Forcing clients to buy supplies for care. Due to insufficient supplies at the health facilities, mothers and other recipients of care were often required to buy the essential supplies such as gloves, needles, syringes, and sometimes drugs at this point of care. The following participant was concerned that the lack of essential supplies at the health facilities would push the mothers away from seeking skilled healthcare.

It is a bit challenging because as per now, most of the clients are aware of the “beyond zero programs” that include free maternity services, so it reaches a point whereby we lack supplies. So it becomes a bit challenging because you want them to come to deliver at the hospital, then when they reach the hospital set-up, there are no supplies, so they are forced to buy, of which to some, they are not able to buy. So you see, most of them will comment “if we go to the hospital, we will still be sent to buy this and that, we better move to our nearby midwife who can assist us and we pay them back.” It is a good initiative whereby they want all mothers to deliver in the health center but the shortage of supplies makes it a bit challenging. (P022)

Without discounting the free maternity services, some participants indicated that they preferred the old system where mothers paid a small fee for service. They explained that with the fee system, the health facilities had a constant supply of money, which could be used to buy emergency essential supplies at the health facilities.

Poor procurement of major equipment. The majority of the participants revealed that the beds used in the health facilities are not ergonomically suited for hospital use because their height was not adjustable. Moreover, most of the beds were not the proper obstetrical beds, hence placing both mothers and nurses/midwives at risk of musculoskeletal injuries due to improper posture during care. Another essential piece of equipment missing in most of the health facilities were incubators, putting newborns at risk of developing respiratory distress if they were

unable to be kept warm immediately after delivery. Most participants explained that the procurement of supplies and equipment worsened after the devolution of the government in the year 2010, when healthcare services were handed over to the County government. As the following participant explains,

The government is trying, but after devolution, things became different and difficult to survive. We have been having shortages of supplies very much ... supplies have been a problem since devolution ... Yes, it was better [the supply chain before devolution] ... But from the County government, things have been worse ... For instance, we are lacking important equipment in our health center, we don't have an incubator that can provide warmth to the newborn, like the ones in the County referral. Expansion of the facility is also necessary. We have only one delivery bed and sometimes you have three mothers delivering at the same time. So some will deliver in the antenatal ward because we don't have a place for them to deliver. Even the beds in the antenatal unit cannot be adjusted to the right height, so it is easy for the midwives to hurt themselves while assisting with the delivery. (P021)

Nurses and midwives require the necessary tools for them to provide quality care to their clients. They need an adequate and constant supply of essential supplies and equipment in order for them to intervene in various practice conditions.

5.3.3 Increased workload related to care of special needs mothers and babies.

The maternal and infant health services are integrated with family planning, prevention of mother to infant transmission (PMTCT), and infant welfare clinics. The integration of these services aims to improve the quality of the services offered, reduce costs, and save time for mothers. Having these services under the same umbrella is convenient for mothers and their infants and reduces missed opportunities for these services. Conversely, participants indicated that some programs and particularly the PMTCT increased the workload of the nurses and midwives, due to its required intense assessments and need for documentation. The following participant explained how the PMTCT program has created “extra work” in their already busy

postpartum practice because of the detailed assessments and interventions that these clients require.

PMTCT clinic is more work ... The extra work for these mothers is that besides the routine postpartum care, we do investigations if they are due for them, for example, viral load, send them to the lab for those investigations. We also provide them their routine medications, which take a lot of time dispensing them. So it is extra work. We also have adult visit forms that we fill in information if the client has any complications. (P021)

In addition to the increased workload due to perinatal care, participants explained that integrating HIV programs with other maternal and infant programs has impeded other health initiatives such as focused postnatal care. One participant argued that the strict adherence to data collection and closer supervision for the PMTCT program competed for the nurses' and midwives' time as well as for space in providing postpartum care services.

It is still low [utilization of postpartum care]. Underutilized. One problem is that space is not there. We have come up with so many programs that even the space we had put for postpartum care is already being utilized by something else that is more aggressive or looks more interesting than the postpartum. It is like PMTCT is competing with postpartum, while the same staff are expected to provide these services. The data collection for PMTCT is very strict, and the supervision is also very strict, so it takes a lot of time. (P016)

In order to increase the satisfaction of nurses and midwives in the provision of postpartum care, it is necessary to implement relevant policies that respond to the health needs of postpartum women and their babies as well as to avoid competing tasks for the nurses and midwives. It is evident that nurses and midwives cannot give the time that they do not have. Although participants in this study indicated that they made every effort to provide quality and efficient care to their clients, their efforts are challenged by an unfavorable working environment powered by inadequate human and material resources.

This theme has described the challenges that have created an unfavorable work environment for the nurses and midwives such as staffing shortages, limited numbers of essential

supplies and equipment, and increased workload due to intense extra assessments and documentation for those special-project clients such as the PMTCT that arose out of the HIV/AIDS programs.

5.4 Transcending Adversity

This theme emerged when the majority of the participants expressed the need to overcome the current contextual factors affecting their current practice. Nurses and midwives in this study explained that they faced many challenges in their workplace that included shortages of staff, lack of essential supplies and equipment to adequately do their job, increased work load, lack of autonomy, and increased occupational hazards due to limited resources. However, participants in this study were not giving up on their work. They indicated that despite all the challenges, they had hope that the nurses' and midwives' experiences would improve if the right policies and changes are effected in the Kenyan health sectors. When asked if they intended to leave their current job, most of the participants answered "no."

Participants also commented on how some policies such as the Free Maternity Services (FMS) policy have increased access to skilled healthcare services. With the FMS, the number of clients seeking skilled health has dramatically increased, whereas the number of healthcare staff attending to them has remained the same. This has caused a heavy workload for the staff and it has reduced the quality of care provided to clients. Participants showed that they owed it to their clients to provide the best care they could, irrespective of these constraints. The findings under this theme has been categorized into three sub-themes: 1) Powerlessness, 2) Limited leadership roles, and 3) Resilience.

5.4.1 Powerlessness.

The sub-theme of “powerlessness” emerged when participants expressed feelings of lack of control over the care that they provided to their clients. They indicated that efficiency of their work is compromised by constraints that they do not have control over. Some of the constraints identified were: lack of resources to do their job, poor staffing ratios, inadequate equipment and lack of essential medical supplies, inconsistent access to essential drug supplies, and inequitable distribution of educational opportunities. Although nurses and midwives did not approve of their current working conditions in rural health facilities, they believed that they were providing ethical and professional care to mothers and newborns with the resources available to them. Even so, these situations made them feel helpless, as expressed by the following participant:

I feel like I am not giving my best when the clients are so many, and I am not monitoring these mothers well because I have to rush to the next because I don't have another nurse to help me. At times, we can be busy with the other clients, and maybe the fetal heart has changed somewhere, and you don't know, so it makes me feel so helpless and bad about the situation. (P002)

Several participants talked about “getting by” these stressors. They indicated that most of the challenges that they faced were a result of healthcare structural failures that they ultimately did not have control over. The participants stated, however, that in most circumstances, the nurses and the midwives are blamed for poor patient outcomes. Some of the participants indicated that some negative outcomes, including death, could be a result of lack of essential treatment, or it could be because it was a person's time to die. The following participant explained how reactions from others induce a sense of powerlessness for the nurses and midwives.

Yah, we are providing good services with the resources that we have, but then, the outside people, they will never see that. There is always that room, a mother can die while undergoing our services, sometimes because of lack of essential treatment, and sometimes because it was their time to die. But then, people from outside, they will

never believe that the mother is supposed to die. It is not we who called the death. That one, it was, when this mother was not yet born, God had planned that this will happen. Then you feel as a midwife, I have really tried to help this mother, and then at the end of it all, she dies. It will never give you that motivation even to serve the other patients. You feel there is something that has blown off from you (touching her chest with sad emotion). It is painful, you have to relax first. But you have to accept it, it has to be there. If it was harder to leave you, or it was the day to leave her baby, you have to accept, but it is painful, but there is no other way you can express it. Therefore, there is nothing you can do, but just to get by all these. (P007)

Most participants indicated that the lack of time was a major factor in derailing their care practices. Each required task from the nurses and midwives entailed use of time. Participants explained that the time they spent with their clients was limited due to high patient ratios, compounded by poor staffing ratios in their facilities. Participants commented that because of the limited time coupled with disproportional nurse/midwife client ratios, they felt “rushed” while providing care. They felt that the limited time they spent with the mothers negatively affected the quality of care they could provide. The following participant explained how nurses and midwives could miss an opportunity to provide pertinent education to their clients due to time constraints made worse by staffing shortages.

You know, we are supposed to provide care as per the postpartum care guidelines, but we don't have enough time to take care of all the women that come to us. They are too many and we don't have enough staff to take care of them. We are rushing so much that sometimes we miss to educate the women on how to take care of their infants and prevent complications at home. (P011)

Being forced to take short cuts. Some participants explained that although they were aware of best practices as elaborated in the postpartum care guidelines, they had resorted to improvising care because of insufficient staff and unavailability of essential supplies, equipment, and drugs. The following participant illustrated how nurses and midwives were not following protocols on the dilution of *jik* [disinfectant]. She explains that although she likes to follow the right protocols, she has no power over the lack of resources.

You know you are supposed to work according to the guidelines, but you are forced to improvise a few things. Because you find that you are being told to dilute jik to a certain ration, and then maybe the jik is not enough and so you are forced to do your own thing outside the guideline. Or you find that the jik that the client brings is not the same as the ones that we are provided by the government, so when you dilute to the ration provided, it is not the same as when you dilute the government one. Mostly we improvise ... Personally; I do not feel good because I like doing the right thing at the right time. I do not like short-cuts but situations force. Especially when you are in a rural set-up like in the health center, some things are very difficult and you don't have power to overcome them ... We are doing this because we lack supplies. (P021)

Another participant reiterated how nurses and midwives felt powerless due to losing the quality of care that they want to provide during the postpartum period because of inadequate resources to do their work. She explained how conducting a procedure such as birthing could be compromised due to inadequate sterilization devices or disinfectants.

We are not getting all the necessities for maternal infant healthcare. So, there are cases where we don't know how to sterilize the instruments because the autoclave is not there, the Jik is not there. Therefore, you wonder how you will conduct a delivery and call it a skilled delivery when you don't have jik and autoclave! So that's the biggest problem that we have and we don't know what to do about it. (P006)

These feelings of powerlessness struck me as I spoke to the participants during individual interviews and the focus group discussion. Although most nurses and midwives had no intention of leaving their jobs, I could see from their responses that they needed the healthcare system to change for the better. I noticed from their responses that they empathized with their clients and wanted improved health outcomes for them. Because they are the main healthcare providers in rural Kenya, nurses and midwives could turn their feelings of powerlessness into powerful political action by speaking up and making themselves heard in order to improve health system administration and organization.

5.4.2 Limited leadership roles.

This sub-theme refers to the devaluing of nursing work, which has led to inferior treatment of the nurses and midwives in comparison to other healthcare professionals such as

doctors and clinical officers. Participants indicated that there was limited involvement of the nurses and midwives in health leadership roles. Some explained that the healthcare organization has not maximized their potential capacity in leadership roles. One participant believed nurses and midwives were oppressed by being denied opportunities in pertinent health management and leadership roles. She explained that nurses were denied the opportunities to act in managerial roles such as hospital administrators, regardless of their education, while other disciplines such as medical doctors and clinical officers are prioritized.

Mostly in Kenya, nurses are neglected. In fact, if you saw something recently, the president signed a bill that nurses should not be allowed to be in managerial positions ... they don't actually recognize nursing. They think nursing is a helping hand but the real managers ... even when you see our structure, the organogram of the hospitals, like the big hospitals now. There is a doctor up there, and then there is a nurse down below the doctor. It is not nursing department and medicine ... the doctors are managing us. Even clinical officers have now been given the mandate to manage the hospitals. Like the administrator now for the hospital can be a clinical officer or a doctor, but not a nurse. Even if the nurse has a master's in hospital management, it is not even necessary anymore because they won't recognize them. It is something that just happened recently. (P012)

Not recognizing the leadership role that the nurses and midwives could play has led to limited participation in management in the healthcare organization and limited involvement in the development, implementation, and monitoring of health policies and guidelines. The concentration of power among other healthcare professionals such as doctors and clinical officers has led to a lack of motivation among the nurses and midwives, as they feel unsupported, unrewarded, and unappreciated for their work. The following excerpt from one participant explains that although there was a nurses' strike, where nursing staff did not report to work due to unmet demands such as poor compensation, there seemed to be a lack of action by the government to address their demands so that they could return to work. She argues that nurses

and midwives are underrepresented in management positions, and those in power have less understanding of their current working experiences.

Another thing is that the nurses are not well represented in the management level of healthcare. So the ones there really do not understand what we go through and do not have any urgency of helping the situation. They don't even recognize us, like now we are on strike asking to be compensated for our work but it is like no one is listening. This strike has gone on for a long time and patients are suffering. (P017)

In general, nurses and midwives are leaders, in that they foster positive relationships with clients and are collaborating with other healthcare professionals. This everyday leadership role promotes the well-being of the nurses and midwives, as individuals, and results in some appreciation for their nursing work, as well as for the nursing profession in general. The organizational hierarchies that bar nurses and midwives from leadership and managerial roles beyond the ward level contribute to their absence from healthcare policy dialogues. Nurses and midwives must be present and well-represented in policy dialogues in order to further develop their collaborative approach and strengthen the healthcare system in general.

5.4.3 Resilience.

Most of the participants articulated that working in rural Kenyan communities required resilience. Resilience refers to nurses and midwives being able to overcome and adapt to challenges while providing care to their clients. Participants explained that notwithstanding the several challenges and stressors that nurses and midwives faced at work, they have learned to acclimate to changes affecting their responsibilities and overcome adversity. Most participants stated that despite these challenges, the love of their work and their expertise in frontline perinatal care enabled them to still continue taking charge of the situation.

It is ok because when you are committed to doing your job and you are comfortable in your heart doing your work, you have to do your best to make sure that the mothers and their newborns have received satisfactory services. We try our best to give these mothers and their newborns the best quality of care with the little resources we have. (P020)

Others outlined their efforts to support postpartum mothers and their newborns in receiving dignified care, which included using their own personal resources such as razor blades, disinfectants, and Band-Aids. “We ensure at least we have a pair of gloves in the pocket for emergency. But you cannot improvise the gloves. I just buy mine, for emergency” (P005).

Similarly, another participant indicated that in order to provide quality care that adhered to the postpartum guidelines, nurses and midwives in her facility contributed money to buy essential supplies such as gloves, cotton wool, and alcohol rub. She said that they did this because of inadequate facility budget management.

We try, because we owe it to ourselves and to the mothers. Sometimes, it comes a time where we have to contribute money to buy supplies like cotton wool, razor blades, gloves and spirit to help these mothers. We have a very good in-charge [nurse]. Whenever we don't have supplies, she asks us if we can contribute some money to buy them so that we can provide good care to the mother. But this should not be happening because if we had a bill that governs the revenue of the facility finances, then we would have money to purchase the supplies. (P007)

To some, resilience was due to their professionalism and belief in their calling to become a nurse. For example, the following participant explained that,

I became a nurse to help people and that is what I have to do no matter what I am going through at work. All this will pass and maybe one day we will have all we need at work. I even use my own money to buy gloves and gauze for my patients if they don't have. What else can I do? (P018).

Moreover, nurses and midwives deliver their services under demanding conditions because they understand that postpartum care, when provided as per the evidence-based postpartum guidelines, could prevent complications for both the mother and the newborn.

It has a lot of importance [postpartum care]. In fact, if it is done the correct way, then you would reduce the hemorrhages, the secondary hemorrhages after delivery. You will reduce the infections and the deaths of neonates within 28 days. It is really important, that is why we have to do all we can to provide good postpartum care to the mothers and their infants. (P016)

As the nurses and midwives form the bulk of healthcare providers in Kenya, they are the main providers of maternal and infant healthcare services including postpartum care in rural communities. Nurses and midwives understand the needs of perinatal families; therefore, even in the face of constraints such as limited supplies, staffing shortages, and inadequate space to provide care, they cope with the competing pace, demands, pressures, and chaos at their work places to address these needs.

Because of the value that the nurses and midwives place in their professionalism and the health outcome of their clients, nurses and midwives have found ways to circumvent their adversities at work. For example, as one participant asserted, “I am glad I can always call on my colleagues to come and help when I am alone. They come because they know they will need me one day” (P012).

As evidenced by the participants’ views and responses, nurses and midwives have not always been seen as leaders in healthcare transformation in Kenya. However, I disagree with this perception because most of the participants believed that they had the capacity to influence the health system and provide good leadership to the sector. Nurses and midwives are knowledgeable professionals who are capable of leading change in healthcare organizations. Given necessary resources, they can make notable changes in the healthcare system to meet the demand for safe, quality, and affordable care for all. Hence, nurses and midwives require supportive healthcare systems that will endorse their influence in the leadership sector.

This theme has exposed the limited authority of the nurses and midwives to influence their current practice, evoking feelings of powerlessness and lack of control over their work and denying them leadership roles. At the same time, it has also demonstrated their resilience within their work environment.

5.5 Social Support System

This theme refers to the network of support necessary for women and their families to thrive following the birth of an infant. Nurses and midwives viewed the social networks as crucial for shortening the delays in seeking care during the perinatal period. Hence, they advocated for the mothers by sensitizing the community to knowledge related to complications and prevention of those complications during the perinatal period. The social support system encompassed eliciting support from immediate family members, friends, and community members. Participants believed that social supports would provide mothers with an avenue for successfully dealing with a stressful life situation. Through these supports, mothers could be provided with emotional support and physical assistance, helping them to navigate the complex nature of the current health system. This fifth theme has four sub-themes: 1) Family as a social support, 2) Support from friends and other community members, 3) Support from community health workers, and 4) Cultural context of postpartum care.

5.5.1 Family as social support.

Family was seen as an integral part of postpartum care in the study setting. The participants explained that they encouraged family members such as spouses, mothers, sisters, aunts, and grandmothers to visit the mother and her newborn during the postpartum period in order for them to provide emotional support. Participants understood that the postpartum period could be a stressful time for new mothers and their immediate family if the basic needs that bring comfort to them all are not met. Therefore, participants educated the family on how to identify and attend to the danger signs during the postpartum period. As explained by one participant,

In our facility, we encourage mothers to come with their spouses or come with their relatives whom they stay with regularly so that when we are educating them and showing them what to do in case of postpartum emergency, the others learn. As if, for example, if the mother has delivered and she has no husband but is staying with her mother, it means

that her mother is the one who will take care of her baby while she is recovering, or in most cases the girls who deliver while they are still in school. So, we encourage the young mother to bring their mothers so they can both learn how to watch for the danger signs for the mother and the baby. (P016)

The involvement of husbands was necessary because in most households, men are the decision makers. The following participant explains why she encouraged husbands to attend all perinatal clinic appointments because she wanted them to understand the perinatal process and its potential effects on the mothers. She indicated that when men understand, they act appropriately during postpartum emergencies.

That is why it is very important to involve the husband throughout the perinatal period because they are the decision makers of the homes. I always encourage them to attend education sessions. They can make the decision for the mother to go and deliver at the hospital, and also they provide them with transport to the hospital. So, they come in handy during emergencies because they understand the seriousness of these complications. (P021)

Similarly, the results of this study found that husband involvement during postpartum care promoted good health outcomes for the mother and her newborn. Other participants explained that they involved the husbands because their presence helped reduce anxiety and depression for the mothers due to their reassurance in uncertain situations during the postpartum period.

If you separate the husband from the wife and his newborn, he will be tortured and the wife is also tortured. He will want to see his infant. So, it is good to be having both husband and mother together with the baby. This reduces anxiety and also the chance of the mother getting depressed because the husband reassures her when she is uncertain. It is important that the husband stays with the mother after the infant is born. (P001)

Conversely, some participants indicated that mothers still valued the tradition where grandmothers or other elderly women in the community guided their care during the perinatal period. Traditionally, in this study setting, grandmothers are influential in meeting the basic needs of the mother during the postpartum period and they assist them with basic personal care

and household chores. Participants therefore expressed that they had to be tactical and strategic on how they provided information to mothers so that they could get buy-in from the grandmothers. Participants recognized that if the grandmothers did not understand or if they disagreed with the information provided, their health education would not be effective, as most of the mothers would normally do what the grandmothers recommended. Participants explained that they invited grandmothers and other relatives to the health talks during the postpartum period as a way of improving knowledge transfer. For example, as the following participant explains,

Yah, we always give education to the mothers during antenatal and postnatal visits, but we know that those grandmothers back at home have more power over what the mother will do. I think the community does understand them more than even the healthcare professionals, so when they say something, the mothers listen to them more than even the health care workers. That's the challenge, we have been trying to capture them [grandmothers] to accompany the mother during the visits so that they can learn the importance of the teaching that we provide to the mothers, for example, how to ensure the mothers received a balanced diet all the time, especially after the baby is born. (P002)

5.5.2 Support from friends and community.

People in rural Kenya live in communal settings comprised mostly of family, friends, and neighbors. Family, friends, and the community are an integral part of supporting mothers and their immediate family during the perinatal period because within these groups, there are women who have experience with social roles as well as the postpartum period. One participant explained that the experienced women would advise mothers to utilize skilled healthcare during the perinatal period because they had come to understand the consequences of postpartum complications.

However, when you find other mothers in the community who are aware of postpartum complications, they try to encourage others to use the hospital when having a baby because they know that it can be dangerous for the mother to deliver at home. (P009)

Similarly, another participant explains that, on some occasions, family, friends and neighbors assist by bringing the mother to the hospital and providing the nurses and midwives with the mother's health history if she is unable to communicate.

We also have the support of the relatives and friends who bring the mothers to hospitals. These people are a great help to us. They help us with comforting the mothers and taking care of the newborn. Sometimes you find a mother who is not able to communicate or who doesn't know what is going on, for example, they could have given birth on their way to hospital and you find that the mother is now exhausted or even suffering from postpartum hemorrhage; these people speak for them and help us in getting the history. (P012).

The involvement of family and community members provided more understanding for the nurses and midwives in managing the expectations of the new mothers around the support from their loved ones. The nurses and midwives were able to gauge the likely support that the mothers received in the community, based on day-to-day discussions with them, and planned on any support required, such as counseling, in order to prevent postpartum depression. They also provided the mother with information regarding any referrals that would be required in the community. As explained by one participant,

I do counselling to the mother as required. I take history on admission to look for support networks and any signs of depression or stress. I ask the mother if she has any help at home, if not, how is she managing with the baby. Then I act as per the history provided. (P009)

5.5.3 Support from community health workers.

The community health workers were noted as key players in positive health outcomes of the mothers and their babies during postpartum care. This is because they provide or facilitate access to health services directly to the households. Having the ambulance number was significant to mothers because some of them live in areas where the nearest health facility is a dispensary. Because dispensaries close by around five in the afternoon, transportation to health centers or hospitals was challenging due to poor geographical terrain and road infrastructure. For

example, one participant explained that with the help of the community health worker, mothers were able to utilize County ambulances for transportation to healthcare facilities during a health emergency. Community health workers were influential in knowledge translation to the community regarding the use of emergency services.

We get most mothers from the peripheries because most of the health facilities (dispensaries) do not conduct deliveries and they close as early as five in the evening. So everybody in the community including the pregnant mothers have access to the ambulance number, so that even if the pregnant mothers are not able to call for the ambulance because they are in labor, other people can call for them. The community health workers can also call the ambulance even if the mother has delivered at home so that they can be assessed at the hospital after delivery. So, it is really important that the community is aware of these rules. The community workers help a lot to pass this information to the community. (P002)

Similarly, nurses and midwives enlisted the help of community healthcare workers during home visits for infant immunization and family planning. Because these workers were familiar with the people in the community and their ways of making a living, they were better placed to sensitize the community on issues that affected its health. As explained by the following participant,

The community healthcare workers help us a lot with the education of the community to use postpartum services including immunization of the infants. They understand the people in the communities and they are respected by the community. So we normally go with them when we do immunization or education in the community. (P009)

The value of traditional birth attendants (TBAs). Although widely discouraged by the Kenyan healthcare system, some women still prefer to use TBA services for childbearing procedures including postpartum care. Participants acknowledged that the TBAs were an important social support for passing relevant health information to the mothers. They indicated that some women preferred to use TBAs during the perinatal period because of the trust that they have in them as well as the minimal cost they incur when they use TBAs instead of attending the

health facility. Some of the reasons provided for using TBAs included their friendliness and the affordability of their services. The following participant explained that:

I think they prefer the TBAs because that is who they know. These are other elderly women in the community that are being respected by the mothers. The mothers trust them better than the hospitals. They also pay them [less] money than what the women would spend in hospital. (014)

Regardless, TBAs can expose the mothers and their newborns to harmful procedures such as manual maneuvers to reposition the baby before delivery. The TBAs also use unconventional procedures whenever they are faced with difficulty during delivery of the baby, such as using sticks to expand the birthing canal. As explained by the following participant,

Yeah, most of the complications we see are from home deliveries. You know these mothers go to the TBAs to give birth but when there is difficulty delivering the baby, they do maneuvers and get injuries to the mother and also to the baby ... they try to use any other means to deliver the baby even using sticks in situations where we would be using vacuum extractor at the hospital. (P013)

Therefore, as a means of preventing complications during perinatal care, nurses and midwives embarked on educating the community, including the TBAs, on the importance of using skilled health services. Nurses and midwives recognized that TBAs can play an important role in women's health during the perinatal period. The participants indicated that TBAs could be a link between the community and the health facilities if they advised mothers to use skilled services. The following participant explained that:

They value their TBAs so much (laughter). But of late, we are changing the routines by educating the TBAs to refer the patients to the hospital, so that they can have a hospital delivery instead of delivering at home. We have educated a lot of TBAs now and we have seen a big difference where they refer the mothers to come and deliver at the hospital or even to come for checkups after delivery. But some still deliver at home. (P008)

Unfortunately, women still arrive at the health facilities with complications such as postpartum hemorrhage, triggered by procedures performed by the TBAs. Because the TBAs

did not accompany the mother to the health facility for fear of repercussions, family members were advised to avoid seeking help from such women.

Sometimes they go the TBA and end up sustaining a lot of injuries that [make it] hard for us to try and save this mother after being tampered [with] and [who is] now bleeding profusely. They will mostly bring them to hospital only if the mother's condition is becoming worse. The midwives don't come; they fear because they will be asked who did this so the relatives escort their patients to the hospital. So in cases like these, we still encourage the family member to be vigilant so that the TBAs do not continue with such behaviours. They need to stop them. (P006)

Although most of the mothers are now utilizing skilled health services, there are still many mothers using TBA services in rural Kenya. Some of the reasons for using TBA instead of skilled health services are financial, personal preference, and lack of knowledge. Despite the free maternity services, mothers are still being asked to purchase essential supplies such as gloves, cord clamps, and in some situations, emergency medications used to treat postpartum complications such as postpartum hemorrhage. Mothers therefore could prefer to use TBAs because they are certain of the amount to pay them instead of seeking skilled healthcare and facing uncertain charges for the services. Others prefer to use TBAs because they perceive TBAs to be friendly to them. There has been a great deal of literature indicating abuse and disrespect of mothers in the health facilities during the perinatal period. Hence, mothers might be advised by other mothers who did not have a good experience at the health facility against using skilled health services. Some mothers might use TBAs because they do not have enough information about the necessity and importance of using skilled health. They might not be aware of postpartum complications that could be prevented. Hence, nurses and midwives have taken the initiative to educate mothers during antenatal care and as well, to educate the TBAs to encourage the mothers to seek skilled health services during the postpartum period.

5.5.4 Cultural context of postpartum care.

The sub-theme “cultural context of postpartum care” emerged out of participants’ responses revealing that culture plays a big role in what the community believes to be healthy. Since the community views pregnancy and childbirth as normal processes, some mothers did not see the necessity of seeking skilled health services. Mothers pursued them only when they encountered obstetric complications such as postpartum hemorrhage, respiratory distress for the newborn, or puerperal sepsis. Hence, as the following participant explains, mothers who delivered at home would only go to the health facility whenever they were faced with postpartum complications.

Mostly, those who come with complications are the ones who delivered at home. When some deliver at home, they don’t come for assessment in the hospital unless they have complications. So, usually they come with POC [products of conception], complaining of continuous bleeding with foul smell, others come with fever, puerperal sepsis, but those are mostly the ones who deliver at home. (P018)

Different participants had different explanations as to why women did not seek skilled healthcare during the perinatal period. Some believed that they were superstitious; they did not bring their newborn to the health facility for immunization and other assessments because they feared that it would be “seen by women with bad eyes” at the clinic.

They believe that when they interact with other mothers, they can be seen by women with bad eyes giving the newborn oral thrush infections and other diseases. So, they either decide not to attend postnatal clinic, or they give them herbal medicines to prevent them from getting sick. The herbs could interfere with the health of the baby. (P018)

Other participants were aware during the care they provided to the mothers because they understood that previous experiences at the health facilities could have affected the uptake of these services. Participants indicated that if a mother was not satisfied with the services received in a health facility, she would advise other mothers against using them. As one participant stated,

I think sometimes, if the woman did not have a good experience before, they will decide not to come back. I also think that these women talk with their friends. If the friend was not satisfied with the care at the hospital, they will advise the women not to come to the hospital to deliver or for other services. So we try so much to make sure the mothers receive good care so that we they don't run away from us. (P008)

In fact, one participant pointed out that some mothers, especially school-aged girls, feared to attend perinatal services due to uncertainty about their reception at the health centers. This is because of society's view of pregnancy in Kenya, where the expectation is that only married women engage in sexual activities. Therefore, when unmarried women become pregnant, Kenyan society views it as shameful and some of the women would rather hide their pregnancy than face this shame. For example, as the following participant explained,

For the primigravidas, especially schoolgirls, they don't come to the hospital for care because they fear that they will be scolded by the nurses or maybe they are hiding the pregnancy so they know if they come to hospital, their parents will know ... No that used to happen before but not now. We treat all of them the same. We even give them extra time because they need a lot of teaching as first-time mothers. (P021)

Although most of the participants indicated that they did not witness many negative cultural practices within the community in the study setting, they did report that some practices, like seclusion of the mother and her baby, the value of traditional birth attendants, and the use of herbs, could bring about negative effects to the mother and the newborn during the postpartum period.

Seclusion of the mother and baby. Confinement of mother and baby for several months following childbirth is a common practice in most Kenyan communities. This practice was meant to keep the mother and the newborn safe from witchcraft and infections from other people. One participant stated, "For the mothers, the traditional way is really good for the mother because she is secluded for three good months being fed only. So it is very good for the mother actually" (P016). However, the mothers who practice seclusion will mostly miss their immediate

postpartum appointments at the health facilities, normally returning when they bring their infants for immunization at six weeks following birth.

Once they [mother and newborn] are discharged from the facility, they stay at home in seclusion until six weeks. They will not come in for the in-between assessments as per the protocol. There is that belief that when an infant is still small, eh, they are not allowed to be around other people – are not supposed to be seen by other people because the infant will get sick. (P014)

Another common reason cited for seclusion was that in some communities, it is taboo for a couple to engage in sexual activities for at least three months following the birth of the baby.

Therefore, the mother and the newborn were secluded to prevent contact with her husband during this period.

Some of the Kalenjins believe in witchcraft, so they will not allow the baby to be seen by other people for some time. In this case, the mother and the baby are not allowed to go out of the house for some months. Also there is a taboo that when a woman is breastfeeding, they are not supposed to have sexual intercourse because the breast milk will disappear. I don't understand the relationship between breast milk and sex but the husband is not allowed to sleep in the same room with the woman for about three months. (P001)

Seclusion of mother and baby can be both beneficial and harmful to the mother and the newborn. Women, being the natural caretakers of their household, require this seclusion period so that they can be cared for by others and they can focus their energy on getting better, recovering from childbirth and bonding with the newborn. The newborn could also benefit from the seclusion, as it will minimize her or his exposure to communicable diseases. However, certain complications such as neonatal infection could go undetected if the mother is not observant in identifying these complications.

Use of alternative remedies/herbs. Many participants identified the use of herbs on the newborn's umbilical cord as a common practice within the communities they serve. The use of

herbs was said to promote healing of the cord and for superstitious reasons such as shielding the infant from witchcraft.

Nowadays this is hard to find the cultural practices but sometimes you find that there are herbs which are applied on the baby's umbilical cord to help with the healing of the cord. Sometimes the baby is also given some herbs to drink to help their stomachs when they are having cramps and also to prevent them from witchcraft. (P003)

Mothers use herbs during the perinatal period because they believe that they would ease labor pain and promote easy delivery of the baby. However, some participants associated the use of herbs during labor with postpartum complications such as retained placenta.

There are so many cultural things and taboos that people engage in, for example, use of herbs during pregnancy. They say that the herbs will help the mother not feel pain during labour but then those herbs bring problems by causing retained placenta. (P006)

When nurses and midwives understand the value of socio-cultural practices, they are better placed to dialogue with the mothers on ways of either eliminating these practices because they are unsafe or practicing them safely.

But we always find ways of getting to them [TBAs]. Maybe through the chief? Or any other means that the community health workers can help us in educating these TBAs. We also talk to the mothers, what is it that takes you there [TBA], is it something that we can help you at the hospital? Then we see, it is about compromise. (P006)

Understanding the cultural practices during the postpartum period would further the success of health messages and respond to unhealthy lifestyle choices by the mothers during the perinatal period. As explained by one participant, "So now that we know this is happening [talking about seclusion of mother and newborn], we can educate the mother on how to watch for these signs of complications and to let the caretakers know immediately so they can be brought to the hospital" (P016).

On most occasions, collaboration between the nurses and midwives and the social support systems such as family, friends, and the community partners promoted positive relations

that allowed for a common approach to perinatal care without either of the parties feeling dominated or their ideas repressed. However, in some situations, this relationship was threatened when nurses and midwives had to follow “the law,” for example, when they had to immunize newborns and infants as per the Kenya Immunization Program regardless of whether mothers agreed.

It is a rule now. In Kenya, we must vaccinate, even if it means involving the chief or whoever, that’s what we normally do, but once they have come to hospital, they really don’t have a choice, they cannot control what we can do because we are supposed to immunize all the infants that we deliver in our facilities. Yah, per the law we have to immunize. We follow the law. (012)

The theme “Social Support System” has discussed the support network necessary for women and their families to thrive following the birth of an infant. Families, friends and community health workers are all involved in this social support network, and the theme also illuminated the socio-cultural context in which postpartum care in rural Kenya is delivered.

5.6 Policies and Infrastructure Influencing Postpartum Care

The theme “policies and infrastructure influencing postpartum care” refers to the government policies and guidelines that have influenced the day-to-day delivery of maternal and newborn health services in rural health facilities. This theme has three sub-themes: 1) Free maternity services, 2) Adherence to perinatal care guidelines, and 3) Recruitment and retention of nurses and midwives. Since most pregnancy-related complications occur during the immediate postpartum period, up to six weeks after the baby is born, having a system that addresses timely postpartum care, including prevention, early detection, and treatment of postpartum complications, is important.

Some participants explained that although there has been a big improvement in care that has resulted in some reduction of the maternal and neonatal mortality rates in their facilities,

many mothers and neonates are still dying due to preventable causes such as postpartum hemorrhage, maternal and neonatal sepsis, and asphyxia. They indicated that these deaths could be otherwise averted if the policies and guidelines in place could be adhered to.

We have found a few women with CCF [congestive cardiac failure] because they bled at home after delivery. These women would come to us maybe after two weeks, because now, they are not feeling well. You find that now they have CCF because of maybe anaemia. Some delivered at home and they sustained tears, they got infection and now they have puerperal sepsis. Some bring their infants because they have neonatal sepsis or asphyxia. Some of these women and infants end up dying because sometimes they come to us too late. Sometimes we don't have the equipment to help them or drugs, so we refer them if it is beyond our ability ... But you know, these are things that could have been prevented if the mother went for antenatal clinic, or even came to deliver at the hospital. (P016)

5.6.1 Free maternity services.

The government of Kenya introduced a policy of free delivery of maternity services in all government facilities in June 2013. The Free Maternity Services (FMS) policy eliminated user fees for all maternal and infant health services. Its aim was to encourage mothers to utilize maternal and infant health services in hospitals including skilled health delivery and postpartum services, hence reducing maternal complications as well as maternal and neonatal mortalities. The FMS policy has increased the number of mothers utilizing perinatal services in government health facilities. However, as indicated by most participants, the increase in mothers utilizing skilled perinatal services has compromised the faith and will of the mothers to utilize these services because of inadequate supplies and equipment at the health facilities. As one participant describes,

It's a bit challenging because as per now, most of the clients are aware of the "beyond zero programs" where we are supposed to provide free maternity services. Unfortunately, we lack supplies most of the time. So it becomes a bit challenging because you want them to come to deliver at the hospital, then when they reach the hospital set-up, there are no supplies, so they are forced to buy ... some are not able to buy. So you see, most of the times, like currently we have issues of supplies. So you hear comments from the people in the community, "if we go to the hospital, we will still be sent to buy this and

that, we better move to our nearby midwife who can assist us and we pay back.” It’s a good initiative by the government whereby they want all mothers to deliver in the health center but the shortage of supplies makes it a bit challenging for us to do our work. (P022)

Another participant echoed this sentiment, indicating missed opportunities at the healthcare facilities due to long wait times for the mothers who have tried to come in. The participant explained that long wait lines discourage the mothers who end up leaving without being assessed by healthcare professionals.

Generally, the care that we provide is not adequate. Maybe it is because of lack of time to assess the mothers and their babies. We have many mothers coming to us especially with the free maternity being offered but sometimes they are too many for us to even see them and some end up going back home without being seen by the nurse. The mothers get tired of waiting in lines. Sometimes the babies are hungry, the mother is hungry too and so they prefer to go back home instead of waiting in line the whole day. (P016)

Other participants indicated that the FMS has compromised the quality of care that the women and their infants receive at the health facilities. They indicated that because of the delayed reimbursement from the national government, the facilities were financially constrained. Hence, they were unable to stock the necessary equipment and other essential supplies required to provide quality care to the mothers and their infants. As explained by one of the participants,

The government has promised to provide free maternity care, but apart from promising, there are some challenges we encounter. The government is supposed to reimburse us for the free maternity care but so far, we have had only two reimbursements since the free maternity began and you see, the facilities deliver a lot of mothers. There is still a lot of money lying in the government that should have been used in the facilities. It is free, but we have encountered a lot of challenges in the provision of supplies. We cannot give good care if we don’t have the supplies. Because we depend on reimbursement of free maternity, we find that we encounter some challenges because the money is not paid. Although the government will was good, it is not as effective as we thought it could be. (P014)

As well, due to the increased number of women seeking perinatal services, participants were concerned that the current building was not adequate to accommodate them all. Most of the participants feared that the number of beds allocated for perinatal care was not meeting the

demand, hence in most facilities, mothers shared beds or slept on the floors. This participant stated that:

For example, in our postnatal care unit, since they introduced the free maternity, we have more mothers coming and we don't have enough equipment to help these mothers. We have fewer beds and it is not convenient for the mothers. For example, you could have like ten mothers and we have only five beds, so it is inconvenient, you find some mothers are sleeping on the floor. (P013)

Another commonly mentioned challenge was limited space in the facility's wards.

Participants acknowledged that there has been an increase in uptake of skilled birth utilization because of the free maternity services, causing constraints in availability of space at the health facilities. They indicated that despite the increase in mothers utilizing perinatal services, the building infrastructure remained the same, hence causing mothers to share beds with other mothers and their newborns. Most participants indicated that the quality of care provided to the women and the infants was compromised because nurses and midwives were unable to promote pertinent postpartum care, such as enabling rooming-in practices for the mother and the newborn.

Rooming-in is good for the mother and baby and it could be better if we had enough space in the wards. However, our hospital is still the same, which was built in the 90s. So now, with the inception of free maternity, more mothers are coming to deliver at the hospital. Therefore, mothers and their newborns are sharing beds with other mothers with their newborns. The beds are also so small. This also poses infection prevention problems because of sharing beds. (P010)

The FMS policy increased the number of mothers and infants accessing skilled health services. Unfortunately, the number of staffs providing these services remained the same, causing a strain between the demand for services and the ability of staff to provide these services. With the lack of reimbursement from the government, the health facilities have reverted to asking clients to purchase necessary supplies.

5.6.2 Adherence to perinatal care guidelines.

All participants agreed that postpartum care is an important component of the continuum of the childbearing process. Most of them acknowledged being aware of the postpartum guidelines that require mothers and their newborns to be assessed by a healthcare practitioner four times following the birth of the baby; the first visit to be within 48 hours following delivery, the second visit within 1-2 weeks, the third visit within 4-6 weeks, and the last visit within 4-6 months.

Most of the time, when they deliver at home, and they develop a complication, they do reach us when it is a bit late. Some would reach us within six hours or if they are coming from the vicinity of the rural areas, it will take longer depending on where they live, communication, transport. But they do reach us in the span of 48 hours and usually because of the complications. But we all know that mothers need to come for assessment at least four times after the baby is born. Within 48 hours, 2 weeks, 4 weeks, and 4 months. (P010)

The success of this guideline requires sufficient coordination and enough skilled health care professionals to ensure its implementation. Some participants acknowledged having access to postpartum care protocols in their workplace, but although they have the protocols, implementing them as per the guidelines is not always possible because of lack of staffing and equipment.

To my knowledge, I think the principles are there but implementing them is not sufficient. Yeah, so as we are trying to implement these guidelines which have been made. But for them to be implemented, the government ... should make sure that the services to the patients are upheld to some level ... I told you earlier that they need to equip all the rural facilities both with the manpower and also with the equipment. (P013)

Similarly, for most participants, the likelihood of adhering to postpartum guidelines was influenced by the implementation and maintenance process of the guidelines. For instance, the following participant explained how attending an emergency obstetric care training course had

enhanced her skills and had empowered her when caring for the mothers and infants in her facility. However, lack of resources had disempowered the staff.

Yes, we have standard operational procedures on the walls. We have one for management of postpartum care that indicates that when you identify a mother with PPH, the first thing you do is to call for help. You ensure that the mother has an IV line, start IV fluids, massage uterus, identify the cause of bleeding, refer to the next level facility as required ... we have been trained on the Emergency obstetric care management. So it is easy to follow the operational procedures because we know ... sometimes it is hard for us but we are trying (both laugh). We are trying because sometimes you know you are supposed to work according to the guidelines but you are forced to improvise a few things. Most of the time we improvise because we don't have the proper equipment and supplies. (P021)

Another participant contended that because of lack of time, impending complications could be undiagnosed because the nurses and midwives hastened through assessments so that they could attend to as many mothers as possible. "So, we normally do quick assessments to these mothers and miss other things because we have to rush to the others waiting in line" (P016). This participant also indicated that some of the complications that the mothers came with during the postpartum period could have been prevented if they had attended antenatal clinics.

Then some of them they come when they have problems because they did not attend the antenatal clinic, it was not detected, so you find that the complication could have been treated if they had attended antenatal clinic. (P016)

Some women who delivered in a healthcare facility are not observed or assessed 48 hours after birth as per the postpartum care guidelines because they are discharged home early due to congestion in the health centers. One participant explains that:

Yah, they receive but not necessarily for 48 hours. What we normally do, because of the congestion in the hospital, we don't keep them for the two days that we are supposed to keep them. So we normally, they just stay overnight, and then the following day in the morning, if everything is stable, and the baby is OK, we just discharge them through the family planning and MCH which is the infant wellness infant clinic. (P012)

Other participants explained that poor implementation of health policies, such as introducing pertinent health programs to the health facilities without considering the availability

of space to carry out the programs, have impacted the provision of postpartum care services. For example, programs such as Prevention of Mother to Infant Transmission (PMTCT) that have been integrated with other maternal health services have now occupied the space that would have been used for postpartum care, causing a challenge to care for mothers and their newborns. For example, as the following participants explains,

One problem being that the space is not there. We have come up with so many programs that even the space we had put for postpartum care is already being utilized by something else that is more aggressive or looks more interesting than the postpartum. Therefore, we don't have enough space to provide adequate care to the mothers. (P016)

Similarly, some participants reported that postpartum care was not considered as “interesting” a program compared to those like PMTCT; hence, they have been allocated space that was previously used for postpartum care.

Space is a bit challenging, there are a times when we cannot provide proper care or education to the mothers because they are sharing a bed [with] two other mothers and their infants. We have so many programs like PMTCT that seem to have more priority than postpartum care. These programs have taken the space that we used to care for the mothers during postpartum care, and now all the mothers [antenatal and postpartum] are taken care of in the same ward. (P022)

In general, all participants agreed that the postpartum guidelines were available on their units, but the consensus was that they did not have time to read and apply all procedures as indicated in the guidelines. They reported that providing professional education around these guidelines and having an increase in staff-patient ratios and in the availability of equipment and essential supplies, would ensure their success.

5.6.3 Recruitment and retention of nurses and midwives: A challenge beyond reach.

This sub-theme emerged when all participants voiced the need for recruitment and retention of more nurses and midwives in rural health facilities. The following participant represented the voices of all in this study when she argued for more staff. “We have many nurses

out there, so if the government can employ them, we will improve our maternal care. Our staffing ratios are so low and it makes our work really difficult” (P010). Participants indicated that sufficient staffing would promote a balanced work-life experience for the nurses and midwives as well as an improved standard of care for their clients.

Similarly, most participants pointed out that despite the shortage of staff in the rural health facilities, there is a high rate of unemployed nurses who are not able to find jobs. With the understanding that staffing is a human resource and management issue, one of the participants, whose words emphasize this theme, expressed that the challenge of insufficient staffing is “beyond us.” This is due to the fact that nurses and midwives have limited representation in management positions. She continued to explain how staffing ratios could be improved in facilities by hiring temporary staff to fill in the gaps.

One that we cannot get by is staffing. Staffing you know is beyond us. The County management that has to hire and before the County hires, it has to consult with the national government to see if there is enough money for staffing and all that. So I find that as a challenge that is almost beyond reach. Because first of all, we don't have enough representation as nurses in the management positions ... The solution to that one, I am not sure but because we have many trained nurses actually in the County who are not employed, just waiting for an opportunity, they should be hired even on contract ... They just need to hire a few nurses on contract. Because when they hire on contract, it's not a lot of money. It's about half the salary. So they can just hire some of them on contract for a few years that will relieve the shortage. (P012)

Another participant blamed the shortage of staff on a hiring freeze and the recent devolution of the health system in Kenya. She stated that there seemed to be a lack of consensus between the County and the national government around hiring of healthcare staff. This participant, along with others, recommended that the government should increase the budget for healthcare so that more nurses and midwives could be hired.

The solution is just to increase the staff. I think in a health center we should be having at least around 12-15 nurses and not 5 like ours. The government should increase the budget to hire more nurses. You know, there was a hiring freeze before but now I think there is

also confusion because of the devolution. It seems none of the governments is taking responsibility to hire staff. Also, in the staffing, you should be having at least 3-4 clinical officers in the health center but according to us, we only have one. (P017)

Participants stated that the health centers were more disadvantaged with staffing than the referral hospitals.

We are overworking. Especially the staffing in the health centers is worse than the referral hospital. Because at the health centers, you can find that there is only one nurse at work and maybe a clinical officer is [all that is] there. The night always has one nurse at some of the health centers. (P021)

Participants agree that in order for perinatal services to succeed, there must be improvements in the process and implementation of policies so that maternal complications as well as maternal mortalities can be reduced. The financial systems of the governments (County and national) must improve in order to enable health facilities to meet the requirements of equipment, essential supplies, space, and adequate staffing. This theme critically explored some government policies and guidelines that have influenced the day-to-day delivery of maternal and newborn health services in rural health facilities.

5.7 Summary of the Chapter

Nurses and midwives in rural Kenya are influential in the provision of maternal healthcare services. As outlined in this chapter, their experiences with postpartum women have been categorized under the themes of anchoring the provider-client relationship, fostering a healthy work environment, barriers to postpartum care, transcending adversity, social support systems and policies, and infrastructure influencing postpartum care. Nurses and midwives in rural Kenya are influential in providing maternal healthcare services, such as assessment of mothers and newborns, identification of abnormalities and intervening by either treating or referring them to the next level of care, following up with the mothers and newborns, immunization, family planning, and education of mothers during the postpartum period and

beyond. However, this study has identified some of the individual and structural (systemic) issues influencing their day-to-day work while providing postpartum care in this complex environment. As indicated in the literature review, the study findings emphasized that nurses and midwives providing postpartum care in rural Kenya are the backbone of the healthcare system and have a strong influence on the positive health outcomes of the people they serve. Nurses and midwives described building and nurturing trusting and respectful relationships with new mothers and their families. They strived for a healthy work environment and facilitated collaboration among the healthcare professionals. Yet, these findings have elucidated that, although the nurses and midwives made every effort to provide quality and efficient care to their clients, their efforts were challenged by an unfavorable working environment due to inadequate human and material resources. Because nurses and midwives are invisible in the decision-making arena, their influence in the leadership sector is limited.

CHAPTER 6: Discussion

This study, which explicated the experiences of nurses and midwives who provide postpartum care in rural Kenyan facilities, has highlighted several issues that impact on their work. These issues have the potential to influence the health outcomes of mothers and infants during the postpartum period. The issues have both individual and systemic (structural) level implications. For example, at the individual level, the nurses and midwives have limited opportunities for professional development to maintain the knowledge and skills necessary to effectively address today's healthcare challenges. They also experience significant role overload, lack of role clarity, as well as limited time to complete the many tasks they are often confronted with. This was evident in their powerlessness and inability to set boundaries in terms of reasonable responsibilities in a given professional situation. Ultimately, this translates to their absence from and invisibility in decision-making arenas. At the structural level, the stories of these nurses and midwives illuminate issues that are nested within broader factors that include sociopolitical and cultural contexts. These speak to issues of gender relations, nursing as a historically marginalized profession, social construction of nursing knowledge, the nature of nursing education, and nursing's subordination within the healthcare system.

In this chapter, I will use these key individual and structural issues influencing the provision of postpartum care by nurses and midwives in rural Kenya from the findings chapter (Chapter Five) to situate the results of this study within the existing literature. Individual and structural issues will be presented under sub-headings that best represent the issues described by the participants. First, individual level issues will be discussed under the following sub-headings: 1) Nursing and midwifery as a resource for perinatal care; 2) Role overload; 3) Limited professional development opportunities; and 4) Invisibility of nurses and midwives in decision-

making arenas. Second, structural level issues will be presented under these sub-headings: 1) Gender relations and societal expectations; 2) Social construction of knowledge; and 3) Rurality as a social determinant of health.

Third, I propose an intersectional approach as a potential way forward in terms of addressing the complex determinants of effective postpartum care in the rural communities of Kenya. The study has shown how the individual and structural issues may influence the provision of evidence-based postpartum care by nurses and midwives in rural Kenya, shaping the health outcomes of women and their infants in Kenya. Due to the complexities of how these influencers affect postpartum care, I am proposing that a model with an intersectionality lens has potential to effectively address the individual and structural issues affecting delivery of postpartum care in rural Kenya. An intersectionality lens could enable the nurses and midwives to see beyond the immediate problems and target both the visible problems and their root causes. Finally, I will present the limitations to the study.

6.1 Individual Level Issues

The individual level issues are those influencers that capture the reality of the nurses and midwives at the personal level. Nurses and midwives in the current study identified issues that limited their ability to adequately provide postpartum services. These issues prevented them from developing themselves professionally, increased their workload, which translated to limited time to complete tasks, and created feelings of powerlessness and an inability to set boundaries. These contributed to their absence at decision-making tables.

6.1.1 Nursing and midwifery as a resource for perinatal care.

Globally, nurses and midwives are instrumental in providing high-impact and low-cost interventions by bringing critical services closer to their communities (WHO, 2016). It was

apparent in this study that the sample of nurses and midwives interviewed have great skills and knowledge in providing postpartum care in rural Kenya. Not only did they care for mothers and infants during this period, but they also created an empowered work environment through knowledge transfer. They promoted a wide spectrum of health education and services despite the challenges and complexities that they encountered in these contexts. Nurses and midwives provided important services that included interventions such as family planning, screening, and treatment of communicable and non-communicable diseases such as diabetes, HIV-AIDS, and malaria, among others (KNBS, 2015).

In collaboration with other healthcare professionals, nurse leaders in developed countries, such as Australia, Canada, and the United States of America, have been effective administrators and managers who actively promote patient well-being in many healthcare organizations (WHO, 2016). Similarly, nurses and midwives in this study described that their collaboration with other healthcare professionals allowed them access to information and resources necessary for them to provide postpartum care services. On the other hand, lack of collaboration hindered the provision of postpartum care. Thus, by providing effective postpartum care services in rural Kenya, the nurses and midwives are influential in the attainment of universal health coverage in Kenya (UHC), and effectively support the United Nation's SDG #3, which is to ensure healthy lives and promote well-being to all regardless of age (WHO, 2016). Through effective postpartum care practices, nurses and midwives contributed to promoting and protecting the health of women and their infants.

Given the intimate level of interactions with mothers during the perinatal period, nurses and midwives were required to have knowledge and awareness of cultural issues in order to support the women. Nurses and midwives who participated in this study described that they were

exposed to clients in their day-to-day practice from diverse cultural groups, such as individuals from various ethnic and religious groups. Nurses and midwives in this study acknowledged the importance of social support systems in rural Kenya, in promoting use of skilled health services and preventing complications during the perinatal period. Therefore, there is a need for nurses' and midwives' self-awareness through reflection of their own cultural health care beliefs in order to promote culturally competent care to their clients (Campinha-Bacote, 2002). Recognizing cultural differences and displaying cultural awareness is an important competency for nurses and midwives (Spies et al., 2017). This kind of awareness promotes cultural safety, where the nurses and midwives acknowledge the power disparity between them and their clients in order to avoid disempowering and diminishing their clients' cultural identities (Bidzinski, Boustead, Gleave, Russo, & Scott, 2012).

Nurses and midwives promoted women and infant health outcomes through healthy relationships. Cultural safety allows nurses and midwives to develop respectful relationships based on dialogue, listening, and attention to the women during their consultations (Rabelo & Silva, 2016). As such, spaces are created where respect and trust are very important issues, promoting autonomy for women. Dyson and Moore (1983) define autonomy as "the technical, social, and psychological ability to obtain information and to use it as the basis for making decisions about one's private concerns and those of one's intimates" (p. 45). The nurses and midwives in rural Kenya had a unique approach of providing respectful and dignified postpartum services to the women. They imparted knowledge to the women so that they could make informed decisions related to their health and wellbeing, for example, decisions around family planning and infant spacing which traditionally would be made by husbands.

Individual nurses and midwives in this study were knowledgeable about their central role in maintaining women's rights and dignity, enabling their clients to make informed decisions, at the same time as they considered the factors – social, cultural, level of education, religion, and economic status – that influenced their level of autonomy. However, nurses and midwives indicated that on most occasions, decision around women's healthcare was made by others such as husbands or mothers-in-law. Synthesis of the literature by Osamor and Grady (2016) on women's autonomy in healthcare decision-making in developing countries concluded that there were varied levels of autonomy in different countries, and of more importance, that many women had limited autonomy and control over their health decisions due to social structures. Women with more autonomy are more likely to seek healthcare services for themselves as well as utilize the different healthcare services available for them, such as family planning services (Osamor & Grady, 2016).

Knowing that most women in rural Kenya do not possess the luxury of autonomy but depend on their husbands or other family members to make their healthcare decisions (Muthoni & Miller, 2010), nurses and midwives advocated for women's autonomy during the postpartum period. For example, they educated women on how to examine their bodies, to check their breasts, and to pay attention to their vaginal discharge. They also taught them how to reduce health risks by adopting healthy behaviors, such as using condoms during sexual intercourse. Self-examination is a delicate subject to discuss, and it is imperative that nurses and midwives are culturally sensitive when passing on this type of knowledge, because in most Kenyan societies, women do not see the need to touch themselves in such an intimate way, especially when they do not feel sick (Muthoni & Miller, 2010). Ultimately, when women learn to examine their bodies, they can be more vigilant about any abnormalities and seek medical help as soon as

possible (Rabelo & Silva, 2016). Thus, when nurses and midwives promote women's autonomy, they are promoting health seeking behaviors that translate to better health outcomes for women and their infants.

As well, nurses and midwives advocated for women's choices and supported them through involving the women in the development of their plan of care. This created a space for women to have some autonomy over their care. Within these spaces, women acquired the power to be able to choose and decide on the care practices that they wanted along with the nurses (Rabelo & Silva, 2016). This knowledge enabled women to make informed choices about family planning methods and immunization clinics for their infants. Hence, this relationship supported humanizing healthcare by sharing knowledge and recognizing rights (Rabelo & Silva, 2016).

While working with the women during the postpartum period, nurses and midwives developed trusting relationships through caring attitudes, listening, showing understanding, and providing patient-centered care. This study's findings indicated that collaboration through clear communication amongst healthcare professionals and with the mothers built confidence and relieved anxiety for the women. Patient-centered care encompasses socially oriented learning activities, including exchanging, sharing, and confirming knowledge with co-workers in situations of uncertainty, thus improving efficiency, communication, and overall patient satisfaction during postpartum care (Estabrooks et al. 2005; Segel, Hashima, Gregory, Edelman, Li, and Guise, 2010). Promoting shared decision-making platforms with the women during postpartum care prevents marginalization of the women in rural Kenya and allows them to access the experiences and knowledge that the nurses and midwives have.

To prevent nurse/midwife-client power imbalances, nurses and midwives actively sought to respect the mothers as well as their own professional limits. For example, participants

indicated that they obtained consent from their clients prior to performing any kind of intervention on them. They explained the rationale for each intervention and provided their clients an opportunity to ask questions related to their care. With the understanding that the childbearing process could be stressful to the mothers and their families, nurses and midwives strove to offer comfort and physical and emotional support to their clients. Identifying support needs and expectations of new mothers is important for their recovery after childbirth (Lundgren & Dahlberg, 2002).

In respecting the women's postpartum beliefs and practices, the nurses and midwives capitalized on several activities that had the capacity to change health behaviors. Fostering the mother-baby bonding through several techniques such as rooming-in and breastfeeding support was considered as important for the infant's development as it was for the physical and emotional well-being of the mother. Skin-to skin-contact was encouraged between the mother and the newborn. It has been noted that bonding has a positive impact in meeting physical, emotional, and developmental milestones that begins in pregnancy and continues throughout a lifetime, and techniques such as breastfeeding may reduce later internalizing behaviors in infants (Liu, Leung, & Yang, 2014; Young, 2013). Participants in this study indicated that bonding techniques empowered the mothers to take charge of their mothering skills, promoted exclusive breastfeeding, and improved communication between the mothers and nurses and midwives.

In general, nurses and midwives working in rural Nandi County of Kenya were knowledgeable in regard to postpartum care. This study showed that nurses and midwives were quite conversant with the postpartum guidelines disseminated by the national government. They were passionate about their work. I could see their passion during the individual interviews when

they spoke about the care that they provided to the women and their infants. They valued their work, served the population, and advocated for healthcare for all.

However, due to the diverse populations that the nurses and midwives serve, their practice could be enhanced through improved cultural safety. With this, nurses and midwives could integrate the women's postpartum beliefs into their care plans during the postpartum period. This is not the case at the moment in the rural health facilities of Kenya. Although the nurses and midwives encourage autonomy with decision making, the skilled health regime does not allow some of the cultural practices to be implemented in the health facilities. For example, while mothers would eat particular foods at home following the birth of the baby, mothers at the health facilities do not have a choice of meals that are served. Appropriately responding to the women's beliefs using a cultural safety lens would improve healthcare delivery as well as health outcomes for the women and their infants in rural Kenya.

6.1.2 Role overload.

Role overload has been defined as a situation of an individual being given too much work to complete within an expected time period (Thiagarajan, Chakrabarty, & Taylor, 2006). It is the perception that the time and energy resources available cannot accommodate the demands of the roles to be completed to the satisfaction of one's self or others (Duxbury, Lyons, & Higgins, 2008). Nurses and midwives in this study reported role overload as a barrier to providing postpartum care. For example, due to shortages of staff, limited availability of essential supplies and resources, and increased numbers of women who were seeking postpartum care in rural Kenya, nurses and midwives could not adequately provide this service. This shortage has led to an informal increase in the scope of practice for the nurses and midwives: they are now offering

services that would normally be offered by specialists such as obstetricians (Munabi-Babigumira, Glenton, Lewin, Fretheim, & Nabudere, 2017).

In their effort to remedy staffing shortages in the healthcare facilities, nurses and midwives in rural Kenya have taken up complex tasks that have burdened their day-to-day work, making them subjects of an endless circle of enmeshed healthcare strategic directions. For example, poor staffing ratios lead to unsatisfactory care for the women, causing them to abandon or delay seeking skilled healthcare, which in turn increases morbidity or mortality during the perinatal period, leading to a further increase in the workload of the nurses and midwives.

Nurses and midwives could provide 87% of essential care to mothers and newborns, especially in rural areas, contributing to the prevention of maternal and infant mortality (WHO, 2016). Despite being key players in maternal and infant health, shortages of nurses and midwives is acknowledged globally, especially in low-resourced countries such as Kenya (WHO, 2016). Consequently, the health centers in Nandi County are regularly understaffed with nurses, midwives, and clinical officers, causing role overload. The inadequate number of nurses and midwives to meet the demands of the population served in Kenya has led to understaffing of nurses and midwives in rural health facilities. The ratio of healthcare workers to population in Kenya is far below the WHO benchmark. Countries need more than 23 nurses, physicians, and midwives combined per 10 000 people in order to meet basic healthcare needs for their populations (WHO, 2013). The nurse to population density per 1,000 is very low at 0.08-1.2 in Kenya, while the Nandi County nurse to population density per 1,000 is 0.12-0.4 (Wakaba et al., 2014). The shortages of nurses and midwives increase the workload of the existing staff and undoubtedly is a great barrier of postpartum care in rural Kenya, due to the compromised quality of care.

The quality of health of Kenyans is compromised by migration of nurses and midwives and other healthcare professionals to countries that provide better compensation, causing the shortages of healthcare staff (Kirigia et al., 2006). Similarly, critical shortages of nurses and midwives in rural health facilities have been reported in many African countries. In Malawi, the shortages of obstetrical care providers cause significant negative health outcomes to the mothers and leads to difficult circumstances for the healthcare providers, both professionally and emotionally (Bradley et al., 2015). Muula, Panulo and Maseko (2006) concluded that a critical shortage of staff was the main bottleneck in the provision of timely and quality obstetrical care in Malawi.

In Tanzania, the referral system is incapacitated by critical shortages of professional staff, which contribute to low motivation of the few staff remaining (Kwesigabo et al., 2012). In Zambia, Walsh et al. (2017) established that a rational distribution system for health workers could improve access to care, especially in underserved communities, hence advancing the capacity for projecting future health staff planning requirements. In general, the studies mentioned above concluded that greater shortages of healthcare staff exist in rural areas, causing work overload for the staff, as is the case in rural Kenya. This could be because working in rural areas is perceived by many healthcare providers as less lucrative than working in urban areas or in developed countries because of several factors: low wages, poor working conditions due to lack of equipment and infrastructure, lack of supervision, limited research funding, and the prevalence of HIV/AIDS (Kwesigabo et al., 2012; Walsh et al., 2017).

The shortages of nurses and midwives in rural Kenya could lead to poor assessments and inadequate follow-up of mothers and their infants during the postpartum period. Understaffing demotivates staff, which could lead to substandard care and subsequent poor outcomes of

maternal and infant health (Bradley et al., 2015). The findings of this study indicated that the nurses' and midwives' workload in rural Kenya was higher compared to other healthcare professionals such as the clinical officers and doctors. Understaffing has also fueled maternal and infant mortality in low- to middle-income countries due to delays in initiating emergency interventions (Bradley et al., 2015). Furthermore, as revealed by the study findings, poor assessment of the mothers could create a bigger burden for the healthcare system, when mothers develop complications and return to the facilities with even more complex health issues, which could have been prevented in the first place.

Moreover, this shortage of healthcare staff could be detrimental to the country's health outcomes. For example, Kenya's health statistics on global health that include the reduction of maternal, child, and neonatal mortalities, indicate that there are still higher rates of maternal and neonatal mortality in Kenya (KNBS, 2015). These mortalities are compounded by the burden of disease and limited health resources, including shortages of healthcare staff (KNBS, 2015). As well, approximately 40% of women in Kenya experience critical complications during the postpartum care period (KNBS, 2010). The participants in this study indicated that the number of women who experience complications during postpartum care is still high. As such, it is necessary to address the barriers to postpartum care in order to prevent further postpartum complications or mortalities.

The shortage of staff could also indicate that minimal attention is given to the work of the nurses and midwives. The staffing shortage was one of the main reasons that the nurses and midwives were on strike during the data collection period of this study. They clearly felt powerless over the staffing shortages in their health facilities. Since staffing was construed as a

human resource and management issue, one of the participants indicated “there is nothing we can do about it” (p.012). This could be an indication that the nurses and midwives were burned out.

With respect to recruitment and retention of nurses and midwives, most of the participants in the study explained that newly qualified nurses were not being absorbed into the healthcare system and that there were many qualified nurses in the County who were not employed. This phenomenon has been observed in other Sub-Saharan African countries where governments are unable to absorb the trained nurses due to bottleneck structural policies that inhibit the country’s health budgets (Kinfu, Poz, Mario, Mercer, & Evans, 2009).

In an effort to resolve the shortages of nurses and midwives, in 2005 Kenya embarked on a program, referred to as the Emergency Hiring Plan (EHP), to hire new graduate nurses. This program was supported by five donor organizations: the Clinton Foundation jointly with the Danish International Development Agency (DANIDA); the United States Agency for International Development (USAID)-funded Capacity Project; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the International Center for AIDS Care and Treatment Programs (ICAP); and the United Nations Children’s Fund (UNICEF) (Gross et al., 2010). With the EHP, the government of Kenya made agreements with the support of the donor organizations to employ nurses for one- to three-year contracts. The donors recruited and deployed these nurses and subsidized their salaries, with the possibility of the government absorbing these nurses into the civil service after the contracts expired (Gross, 2010). By 2009, 1836 nurses had been hired through the EHP, although it is unclear if they have been integrated into the Kenyan public service.

However, despite the increase of nurse-to-population ratio through the EHP, there are still significant shortages of nurses and midwives in Kenya, especially in the rural areas (Wakaba et

al., 2014). The critical shortages have forced the nurses' and midwives' work environment to become like an assembly line, where clients are treated like objects that need fixing and are released to the community early in order to create room for other clients. This study indicated that nurses and midwives rushed from one client to the next in an effort to provide care to all. Both clients and bystanders often construe this rushing as negligence on the part of the nurses and midwives. Other studies on disrespect and abuse of women during the perinatal process indicated that poor staffing ratios contributed to lack of proper care for the women (Abuya et al., 2015).

Therefore, to remedy the increased workload, nurses and midwives in this study took control of their practice by prioritizing, communicating, and delegating where possible, and pacing themselves. One participant explained that she utilized the security guard on the night shift whenever she had an emergency to tackle that required more than one staff member: "so sometimes you have to get the watchman to help you with boiling water and with sterilizing the instruments as you assist a mother or baby who is bleeding" (P001). In this case, the shortage of staff hinders the ability of the nurses and midwives to adequately provide quality and timely obstetric emergency care, which could be detrimental to mothers and newborns. This was also observed in Malawi (Chodzaza, & Bultemeier, 2010), and in Tanzania (Macdonald et al., 2018), where it was noted that lack of resources and insufficient staffing compromised the health and the safety of women and their infants. Therefore, it is imperative that the national bodies for nurses and midwives must advocate for an increase in hiring and for a better distribution of staffing.

6.1.3 Limited professional development opportunities.

By virtue of their education and experience, nurses and midwives are experts in the kind of knowledge that could contribute to facilitating and improving healthcare strategies. However, they require continuous professional development (CPD) in order to keep their knowledge and skills up-to-date, hence keeping up with competence in their practice (Gopee, 2001). CPD in the context of this study refers to professional education gained after professional entry to nursing midwifery practice. CPD is a process of lifelong learning that embodies both professional and personal development (Davis et al., 2003). Although participants from this study were knowledgeable in the basic skills required for postpartum care, they acknowledged the importance of nurses and midwives participating in CPD in order to provide competent evidence-based care as well as meet the current health needs of the population that they serve. Hence, access to CPD contributed to a healthy work environment for the nurses and midwives because they were empowered to deal with the life-threatening complications during the postpartum period.

It is globally acknowledged that on-going education and training for healthcare professionals is seen as a key investment strategy in the improvement of health outcomes, especially with the advancement in knowledge, tools, and technologies in healthcare (WHO, 2000). Given the dynamics of today's health-related complications, skills reaching beyond the bedside and unit level are needed (Clark et al, 2016) in order to assure the quality of care that patients should be receiving during the postpartum period. This is affirmed by the WHO's call for global health partners to provide support in comprehensive training for healthcare workers including nurses, midwives, and doctors in low-resourced countries (WHO, 2006). Countries are also tasked with reforming the health professionals' education and training, with the aim of

improving the quality of care, increasing the number of professionals, and ensuring professionals are working to their full capacities (WHO, 2013).

Similarly, in Kenya, all health professionals including nurses and midwives are required to complete CPD (MOH, 2014b). The CPD is a means of enabling a continuous development of knowledge and skills required by the healthcare professionals for them to provide safe and quality care to their patients. CPD sessions in this study setting were primarily organized classroom events in the form of workshops or seminars, mostly held offsite. Participants indicated that CPD sessions were offered mostly to inform healthcare professionals of new policies and to train them on new best practices. Partners in health stakeholders such as AMPATH sponsored most of the CPD sessions. A representative from each health facility was invited to attend the CPD sessions; however, not all health facilities could afford to send a staff member due to a lack of staff to cover their roles while they were away.

Conversely, knowledge development did not come from the classroom setting only. This study showed that when nurses and midwives were faced with challenging situations where they had limited knowledge of the tasks, they were expected to perform due to the integration of health services, they sought support from their colleagues and learned on the job. Nurses and midwives in rural Kenya provided good care, given the unfavorable conditions they faced at the health facilities. Bierema and Eraut (2004) established that learning from real work experience and learning from other people, either reactive or deliberative, is more common than learning through organized events. These researchers also asserted that learning in the workplace can be enhanced by improving opportunities that promote engagement in different work processes. As well, working consistently alongside the same colleagues enables an environment where one is free to ask questions and receive constructive feedback (Eraut, 2011).

Nurses and midwives in this study described that the CPD opportunities were not equitably distributed among them in Nandi County. The decision to attend CPD was not systematically decided within the health facility based on the need for staff development but was at the discretion of the facility managers. Most participants explained that not everyone who attended the training required that particular knowledge, hence limiting the pertinent opportunities for nurses and midwives who did require the knowledge. In addition, due to the lack of organizational practices that support CPD, participants indicated that a few groups of individuals, mostly supervisors and managers, would attend the training, even if the training was meant to benefit the frontline staff. Participants thus felt demotivated with the inequitable distribution of learning opportunities. Previous research has also suggested that, when there are increased levels of work-related stresses and lack of support for the employees, their confidence and motivation to learn is negatively influenced (Bierema & Eraut, 2004). Thus, nurses and midwives in rural Kenya expressed dissatisfaction with the unequitable distribution of CPD opportunities.

As part of their CPD, the majority of the participants in this study had received the basic emergency obstetric and newborn care (BEmONC) and HIV/AIDS care training, while a few had comprehensive emergency obstetric and newborn care (CEmONC) training. BEmONC training entails administration of parenteral antibiotics, anticonvulsants, and uterotonics, removal of retained products, assisted vaginal delivery, manual removal of the placenta, and resuscitation of the newborns, while CEmONC includes surgical capacity and blood transfusion (WHO, 2009).

The obstetric and HIV/AIDS training was provided to the nurses and midwives in order to enhance their clinical skills components to manage maternal and neonatal complications during the postpartum period (Warren et al., 2010). Because most pregnancy-related

complications occur during the immediate postpartum period, up to six weeks after birth (WHO, 2014), having a system that addresses timely postpartum care including the prevention, early detection, and treatment of postpartum complications, is important. Hence, healthcare systems that evaluate the adequacy of postpartum clinical assessments are required in order to ensure women and infants are receiving quality care (Adams et al., 2017).

Some participants in this study indicated that shortages of staffing prohibited nurses and midwives from participating in CPD programs, including the (BE_mONC). Therefore, those who attended were expected to provide feedback to the other staff upon completion of the activity. This often did not occur mostly due to lack of time created by the shortage of staff. With the evolving role of the nurses and midwives due to the task-shifting in healthcare services in Kenya (Deller et al., 2015), it is necessary to provide the required support by enabling an environment where CPD can be completed. Hence, given the current shortages of nurses and midwives in rural Kenya, innovative ways such as on-line CPD courses must be adapted to allow them to participate without necessarily removing them from their areas of practice. This could be made possible by designating a learning center that is equipped with computers and internet access.

The barriers to CPD participation identified in this study that included lack of supervisor support, lack of time, and limited financial resources were consistent with those identified by previous studies. For example, a study conducted in South Africa on global challenges to continuing professional education concluded that, in general, rural nurses are consistently faced with a lack of time, support, and financial resources for participation in CPD activities (De Villiers, 2008). Similarly, another analysis conducted by Penz and his colleagues indicated that nurses working in rural areas were faced with barriers such as lack of supervisor support and time to complete their continuous education (Penz, D'Arcy, & Stewart, 2007). Supportive

supervisory practices can positively influence employee job satisfaction (Bradley et al., 2015; Frimpong et al., 2011), and supportive workplaces that will attract and retain healthcare workers require shared responsibility and problem solving between the staff and their supervisors, thus improving health outcomes (Spies et al., 2016; Warren et al., 2016). Findings from this study indicated that there was lack of supervisor and management support in CPD for the nurses and midwives in rural Kenya. Ross, Barr & Stevens (2013) identified that lack of financial support, lack of employer support, and limited access to computers and the internet are the main hurdles to the quality of CPD. Due to the lack of adequate technology, some participants in this study used their personal cell phones and personal internet data to search for evidence-based practices. Nurses and midwives must have access to evidence-based procedures that support use of best practices in postpartum care in order for them to deliver optimum care to mothers and their infants.

Consequently, capacity building through education is critical to improving health outcomes for mothers and newborns during postpartum care. Some participants indicated that having a resource center in the facility where they could go and learn on their own time would be beneficial to most of them. Although computers and internet access at the workplace are seen as important for CPD activity, lack of such access is noted as a common barrier for nurses to participate in CPD (Ross et al., 2013).

A review by Akter, Sibbritt, and Dawson (2016) indicated that acquisition of appropriate knowledge and skills required to detect relevant clinical signs that may enhance the performance of health workers is necessary for enhancing the competency of the workforce. This review highlights the importance of training guidelines and points toward the need for developing standard training guidelines for health workers to ensure the successful implementation of

healthcare programs. Akter et al. (2016) indicated that the success and quality of an implementation process is higher with a clear multifaceted training of healthcare staff. Findings from this study indicated that there were no standard training guidelines for nurses and midwives. Participants explained the lack of clear structure in the implementations of new policies, processes, and guidelines in Kenya, leading to lack of standardized healthcare interventions. This created an environment where nurses and midwives were not clear about their responsibilities during the implementation process of new policies, processes, and guidelines, such as the postpartum guidelines. With continuous professional education and clinical skills updating, nurses and midwives in Kenya could be autonomous when providing healthcare services, helping to improve the health outcomes of their patients (Krubiner, et al., 2016).

6.1.4 Invisibility of nurses and midwives in decision-making arenas.

Being the main healthcare providers in rural Kenya, nurses and midwives are well suited to participate in decision making that identifies contextual factors affecting postpartum care, as well as to develop interventions aimed at increasing the quality and utilization of postpartum care. However, nurses and midwives in this study described a lack of involvement in decision making regarding postpartum care policies and processes even though they are on the ground working with the mothers and their infants, observing each interaction or reaction from them. Limited leadership roles are diminished for these nurses and midwives; therefore they could not mobilize their resources. The existing hierarchies of authority in the Kenyan health system have prevented nurses from being represented in policy formulation and have diminished their presence in this area (Juma et al., 2014). Hence, nurses' and midwives' limited visibility in political arenas could be perceived in part as their lack of power in the healthcare system (Oden et al., 2000). Further, nurses' and midwives' involvement in policy is both contested and

complex, where it is unclear as to who reasonably represents nursing and midwifery issues at the policy level (Rispel, 2015).

Despite their large numbers within the healthcare profession, many, including nurses themselves, have perceived the nursing profession as an oppressed group within the bio-medical model (Farrel, 2001; Manojlovic, 2007; Trossman, 2003). However, the Institute of Medicine (IOM) report (2010) on leading change and advancing nursing, acknowledged that because of the close involvement with patients, nurses and midwives are potential equal partners along with other health professionals (e.g., doctors) in the restructuring of policy decisions of the healthcare system. Nurses and midwives are scientifically trained healthcare professionals, full of knowledge, skills, and attitudes that could help reshape current healthcare policies and promote positive health outcomes for the populations they serve.

Further, nurses and midwives in low-resource countries could improve the health outcomes of mothers and their infants during the postpartum period through active participation in leadership roles, policy development and research, and engagement in educational opportunities (Asuquo et al., 2013). Therefore, many calls have been made to enhance the capacity development for nurses and midwives to engage in proactive leadership in the healthcare system (Edwards, Webber, Mill, Kahwa, & Roelofs, 2009). Nurses and midwives in this study indicated that they participated mostly in the policy implementation arena but acknowledged the need for active participation in policy development. Similarly, other studies have indicated that most nurses in Kenya do not participate in the health-policy development and evaluation stages, as opposed to the doctors who dominate health-policy decision making (Juma et al., 2014). A major reason identified for the lack of participation in health policies by Kenyan nurse and midwife leaders was their lack of knowledge about and skills in the policy-making

process (Juma et al., 2014). These knowledge skills could be improved by including training in nursing and midwifery curriculums as well as having health policies that promote capacity development for leadership and policy development.

From my own educational experience in Kenya, politics and policies were learned in the primary and secondary levels of education. However, politics and policies were not part of the nursing curriculum at the University level. Given the impact that politics and policy development have on the work of the nurses and midwives, it is important to include these discussions in the curricula of nursing and midwifery schools. The faculty in schools of nursing should campaign to include political education and/or policymaking (Gebbie et al., 2000; Juma et al., 2014). Additionally, policies are influenced by local research, which potentially could influence the work of the nurses and midwives (Etowa et al., 2016).

Being involved in the policy development arena could empower nurses and midwives and make their voices heard. Findings from the Winter and Lockhart study (1997) indicated that political involvement provided nurses with opportunities to influence social policy and improve patient health outcomes as well as healthcare environments. The presence of nurses and midwives in decision-making arenas could influence policymakers to respond to the experiences and determinants of health and illness as presented by the nurses and midwives (Gebbie et al., 2000; Hardie, 1997). Therefore, as indicated by Blaauw et al. (2010), different countries require different combinations of health policies, and different healthcare professionals would appreciate different sets of incentives.

Similar to this study, Asuquo et al. (2013), revealed that only a few nurses were involved in health research and policy engagement in Nigeria. The lack of involvement in health policy limits the ability of the nursing and midwifery professions to have an impact on the health and

wellbeing of the public (Oden, Price, Alteneider, Bourdley, & Ubokudom, 2000). For example, participants in this study explained that nurses and midwives in rural Kenya participated in the HIV/AIDS-related data collection through documentation of care for clients who were HIV-positive and who were followed by AMPATH. The AMPATH organization required stringent documentation processes for every service their clients received from the health facilities, as per the implementation of the HIV/AIDS interventions program. However, nurses and midwives were not involved in the healthcare policy decisions made for the HIV/AIDS programs.

Nurses' involvement in health policy development ensures that health care is safe, of a high quality, and is accessible and affordable (Ferguson, 2001). Sun, Jia, and Larson (2016), however, warn that due to high dependence on international funding for research, nursing and midwifery research in low-resource countries may be misaligned to the priorities of these regions. Hence, the issues acceptable for research monies and publication is determined by the present forms of truth and rationality of the research funders, and not specifically what is required in these regions. The misalignment of health research could lead to the development of health policies interventions that do not support the required health practices for a particular region (Sun et al., 2016).

Therefore, skilled and knowledgeable nurses at the policy decision-making table will help re-align the priorities of healthcare policy. As Foucault indicated, individuals are not powerless since power is also held by those who are governed (Cheek and Porter, 1997). The authority of nurses and midwives that enables them to advocate for their clients through collaboration with other healthcare professionals ensures that the needs of the mothers and infants are met during postpartum care. Given the current rich knowledge base of nurses and midwives in the Nandi County, tapping into these experiences and creating a healthy working environment for the

nurses and midwives is necessary in order to prevent attrition that could cause more staffing shortages, leading to the poor quality of postpartum care services.

Nurses and midwives, therefore, must continue to strategize in the political arena in order to achieve coordination and make their voices heard. As Foucault stated, “we must not make the mistake of thinking that techniques of power have crushed those natural forces which mark us as distinct types of human beings with various personality traits” (Foucault, 1977, p.193).

Participants in this study understood that having representation of nurses and midwives at the policy and decision-making tables was important for their issues to be addressed.

6.2 Systemic Level Issues

The systemic level issues are those factors that influence postpartum care systemically. This highlights the sociopolitical and cultural contexts, gender relations, and the nature of historical development of the nursing profession and its subordination within the healthcare system. I will discuss these issues under the following topics: 1) Gender relations and societal expectations; 2) Social construction of knowledge; and 3) Rurality as a social determinant of health.

6.2.1 Gender relations and societal expectations.

Nursing and midwifery are predominantly a female profession in Kenya, and nurses and midwives have been marginalized in terms of healthcare leadership. Gender is an important concept in the development of the nursing profession, since nursing is depicted as a female profession due to women’s supposedly natural caring and nurturing attributes (Wicks, 1998). Moreover, many experiences shape women’s health in rural Kenya, from social determinants such as gendered subjugation within the home and public sphere, to the structural determinants of health such as poor access to skilled healthcare during the perinatal period. Therefore, since

nursing and midwifery is predominantly a female profession in Kenya, nurses and midwives not only experience the social determinants as professionals, but they also experience these determinants by virtue of being women.

The belief that nursing is an extension of women's domestic roles depicted the nursing profession as unskilled and inferior to other male-dominated healthcare professions such as medicine (Evans, 2004). Furthermore, in many societies such as rural Kenya, there are few employment opportunities for women, and hence nursing and midwifery tend to be the default profession for them (Krubiner, Salmon, Synowiec, & Lagomarsino, 2016). Since most of the nurses and midwives working in rural Kenya are female (Wakaba, 2014), they maintain a shared understanding of the healthcare process with the mothers under their care.

Although the female nurses and midwives identified themselves as professionals, they did not abandon the "everyday" women's domestic and maternity duties with which they were raised (Rabelo & Silva, 2016). Hence, their dual roles of both professional and woman imposed by society (Foucault, 1980) created role conflict for the nurses and midwives due to changing expectations. This role conflict, fueled by power dynamics arising from social, gender, and class relations, disadvantaged nurses and midwives in rural Kenya. In fact, within the Kenyan rural health facilities, the public called any man who worked in the health facility and wore a white coat "Daktari," the Swahili word for doctor.

The society has the authority to decide which knowledge to accept and which to marginalize (Foucault, 1980). Therefore, even though nurses and midwives possess the skills necessary to enhance women's care, they were often not taken seriously by society (Evans, 2004), making it difficult for them to navigate the healthcare system on behalf of their clients. This has led to reports of discrimination and social isolation for men who are nurses (Rajacich,

Kane, Williston, & Cameron, 2013). Thus, men who enter the nursing profession often try to alienate themselves from traditional nursing images by choosing specialties that are associated with masculine gender roles, hence depicting the superior value of men in patriarchal culture (Evans, 2004).

While most research on women's empowerment in healthcare has centered on empowering women as consumers of health services, women can also be empowered as providers of healthcare services (Krubiner, et al., 2016). Nurses and midwives, who are mostly women, play a critical role in rural health facilities of Kenya, but they are underrepresented in leadership positions at these facilities since the Kenyan patriarchal culture does not allow for the fundamental progression of women (Fletcher, 2007). The training and education that the nurses and midwives receive prepares them for employment within healthcare. However, as women, they have been excluded from the spheres in which knowledge is produced and disseminated (Smith, 2005). For example, the healthcare leadership structure in the rural facilities in Kenya was consistent with gender power relations, where the nurses and midwives were neglected. The clinical officers (mostly men) were the administrators at the health centers in Nandi County, whereas doctors and physiotherapists (mostly men) were administrators in the County referral hospital. The head of the County hospital was a male medical doctor. A nurse, the Chief Nursing Officer (CNO), was in charge of the nursing services at the County referral hospital but she was working under the Medical Superintendent. This kind of leadership structure is consistent with all healthcare organization structures in Kenya (MOH, 2014a).

Nurses and midwives have been portrayed as key partners in healthcare, some of the most trusted health professionals and powerful individuals who are leaders in the health sector (IOM, 2010; WHO, 2016). Within the context of their practice, nurses and midwives working in rural

Kenya have created a space where they provide trusted, safe, and skilled health services during the entire perinatal period. But since the identities of professionals are often tied to their workplaces (Foucault, 1980), the experiences of nurses and midwives working in collaboration with clients and other healthcare professionals to improve the health of the population is grounded in deeper discourses of gender and occupation.

The nurses' and midwives' self-perceptions or identities shape systems through their interactions with them and they in turn are shaped by these systems (Van Herk et al, 2011). Therefore, nurses need to take personal initiatives to explore further the issues of power, privilege, and oppression within their practice and profession in order to critically examine the impact they have on the care they provide (Van Herk et al, 2011). These gender issues are visible in the Kenyan rural health facilities. Nurses and midwives have the responsibility to respect their patient's autonomy. As Foucault indicated, power is everywhere, and knowledge are inseparable since each strengthen each other (Foucault, 1980). Nurses and midwives should promote ongoing non-judgmental support the women during postpartum period. They must be careful on how they impart this knowledge to the women so that they can promote the autonomy of the women as well as increase the health behaviors such as exclusive breastfeeding for 6 months. In Kenya, it is the expectations that healthcare workers provide information to mothers on the importance of exclusive breastfeeding for 6 months and continued breastfeeding for 2 years and beyond (WHO, 2017). Regardless, it rests upon the woman to decide whether they want to breastfeed or not.

Further, being aware of the privilege and power afforded to those following the dominant biomedical model (doctors) is important for the nurses and midwives to identify and analyze issues of justice and equity for marginalized populations (Pauly, MacKinnon, and Varcoe 2009).

This allows them to stop normalizing, ignoring, or trying to bandage the underlying gender inequality problem.

Many policies, including the Structural Adjustment Programs (SAPs) devised by the International Monetary Fund (IMF), have greatly affected the delivery of healthcare to women and infants in Kenya, especially in the rural areas (Juma et al., 2014). Women seeking perinatal care services in rural Kenya are already disadvantaged by their socio-economic status. Most of these women are dependent on their husbands in decision making and for financial assistance. With the healthcare budget adjustment, SAPs have shaped the work of nurses and midwives and the quality of care that women and infants are receiving in rural Kenya by impeding decentralization of decision making as well as resource allocation (Juma et al., 2014), for example, by dictating the number of nurses and midwives that are brought into the public health sector workforce. This is in the light of Kenya's continual struggle to reduce the number of maternal and neonatal deaths (MOH, 2014a). Anderson (2000), however, argues that it is not only the SAP that affects women but that it is also gender relations in the workplace. Since the majority of the nurses and midwives are women, the delivery of healthcare must be addressed within the contexts of the social, economic, cultural, and political aspects of their lives. Hence, since the nursing profession has been strongly influenced by its historical development within hierarchical, autocratic, and oppressive institutions, nurses and midwives must fully claim their power as women and as professionals who can influence the health and well-being of those individuals they care for (Fletcher, 2006).

Furthermore, women in rural areas of Kenya still prefer traditional birth attendants (TBAs) over skilled services because the TBAs are women who provide personalized and friendly care and understanding. They perceive that professionals providing skilled care do not

offer choices and often display disrespectful attitudes (Abuya et al., 2015; Izugbara, Ezeh, & Fotso, 2009). Although widely discouraged by the skilled healthcare system, the practices of the TBAs have survived over time, especially in rural Kenya. TBAs provide a one-on-one service that cannot be compared to the much higher patient-nurse/midwife ratios at the health centers (Izugbara et al., 2009). Cultural barriers also prevent mothers from utilizing postpartum care. For example, women may choose not to use skilled postpartum care services because their own mothers did not utilize these services, due to their trust in the TBAs (Nabukera et al., 2006).

Participants in this study also are aware of the socio-economic factors that greatly affect the utilization of postpartum care in rural Kenya. For example, they knew about the financial status of the women and their perceptions about their previous experiences in healthcare facilities. When mothers perceived their pregnancy as not being at risk, they preferred to deliver at home with the help of the TBA to avoid incurring costs associated with seeking skilled healthcare. Due to poverty, mothers preferred to use the little money they had to buy food and other essential household supplies rather than put their money into postpartum care services. Nurses and midwives, however, indicated that most of the women seen at the health facilities due to postpartum complications were those who delivered at home with the help of the TBA.

Attitudes about the use of skilled healthcare that supported women during their postpartum period might be changed through counselling. A qualitative study in South Africa (Mgolozeli, Shilubane, Khoza & Nesamvuni, 2018) highlighted fathers' supportive and protective roles in postpartum care so that women were able to concentrate on important tasks such as breastfeeding. Nurses and midwives were challenged to encourage fathers to be more engaged in postpartum counselling. However, for counselling to succeed, enough human and

financial resources are required for the nurses and midwives to be able to promote this practice during the prenatal and postpartum periods.

Empowering nurses and midwives to provide health leadership through educating and encouraging women could increase the utilization of skilled postpartum care in rural Kenya. Personally, having been born and raised in rural Kenya, I believe that most women have not been given opportunities in leadership and decision making. Using women leaders such as nurses and midwives, in collaboration with the TBA, could increase male involvement in supporting the use of skilled postpartum care, thus promoting better health outcomes for women and infants in low-resourced countries (Turinawe et al., 2016). Clearly, examining the patriarchal forces exerted on nurses and midwives and women in general in rural areas of Kenya is necessary in order to reduce the social constraints placed on the nursing and midwifery professions. Nursing and midwifery education programs should address the patriarchal structures and gender norms in order to reduce gender stereotypes, eventually allowing the nurses' and midwives' work to have greater impact.

In summary, absence of nurses and midwives in the leadership table means that they cannot advocate for the resources necessary for effective postpartum care including staffing. The patriarchal nature of healthcare structures tends to favor men, and other health care professionals in leadership roles. Women in women dominated professions such as nursing and midwifery face 'double jeopardy'

6.2.2 Social construction of knowledge.

Since knowledge can be conceptualized as the result of multiple truths (Foucault, 1980), it can be produced in several ways, including through formal (academic) and informal (cultural or history of events) means. Foucault notes that in the process of knowledge production, some

groups are often marginalized, destabilizing power relations among the groups. Nurses and midwives continue to view academic credibility as good practice, relying on scientific evidence to understand what counts as knowledge (Rolfe, 2000). Against this backdrop, nursing remains entangled in a struggle to become professionalized. Despite the complexity of nursing practice today, nurses have not increased their educational requirements comparable to other healthcare professionals like physicians, clinical psychologists, and physical therapists, who have done so as higher standard needs were identified (Fletcher, 2006). The certificate and diploma entrance to nursing practice in Kenya renders nurses and midwives less educated than most healthcare professionals. This has implications for their lack of involvement in decision making regarding postpartum care and their overall invisibility in healthcare policy making.

Besides, the efforts to make a university degree the minimum education for entry into nursing practice have been constrained by the cost of university level nursing education and by cultural values in which nurses are viewed as technicians rather than as professionals with a unique knowledge base (Davies, 2008). Foucault indicated that normalization is an instrument of power that imposes homogeneity, determines compliance, and encourages disqualification of knowledge by dominant disciplines (Foucault, 1980). Nurses' and midwives' knowledge could be shuttered from health policy involvement due to power influence of other health disciplines such as medicine.

According to the Nursing Workforce Report (MOH, 2012), the National Council of Kenya (NCK) has approved 83 nursing training institutions, of which 53% are public, 32.5% are faith-based, and 14.5% are private. Training institutions offer certificate courses (for enrolled nurses), diploma courses (for Kenyan Registered Nurses and Registered Community Health Nurses) and a degree program (for the Bachelor of Science in Nursing). The training for all

nursing cadres entails classroom training as well as clinical placements. Most of the participants in this study had received Diploma level training, consistent with the majority of the nurses in the country. Most nursing students (57.4%) are enrolled in Kenyan medical schools, which offer mostly diplomas in nursing (Nursing Council of Kenya, 2012). As well, the Public Sector Nursing Workforce Report indicated that out of the 16, 371 nurses in the public non-tertiary sector, 76% are women but only 53% are registered nurses (Wakaba et al., 2014). Hence, there is still a high percentage of certificate nurses practicing in the Kenyan health sector.

The certificate and diploma entrance to nursing practice renders nurses and midwives less educated than most healthcare professionals (Fletcher, 2006). Although the NCK have initiated abolishment of the certificate training, some private institutions still offer this training. There are also many certificate nurses still in the system. The entry level requirements for the Bachelor of Science in nursing program is also still lower than the entry level required for medical school. While nurses train for four years, the doctors train for seven years. This places nurses and midwives in a lower educated category compared to doctors.

However, the community health component of most of the nursing and midwifery programs in Kenya enhances students' knowledge construction by allowing them to connect the classroom content and real-life experiences in the community, hence promoting critical thinking and multidisciplinary concept development (Mthembu, & Mtshali, 2013). With community service learning, both the student and the community are beneficiaries, because the student will provide services required by the community, and the provision of the services augments the student's learning (Mthembu, & Mtshali, 2013). Being sensitive to different forms of knowledge construction allows nurses and midwives a better understanding of multiple truths and regimes that shape healthcare processes.

McKay and Narasimhan (2012) explained that, with the current level of education that the nurses and midwives are receiving, they are deprived of the competency to diagnose. Nurses and midwives train in relatively half the time that it takes for doctors, and yet in rural areas of low-resourced countries, they are expected to perform tasks that include diagnosing and treating minor illnesses. I can recall some doctors calling us “half-baked” during our clinical placement in one of the referral hospitals. For nurses and midwives to succeed, there is a need for robust modification of the current nursing and midwifery curricula, so that they can shift from a task-oriented approach to one that is clinically based. This shift will deconstruct power relations and discursive practices in healthcare so that the patients can receive optimal care (McKay & Narasimhan, 2012).

My study indicated that although nurses and midwives practicing in rural health facilities are well prepared with current knowledge to care for mothers and newborns, their bargaining power is still inferior compared with other healthcare professionals such as doctors, rendering them invisible. This is partly because of society’s view of the nurses and midwives. For example, clients in rural Kenya appreciate the services that the nurses and midwives provide, but their work is perceived by many as “unclean” because of the tasks they perform, such as perineal care and bed baths, among others. This ideology is evident also when the doctors leave the nurses to clean up after them following a medical assessment or procedure. I have also experienced this working in Canada, where the doctor would examine a patient and leave the used gloves on top of the patient’s bed, expecting the nurse to clean up. The perception of the nurses and midwives as subordinates to the doctors is reinforced when clients observe how nurses and midwives relate to the doctors at the health facilities. Hence, inter-professional education (between doctors and nurses/midwives) is necessary to eliminate negative synergy and promote a positive change in

attitude, where they each acknowledge the other's profession and value the identity of each group (McKay & Narasimhan, 2012).

The power that doctors have over other healthcare professionals is revealed by hospital ward rounds. For example, typically at a patient's bedside, the most senior doctor asks one of the junior doctors to present the case to the team of other doctors, nurses, physiotherapists, and students. Other doctors are then asked to provide their opinions about the case, then a medical student is asked to conduct an assessment and provide feedback to the group. The nurse merely documents any orders from the senior doctor and notes the information from the presentation on the patient's chart. Nursing and midwifery students listen and continue to follow the procession to the next patient. With current health complexities, inter-professional education focusing on teamwork and collaboration, as well as promoting lifelong learning for nurses, is a way forward to achieving patient safety and better patient health outcomes (IOM, 2010). Hence, changing ward-rounds into interdisciplinary meetings could help improve collaboration amongst healthcare providers.

Some participants described that they would be more confident attending to postpartum complications if they had advanced midwifery or pediatric training. Advanced practice and specialization enhance nurses' and midwives' competency-based education and enables them to remain current with new technologies, skills, and treatment interventions (Heartfield, 2006). Nursing specialization provides knowledge and skills needed to provide exceptional patient care and allows nurses to exercise higher levels of clinical judgment and decision-making using evidence-based practice in the specialty areas (Heartfield, 2006). Further, advanced practice nurses and midwives are well positioned to be clinical leaders, promoting evidence-based practices among the front-line staff through the use of different sources of evidence (Gerrish et

al., 2011). Conversely, nurses and midwives who have not undertaken advanced or specialized training predominantly use experience-based knowledge in practice rather than evidence-based practice (Dalheim, Harthug, Roy, Nilsen, & Nortvedt, 2012). Nurses and midwives in rural Kenya were resilient. They strived to provide the best care possible to the women and their infants despite the stringent circumstances they faced at the health centers, even if it meant using their own resources to buy such items as gloves, and to access the internet to discover best practices.

6.2.3 Rurality as a social determinant of health.

The KNBS (2015) report indicated that most of the population in Kenya lives in rural areas, and this population has a higher rate of poverty and mortality rates compared to the urban population. Access to, and utilization of healthcare services is still limited for the rural population (KNBS, 2015). This is due to the remote geographical locations and poor road infrastructure, inequitable distribution of health resources such as nurses and midwives within the Kenyan health sector, healthcare benefits are distributed on the basis of ability to pay rather than the need for care (Chuma, Maina, & Ataguba, 2012). This makes it difficult for the women to access skilled healthcare services. Although countries have been urged to move towards universal health coverage (UHC), which will allow each person to receive healthcare benefits based on their need for care (WHO, 2016), most of the rural population in Kenya is poor and has more health needs that are not being adequately met (Chuma et al., 2012). Nurses and midwives indicated that some of the women could not afford food, causing health challenges for women and their infants.

There are still concerns around the management of the health system in Kenya. With the devolution of the central government into 47 Counties in 2010, each County became responsible

for financing its human resources for health (HRH) and providing essential medicines and medical supplies (EMMS). The national government was left responsible for health policy and the formulation of standards, pre-service training for health workers, and management of referral services (Tsofa, Molyneux, Gilson, & Goodman, 2017). The devolution of government was meant to enhance community participation, accountability, and equitable management of resources (Tsofa et al., 2017). But this has not been the case with the healthcare system in Kenya. Participants in this study pointed out that shortages of pharmaceutical and non-pharmaceutical supplies were increasingly frequent, as were shortages of staff since the County government took over healthcare service delivery.

My study indicated that rural health facilities are understaffed, nurses are overworked and have not time for professional activities. Therefore, as Foucault (1980) stated, it is necessary to analyze the power from the micro to the macro level. Hence, analyzing the functional procedures of the health systems from the County level (micro) in order to illuminate particular formations of authority relations with the national level (macro), could lead to social accountability on the use of healthcare finances. The nurses and midwives in this study acknowledged that the current quality of care, health outcomes, and their work environments could be improved with the appropriate County-level structures and the adequate capacity of these structures to undertake their functions within the health system.

Kenya has attempted to eliminate barriers to accessing skilled healthcare for perinatal services by introducing policies such as the Free Maternity Services (FMS) (KNBS, 2015). Timely skilled care is critical in preventing maternal and infant mortality, thus many countries in the SSA have removed user fees for maternal and infant healthcare services (Witter et al., 2017). The FMS policy came into effect in 2013 in Kenya (KNBS, 2015), eliminating all user fees for

maternal, newborn, and infant healthcare services in order to ease financial barriers, improve accessibility and utilization, as well as improve access to these services in disadvantaged communities (KNBS, 2015).

However, FMS has attracted overwhelming numbers of mothers and infants, causing over-crowding, and increasing the workload for healthcare providers, as well as decreasing the quality of care provision (Tama, et al., 2017). Although FMS helped to increase utilization of maternal and infant health services, it has caused constraints on the health facilities, since staffing levels, amount of essential equipment and supplies, and building infrastructure remain the same. Elimination of user fees may well have negative consequences on health outcomes if the facilities are not compensated for the loss of revenue (Hatt, Makinen, Madhavan, & Conlon, 2013).

Further, there were discrepancies between the FMS policy on paper and how it has been put into practice. For example, although the policy indicated that all maternal and infant services were to be free, some facilities still require patients to pay user fees directly to the facility, while others require patients to pay for some services (Tama, et al., 2017). Similarly, the participants in this study reported that women in Nandi County are still spending money out-of-pocket to purchase essential supplies and medications. This seems to be a common trend in the region. For example, a study from Tanzania on the effects of user-fee exemptions for healthcare services by women and infants indicated that more than three-quarters of the women paid for the service delivery despite the abolition of fees by the government (Kruk, Mbaruku, Rockers, & Galea, 2008). In Uganda, one study revealed a perceived reduction in quality of care and also reported on reduced motivation and the potential for unofficial payments to healthcare workers (Nabyonga-Orem, Karamagi, Atuyambe, Bagenda, Okuonzi, & Walker, 2008).

The lack of a clear implementation process for the FMS policy has sent mixed messages to the public regarding the abolition of user-fees for maternity services. While FMS was meant to eliminate financial barriers, other factors affecting the delivery of maternal health services, such as inadequate human resources, limited physical infrastructure, and shortages of drugs and essential supplies, have caused dissatisfaction among the healthcare providers as well as the patients being served (Mrisho et al., 2009; Witter et al., 2017). This can well lead to a decrease in staff morale, disruption of referral systems, and a decrease in the quality of care in facilities (Hatt, et al., 2013). Healthcare staff could also face moral distress in providing postpartum care services in rural areas because they are upset that patients have to pay for services that are meant to be free. Since nurses and midwives are the main healthcare providers in rural health facilities, their relationship with clients will generally determine the experience of those clients in the health facility (Abuya et al., 2015). Hence, the Kenyan government should actively implement processes that will promote good quality of care and staff motivation in order to avert professional resistance among healthcare workers. The success of universal healthcare depends on skilled and motivated health workers who are equitably distributed to provide quality healthcare to the populations (Cometto &Witter, 2013).

Like most low-resourced countries, the health of women and infants in rural Kenya is still at risk due to preventable causes of morbidity and mortality. Working in rural areas, nurses and midwives strive to strengthen women's capabilities through health education, information and health promotion, assessments, screening and care planning (Renfrew et al., 2014). However, person-centered care is one of the missing puzzles for perinatal care due to limited staffing ratios that increase nurses' and midwives' workload, often leaving them without the capacity for emergency obstetric care in these low-resourced health facilities (Kruk et al., 2016; Larson,

Hermosilla, Kimweri, Mbaruku, & Kruk, 2014). A recent assessment of the quality of antenatal and delivery care services indicated that, despite the increased access to perinatal services, the quality of perinatal services in Kenya is still poor, and the disparity in quality of care is higher in the rural areas, compared to the affluent urban areas (Sharma, Leslie, Kundu, & Kruk, 2017). Some mothers prefer not to utilize skilled health services due to the perceived poor quality of care in health facilities, and only access these services following postpartum complications (Sharma et al., 2017). Such behavior increases the workload for the already overstretched nursing and midwifery staff.

Building infrastructure is also a deterrent to utilizing skilled healthcare services in rural Kenya. Participants in this study were concerned about the lack of ward space in their health facilities, which posed risks to the mothers and newborns. They stated that despite the protocols that indicated mothers should be observed for at least 48 hours before being discharged home, mothers and newborns were being discharged within 24 hours of birth in order to create room for others. Although these mothers were provided with instructions to return to the health facilities for follow-up between 48 and 72 hours, there was no clear process to ensure that they adhered to the discharge instructions. This gap was greater with the mothers who were discharged from the County Referral Hospital since they were being advised to go to the nearest health centers for follow-up. Lack of follow-up exposes mothers and newborns to potential unpredictable life-threatening complications, since most of the maternal and neonatal mortalities occur within the first week after birth (Wang et al., 2011). Additionally, participants explained that the shortage of beds and overcrowding in the postpartum units led to mothers and newborns sharing beds with other mothers, or sleeping on the floor, leading to poor hygiene and potential cross-infections among them. Nurses and midwives are then exposed to ethical and practical dilemmas due to

limited space to care for the mothers and newborns separately. Similarly, in Mozambique, midwives viewed lack of space as a barrier to quality postpartum care (Petterson, et al., 2006). In another study, nurses and midwives reported that crowding inhibited their ability to observe their clients and promptly detect any complications, since the number of women seeking perinatal services surpassed the labor ward's capacity in relation to human resources, number of beds, and equipment. All of these factors caused diminished teamwork and was counteractive to optimal maternal and perinatal observation and care (Petterson, et al., 2006). Therefore, a good quality of intrapartum and immediate newborn care requires an adequate infrastructure.

Inadequate amounts of equipment and supplies prompted nurses and midwives to improvise postpartum care service procedures, wasting the staff's already depleted time. For example, participants in this study indicated that due to lack of sterilization equipment, they improvised by diluting the disinfectant jik in order to disinfect equipment between patients. As explained by participants, besides taking a lot of time from the nurses' and midwives' already busy schedule, the improvisation increased the risk of infection, especially if the right proportions of the disinfectant were not used. Graner et al. (2010) observed that good quality of care depends on good technical competence as well as client-provider interaction; the ability to achieve these standards was affected by inadequate essential equipment necessary for the daily work of the nurses and midwives.

Nurses and midwives in rural Kenya indicated that lack of essential equipment increased unnecessary referral of mothers to next-level facilities, causing overcrowding in those facilities. For example, a mother could be referred to the County Referral Hospital for the insertion of an intra-uterine device (IUD) due to the lack of IUD insertion sets in the health center. This type of unnecessary referral could cause a missed opportunity in receiving services if the mother does

not have transportation to the County Referral Hospital. Additionally, this could cause an increased workload to the healthcare staff in the facilities receiving the referral (Penfold et al., 2013).

Hence, improving the process of service delivery and ensuring a functioning infrastructure could significantly improve the nurses' and midwives' experiences of care, and might increase both objective and perceived quality of care (Larson et al., 2014). Client relationships are a fundamental aspect of nursing and midwifery care, and nurses and midwives can only provide quality postpartum care if they have adequate and functional supplies and equipment, as well as physical infrastructure. The immediate postpartum care is a significant adaptation period for the mother and newborn, therefore, clear health system policies that support adequate infrastructure and resources for postpartum care are important.

The context of postpartum care in rural Kenya is highly political because the government makes policy decisions with limited input from providers at the point of care like the nurses and midwives in this study. For example, although the maternal and infant health policies are at the top of the agenda of the Ministry of Health (MOH, 2012), decisions are made without the input of the end users, thus reducing the successful implementation of the policies. One could argue that one of the reasons for the slow progress in risk reduction is the misalignment of policy and practice priorities in Kenya, due to the lack of involvement of front-line healthcare staff like nurses and midwives, a lack that has been fueled by gender stereotypes (Juma et al., 2014).

Although nurses and midwives are seen as central to the success of maternal, newborn, and infant health in Kenya (MOH, 2014a), the limited commitment by the government for adequate resources for their healthcare has led to slow progress in the improvement of maternal and neonatal health outcomes. Furthermore, the poor distribution of health workers has left rural

facilities with few or no health workers to provide services. Despite the constraints that nurses and midwives are faced with in rural health facilities, they are bound by the International Code of Ethics for Nurses (CEN) adopted by the International Council of Nurses (ICN, 2012). The CEN stipulates that nurses will promote health, prevent illness, restore health, and alleviate suffering (ICN, 2012). Hence, nurses and midwives are faced with an ethical dilemma when confronted with the constraints of poor working conditions, which are morally counter-effective (Rispel, 2015). Nonetheless, the work of the nurses and midwives in rural Kenya is heavily dependent on the national health system policies, which could either enable or hinder their efforts to provide quality health care and improve patient health outcomes.

Most of the nurses and midwives in this study indicated that they did not intend to leave their current job, despite their frustration with these contextual barriers. Therefore, policies geared to a sustainable increase in the skilled healthcare workforce are necessary to alleviate the shortages in the rural health facilities in Kenya. Such policies must advocate for equitable distribution of nurses and midwives, ensure that they are accessible by the population and possess the required competencies and motivation to deliver quality care that is appropriate and acceptable within the sociocultural contexts and expectations of the served population (WHO, 2016)

All of the individual and structural issues outlined above potentially intersect to compromise the care that the nurses and midwives provide to women and infants in rural Kenyan communities. To address the complex and multiple issues at the root of the problem, it is proposed that the intersectionality approach has the potential to organize and manage these issues raised by the participants in the present research study.

6.3 Intersectionality: The Way Forward

The use of critical theory and Foucault's concepts of power and knowledge in this study provided me with an in-depth analysis and understanding of the individual and structural issues that contribute to the experiences of nurses and midwives providing postpartum care in rural Kenya. Given the complexity of the individual and systemic issues affecting postpartum care in rural Kenya, it is necessary to confront them using a lens that can target these issues concurrently. This calls for an intersectionality approach which provides a way of conceiving how structural factors interact to produce inequities in health and health care.

6.3.1 What is intersectionality?

In this section, I will describe intersectionality and how it can be applied to the contexts of this study findings.

Collins and Bilge (2016) describe intersectionality as:

A way of understanding and analyzing complexity in the world, in people, and in human experiences. The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are shaped by many factors in diverse and mutually influencing ways. When it comes to social inequality, people's lives and the organization of power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class, but by many axes that work together and influence each other. Intersectionality as an analytic tool gives people better access to the complexity of the world and of themselves. (Collins & Bilge, 2016, p. 2)

Intersectionality is a way to think about and act upon health inequities such as increased mortality of women and children. The use of critical theory and Foucault's power and knowledge theories in this study explicated the multiple structures (individual and structural) interacting to create 'wicked' determinants of health which manifest in maternal and infant morbidity and mortality, as well as lack of resources for nurses and midwives to do their work effectively. These structural determinants include bad policies and politics. For example,

perinatal health care may not receive the same level of attention given to cardiovascular diseases because the former is women's health issues, and nurses who are the predominant perinatal providers are also mostly women. Furthermore, issues of gender, socio-cultural, geographical location in terms of rurality, level of education, religion, and economic status all intersect to compromise the health and health care of women and their newborns in rural Kenyan communities. By acknowledging that these issues are inter-related, nurses and midwives could navigate the health system and help alleviate issues of inequities that mothers and infant in rural Kenya are faced with.

Collins and Bilge (2016) explain intersectionality as an analytic tool providing people with better access to navigate the complexity of their world and themselves (p. 2). It is an analytic tool because according to Collins and Bilge (2016), intersectionality provides a comprehensive analysis of reasons why disparities exist, as well as respond to issues of social injustices. In looking at both individual and structural factors affecting postpartum care in rural Kenya, solving them individually will not alleviate the current problems confronting mothers' and infants' health.

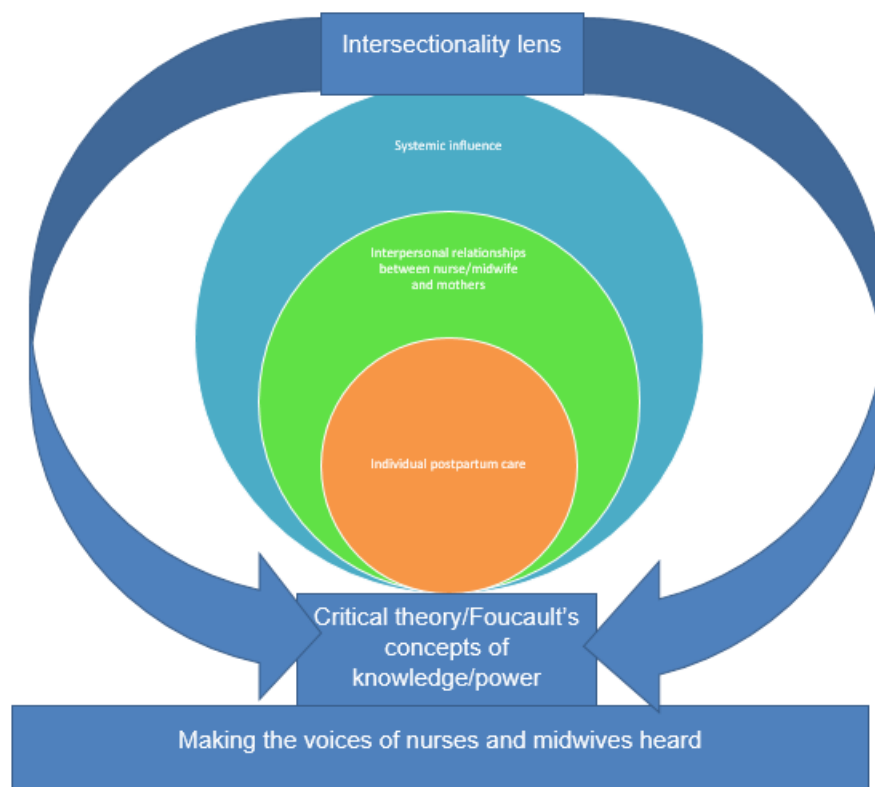
Indeed, several factors shape the health outcomes for women and infants during the postpartum period. Individual and structural factors appear to intersect to influence postpartum care in rural Kenya. The use of an intersectionality lens nested within the broader critical social theories may be necessary for nurses and midwives to deeply understand the issues affecting postpartum care in rural Kenya.

Intersectionality lens has emerged as a promising approach and to advance equity work. Therefore, I am proposing an intersectionality model as a "critical unifying, interpretive, and analytical lens" (Bowleg, 2012) for further examination and reframing how socio-political

inequities influencing nursing and midwifery work in the context of postpartum care in rural communities in Kenya and beyond.

The proposed *model of intersectionality for postpartum care*, (Figure 4) may illuminate embedded determinants of the immediate problem and expose how several power structures interact to determine the health of mothers and infants in rural Kenya.

Figure 4: Model for Intersectionality for Postpartum Care



This model, which is informed by critical theory and Foucault's concepts of power and knowledge will explicate how issues affecting postpartum care could be acted upon using an intersectionality lens. As depicted in Figure 4, the first circle, which is the heart of the model represents the individual factors relating to nurses and midwives providing postpartum care. The second circle represents interpersonal relationships of nurses and midwives affecting maternal

and infant health outcomes. The third circle represents systemic level issues relating to nurses and midwives providing postpartum care. Critical theory and Foucault's concepts of power and knowledge made visible the power dynamics within the Kenyan health system and within the contexts of postpartum care in rural Kenya. The examination of the individual and structural issues affecting postpartum care using an intersectionality lens enhances the voices of nurses and midwives providing postpartum care.

6.3.2 Why intersectionality in the context of this study findings?

In this section, I will justify the proposed model as depicted in Figure 4 by providing supporting evidence and by putting it into context. There is a continuing failure to meet the health issues for women in rural Kenya despite some progress in past years. Over the last three decades, the reduction of maternal mortality (MMR) has been the top global health issue but the MMR in Kenya remains significantly high (WHO, 2014a). With the transformative support by the Sustainable Development Goals (SDGs), the SDG#3 aims to reduce maternal mortality rates to 70 per 100,000 live births and end preventable deaths of newborns and children under 5 years of age, with the goal of reducing the neonatal mortality to at least 12 per 1000 live births and under-5 mortality to at least 25 per 1000 live births (United Nations, 2015).

While many interventions have been put in place to prevent maternal and infant mortality and to improve the health of mothers and infants in Kenya, many mothers and infants are still dying due to preventable causes during postpartum care. For example, despite the abolishing of maternity fees in Kenya, mothers and infants are still dying due to the three delays as indicated by Thaddeus and Maine (1994), (delays in deciding to seek skilled birth services, delays in arriving at health facilities and delays in receiving adequate treatment and referral).

This indicates that there are several factors that intersect to influence the health outcomes of mothers and infants. It also shows that some aspects of maternal and infant healthcare are not only within healthcare facilities, they are also in the wider societal contexts of a given country and must be viewed with an intersectionality lens that is capable of capturing these multiple level factors including the social determinants of health such as gender disparities, level of education, poverty, and unemployment, among others.

Given that women's health issues intersect at the individual level, the same practices that create disadvantage could also yield positions of privilege (Van Herk, et al., 2011). Intersectionality has been used in health-related research to conceptualize the social determinants of health and their role in producing health inequities (Caiola, Docherty, Relf, & Barroso, 2014; Hence, an intersectionality lens would illuminate how the nurses and midwives become change agents in moving forward women's health agenda. This will promote the integration of multiple socially constructed factors such as gender, socio-economic status, and professionalism in healthcare.

Despite the multifaceted and important work of nurses and midwives in rural Kenya, many stakeholders, including doctors, community leaders, and other healthcare professionals, often devalue them and often miss "the big picture" of what nurses do and the impact they have in health care. Nurses and midwives must therefore assert themselves as independent professionals within the healthcare arena. Moreover, beyond the aspects of gender relations, there is a need for "nursing scholarship that conceptualizes the intersection of class, racialization ... and other social relations, because we experience our lives not solely as gendered persons, but as classed and racialized persons" (Anderson, 2000, p. 226). Nurses and midwives, being mostly female are exposed to gendered experiences in the society. Further, by living within the society,

nurses and midwives are aware of the cultural practices of TBAs. Therefore, nurses and midwives need to rise beyond the social class that has been ascribed to them and courageously advocate for women and infants' health as well as for their profession. This could be done through an intersectionality lens.

Women should have autonomy and choice over their health but experiences of social and health inequalities such as education, unemployment and job security, food insecurity, access to health services, all of which are compounded by rural and remote geographical locations and transportation difficulties, create health inequities for women in rural Kenya. Similarly, although nurses and midwives strive to provide quality postpartum services for the women and their infants, oppression based on gender contributes to the failure of women to access quality and timely healthcare. Gender, a social construction of identity could bring about an unbalanced power relation between men and women, affecting the health-seeking-behavior and health outcomes of women during postpartum period (WHO, 2010b). For example, the dependence on men contributes to delays in the decision to seek medical care, in reaching care, and in receiving adequate health care (Thaddeus & Maine, 1994). All of these delays have direct or indirect implications for the quality of healthcare that the nurses and midwives are providing to the childbearing women and infants, especially for those in rural communities.

Due to dependence on their husbands to make decisions to seek skilled healthcare, or to provide finances for transportation to this kind of healthcare (Muthoni & Miller, 2010), women are often delayed in receiving skilled health during the perinatal period. And even once they have reached a health facility, the nurses and midwives may lack essential supplies or work with staff shortages. All these causes of delay, if not adequately addressed, will continue to be detrimental to the health of women and their infants in rural Kenya. Therefore, when investigating issues

relating to adverse effects during postpartum period, it is important to look at the root cause of the problem in order address it.

Kenya has several strategies to eliminate preventable causes of maternal mortality by increasing access to maternal health services, for example, the FMS policy, which was introduced in 2013, and the “Beyond Zero” campaign (MOH, 2014a). Yet, many mothers still die during the perinatal period. The “Beyond Zero” campaign that is led by the current first lady of Kenya, Margaret Kenyatta, is an example of the need for inclusive models such as intersectionality in healthcare. The Beyond Zero campaign is a call to action in Kenya for policy prioritization and formulation to enable increased resource allocation, improved healthcare service delivery, and improved health seeking behaviors and practices such as the use of skilled healthcare during the perinatal process. The campaign is guided by a Strategic Framework for Engagement of the First Lady in HIV Control and Promotion of Maternal, Newborn and Infant Health in Kenya (2013-2017) (MOH, 2014a).

The campaign utilizes nurses and midwives to provide maternal and infant health services through mobile clinics in rural areas where there is an increased challenge to access to skilled care. However, issues related to transportation due to poor road infrastructure and the preference for using a TBA over a skilled healthcare provider still hinder women and infants from accessing skilled healthcare (Akunga et al., 2014). Further, the social and cultural norms restrict the mobility of women and girls and deny them the right to take decisions concerning their sexuality and reproduction, such as use of skilled health services during postpartum care, that include access to family planning services (WHO, 2010b).

Using intersectionality has the potential to provide a way of conceiving how structural factors interact to produce specific health outcomes in individuals and at the cultural and

structural levels, and reframe how social inequality is conceptualized, investigated, analyzed, and dealt with (Bowleg, 2012). Hence, for healthcare policies such as the Beyond Zero campaign to succeed, there should be more targeted and effective policies that promote access to health services, such as improving road infrastructure and training healthcare staff to be more sensitive to women's beliefs as well as to emulate cultural competence.

Without education on the importance of skilled health services, the society will not value access to these services regardless of their availability. For example, nurses and midwives in this study indicated that women and infants presented with postpartum complications after being cared for by the TBA. This is an indication that besides bringing skilled healthcare services closer to the women, mobilization of resources to educate communities on the importance of using skilled perinatal services is necessary. Hence, nurses and midwives require a good understanding of the cultural value of postpartum care for their education to the public to be effective.

Nurses and midwives in rural Kenya utilized community partners to promote awareness of postpartum care services in an effort to secure a higher use of skilled care. The concept of intersectionality could promote collaboration among social support systems such as family, friends, traditional birth attendants, and other healthcare professionals to develop a shared understanding on how to approach perinatal care without any of the parties feeling dominated or their ideas repressed. It is evident that family members have a significant role in women's decision making and can either support or oppose the use of skilled postpartum services (Abushaikha & Khalaf, 2014). Therefore, strengthening community linkages among such key players as husbands or male partners, mothers-in-law, TBAs, and community leaders, could help to encourage the use of skilled healthcare during the postpartum period (Warren et al., 2010).

These partners can help to address the gaps in the quality of postnatal services as they promote awareness of postpartum services (Adams et al., 2017).

Spirituality is also an important aspect in the search for good maternal and infant health outcomes. For example, in this study, most of the nurses and midwives were either Christian or Muslim. They also indicated that the women they cared for were mostly Christian or Muslim. Thus, the nurses and midwives had a shared perspective with their clients when handling difficult health complications as they both had a similar spiritual basis. As elaborated by Rogers and Wattis (2015), the faith and beliefs in many religions are often associated with power structures. Spirituality has proven important when individuals are feeling vulnerable or when facing a crisis of any kind, either as a nurse/midwife or as a patient; hence, this may help them with finding hope and reason (Cook, 2004; Rogers & Wattis, 2015). Cook (2004) stated that spirituality is ultimately important for nurses to create compassion, meaning, and purpose for life. Therefore, despite the many other barriers to providing care, most of the nurses and midwives drew resilience and compassion from the women under their care from their spirituality.

Intersectionality could illuminate how socio-political contexts and structural processes interact to shape the care available to women and their families especially in rural and remote communities (Collins & Bilge, 2016). Most of the low-resourced countries such as Kenya depend on funding from developed countries such as the US and most recently, the Peoples' Republic of China. These powerful countries thus drive the global health agenda, including the national health systems and the policies that govern them in the less powerful or developing countries. These global influencers are overseen by international organizations that support the healthcare systems financially, such as United States Agency for International Development

(USAID), the United States President Emergency Plan for Aids Relief (PEPFAR), among others (WHO, 2018).

Nevertheless, this study recommends that local health policies must be people-centered in order to promote good health outcomes as well as the health security of the people within rural areas. Countries such as Kenya should have the capacity of developing their own policies, or have the authority to amend the existing policy to ensure relevance to the country-specific. This calls for an intersectionality lens to carefully deconstruct social determinants of health and mobilize multiple stakeholders to foster progress in global health through capacity building in research, leadership, policy development, and skills updating, as well as to establish ownership and develop sustainable interventions ((WHO, 2018). Proper alignment of health spending funding and involvement of front-line staff in decisions about financial forecasting could support better implementation of maternal health programs in rural Kenya.

The hiring and distribution of human resources, the financial aspect, the capacity for career development and continuing education, hospital infrastructure, resource availability, hospital management, and personal recognition, all play a large role in the retention of workers (Willis-Shuttuck et al, 2008). Similarly, in Kenya, some studies have shown that unfavorable work environments are one of the main factors in staff attrition (Wakaba et al., 2014). Therefore, all these aspects must be taken into consideration in programs aimed at recruiting and retaining healthcare workers.

For instance, the FMS policy, which was introduced in 2013, led to an increase in women accessing skilled health services, including postpartum care, but the ratio of nurses and midwives to the population has remained the same. This has caused role overload for the nurses and midwives and has negatively affected the provision of postpartum care in rural Kenya because

capacity has remained the same in terms of space, staff, and equipment. Further, there are no clear policies and guidelines on the implementation of FMS (Tama, et al., 2017). The success of healthcare policies and protocols is greatly dependent on the implementation process. Although nurses and midwives have knowledge of the policies and processes regarding postpartum care, their implementation of these policies is hindered by inadequate human resources and essential equipment and drugs, as well as negative socio-economic factors that contribute to inadequate access to skilled health services (Thaddeus & Maine, 1994). These create an unhealthy work environment for the nurses and midwives, as well as poor quality of care with subsequent ~~and~~ negative health outcomes for women and their infants.

6.4 Summary of the Chapter

In this chapter, I have attempted to situate the findings from the study within the existing literature. I discussed the individual and systemic issues that impact on the work of the nurses and midwives, and the potential for these issues to influence the health outcomes of mothers and infants during the postpartum period. Individual level issues are those influencers that capture the reality of the nurses and midwives at the personal level, while systemic issues are those factors that influence postpartum care systemically. Considering the complexity of drivers of inequities and power relations at both individual and structural levels, I proposed the use of an intersectionality lens in relation to critical theory and Foucault's concepts of power and knowledge.

While using critical theory and Foucault's concept of power and knowledge lens could make the nurses and midwives aware of the power dynamics within the health facilities and the surrounding communities, an intersectionality lens could help to integrate issues of gender, social, cultural, geography, level of education, religion, and economic status, into the policies

and programs related to postpartum care in rural areas of Kenya. This will encourage the nurses and midwives to engage in dialogue about these hindrances to their provision of postpartum care in rural Kenya. Hence, nurses and midwives should use their collective voices to advocate for women and challenge the status quo around women's health and their ability to make decisions that would define their health. This includes advocating for social justice, promoting gender equality, and allocating healthcare resources that could consequently affect the health of the women and involvement of the community to improve skilled healthcare attendance.

CHAPTER 7: Implications of the Study, Strengths and limitation, and Conclusion

This study has illuminated factors that contribute to the experiences of nurses and midwives providing postpartum care in rural Kenya. It has also shown that the personal and professional experiences of these nurses and midwives, as well as postpartum care issues in rural Kenya, could be well understood using an intersectionality lens. In this chapter, I will discuss the implications of the study for nursing and midwifery practice, education, research, and policy development/leadership. Therefore, it is necessary to create a robust environment through capacity building in these areas (practice, education, research, and policy development/leadership). This chapter terminates with the strengths and limitations of the present study as well as a conclusion.

7.1 Implications of the Study

Actively engaged nurses and midwives can have a significant positive impact on perinatal services since they play an integral role in providing postpartum care in rural areas of low-resource countries such as Kenya (WHO, 2016). Therefore, for the success of maternal and infant health policies, their experiences are needed in planning and delivering these services. This includes their participation in the planning, implementation, and monitoring of healthcare service delivery in order to promote equitable, respectful, and culturally safe services to their clients. The nursing and midwifery workforce are dependent on several individual and structural factors that affect their work. Advocating for better working conditions for nurses and midwives in rural communities is necessary for better maternal and infant health outcomes. Thus, the presence of nurses and midwives at the decision-making table is important in moving forward a health agenda. Given their intimate knowledge of health care and the issues faced by community

member, these professionals can provide leadership by proposing context-specific interventions that could improve the quality of postpartum care in rural Kenya.

7.1.1 Implications for practice.

Nurses and midwives deliver responsive and cost-effective healthcare services in rural Kenya. Therefore, it is necessary to ensure a supportive environment that allows these nurses and midwives to safely practice to their full capacity while transforming the health outcomes of women and infants. There is a need for nurses and midwives to be responsive to the current healthcare challenges especially in terms of maternal and newborn health outcomes, particularly those related to mortality and morbidity. For example, the presence of a nurse or midwife in labor and birth care could reduce the chances of caesarean birth (Gama et al., 2016). As Foucault (1980) asserts, those with disciplinary power hold positions of influence and control, using power at their disposal, which can either benefit or disadvantage others. The power imbalance created by a lack of transparency in the health systems could hinder intra- and interprofessional collaboration between nurses and other healthcare stakeholders. Intra- and interprofessional collaboration among nurses and midwives and other healthcare professionals can improve health outcomes for mothers and their infants during the perinatal period (Van Herk, et al., 2011).

The findings from the present study suggest that enabling a healthy work environment for the nurses and midwives who provide postpartum care could improve the health outcomes of mothers and their infants. Nurses need more resources including better staffing, equipment, and professional development in order to provide evidence-based postpartum care. This includes facilitating the use of postpartum care guidelines to increase evidence-based practice (Gerrish et al., 2011). As well, nurses' and midwives' awareness of the potential power imbalance between them and the women is essential. Nurses and midwives are educated professionals who possess

postpartum knowledge, while the women in rural areas are mostly less well-educated, are unemployed, and have little knowledge about postpartum care. Thus, nurses and midwives must be aware of how they relate with the women to avoid any power disparities when caring for them during the postpartum period. Being in a vulnerable position, the women deserve dignified and culturally safe care as per the postpartum care policies and guidelines.

7.1.2 Implications for education.

Nursing education need to move to the university setting. A well-prepared nursing and midwifery workforce will adequately meet the current challenges of healthcare and enable their members to have the authority to deliver needed care on their own initiatives (Fletcher, 2006). This starts with a robust curriculum for nursing and midwifery students that support critical thinking and knowledge application beyond the classroom. It entails asking the questions “What are we teaching? What is being learned? Is the knowledge applicable and practicable?”

The World Health Organization recognizes the significant need to strengthen technologies, relevant education, healthcare policies, and practice guidelines that support building the capacity of nurses and midwives through inclusive, structured learning processes in order to create an empowered human resource that is competent in providing evidence-based practices and promoting nursing practice and education (WHO, 2006). Designated learning centers for nurses and midwives would makes it feasible for nurses and midwives to transition their knowledge into practice. Participants in this study voiced the need for a learning center with computers and access to the internet where they could learn about best practices to care for their clients.

7.1.3 Implications for research.

Although there has been an increase in health research, most of the published research in Africa is still dependent on funding sources, causing a gap between healthcare needs and clinical research (Sun & Larson, 2016). Thus, there is a need to boost the capacity of nurses and midwives to conduct clinical research using a critical perspective (Anderson, 2000). As indicated in Chapter 2, there is a paucity of published research regarding the experience of nurses and midwives in rural Kenya. More research on postpartum care in rural areas is required in order to address the gaps in the provision of care. This entails realigning health research to the current changes in the nursing and midwifery delivery of care model associated with task shifting in healthcare systems. The findings from this study indicated that nurses and midwives are not actively engaged in leading research, but rather, they mostly participate in the data collection stages. Indeed, nurses and midwives are suited to conduct health research within their work contexts and to advocate processes that will promote the implementation of evidence-based practices in postpartum care (WHO, 2013).

Most of the healthcare research in Kenya is less specific to nurses and midwives, despite them being the main contributors to patient care. This is contrary to many developed countries, where nursing has developed outstanding examples of expert practice policies, such as the Magnet recognition distinction developed in the United States (Leavitt, 2009). Hence, we should rethink ways of doing postpartum research in low-resourced countries, by building the nurses' and midwives' capacity through intentionally incorporating research studies in their training curriculum, as well as continuous professional development.

Besides ensuring compliance with laws and regulations, the quality measures (designed by the nurses) used in the Magnet system assure outcomes that reflect expert nursing practice

(Leavitt, 2009). Hence, through active involvement in research, nurses could make an impact in contributing to policies that could positively influence patient health outcomes and advance the nursing profession in Kenya. Anderson (2000) argues the need for nursing scholarship using an intersectional lens so that research can have relevance to policy actions that support the current healthcare needs geared to specific contexts.

7.1.4 Implications for policy/leadership.

A stronger presence of nurses and midwives in the policy arena is needed for respectful implementation of strategic directions in healthcare based on evidence-based practices. Although nurses and midwives in this study indicated a commendable leadership within their practice by ensuring patient safety and quality of care, they continue to be absent at the health policy table (Juma et al., 2014). This absence has silenced the voices of the nurses and midwives in rural areas because they are very knowledgeable about issues that concern the health of women and infants, hence silencing the nursing and midwifery knowledge (McMillan, 2016). Nurses and midwives provide preventative and curative health services as well as behavioral health education to women and infants. However, their efforts are hindered by structural factors that includes lack of representation in the decision-making tables (Juma et al., 2014).

In order to attain the SDG 3, healthcare systems in low-resourced countries such as Kenya are undergoing continuous change. For example, the strategies that the Kenyan government have put in place to attain SDG 3 (the national Maternal and Newborn Health (MNH) Model in 2010, national guidelines for quality obstetrics and perinatal care in 2012, and the introduction of free access to maternal and infant health services in 2013), have the nurses and midwives at the center of implementation. These contexts dictate that nurses and midwives

must carry out their work in ways that have been pre-set for them, lending their voices unheard and exposing them to possible change fatigue.

As indicated by Foucault, the way in which the voice is circulated through giving and receiving exemplifies the struggle over knowledge and highlights the potential opportunities of knowledge (Foucault, 1980). Other researchers highlighted that weak leadership and poor service delivery through shortages of staff, and lack of standards, supervision, and accountability are key contributors to disrespect and abuse (Warren et al., 2013). In contrary, others have indicated that front-line workers could experience change fatigue with any organizational changes, that could be portrayed as feelings of apathy, ambivalences, and disengaged (McMillan, 2016). This could create unjust power-relations between women and healthcare providers. Hence, recognizing that the women, nurses, and midwives are key collaborators in decision-making arenas for health-related issues is important to address postpartum care issues. There is also a need to enhance the diversity of nurses and midwives in order to satisfy the demands of diverse cultures that they serve.

The importance of policies that address postpartum care holistically are geared to preventative health practices. By understanding how disciplinary power (Foucault, 1980) could impact their work and the health of women in rural Kenya, nurses and midwives could engage in unpacking the interlocking underlying power structures that produce inequalities in health and that contribute to maternal mortality, either directly or indirectly. Acknowledging and acting on these inequalities is necessary to attain the national goal of improving maternal and infant health outcomes.

All the above factors could be viewed from an intersectionality lens, so that nurses and midwives can become full partners in ameliorating detriments to healthcare at the local, national,

and global levels. Nurses and midwives can advocate for the health of the populations they serve if they are not compromised by inequities arising from lack of knowledge in the delivery of care or being shut out of participation in the decision-making process. Such practical evidence is important for nursing as a profession because it enables nurses and midwives to recognize that power relations are reciprocal.

7.2 Strengths and Limitations

This section presents the strengths and limitations for this research study. First, I will present the strengths. This is the first study of its kind focusing on postpartum care in rural Kenya, involving nurses and midwives, and using focused ethnography. Focused ethnography has proven to be an efficient way of conducting problem-focused and context specific healthcare research (Knoblauch, 2005). Using focused ethnography provided a better understanding of nursing and midwifery culture in rural Kenya, hence a platform for a program of research in maternal and infant health, specifically postpartum care (Cruz & Higginbottom, 2013). The study contributes to nursing knowledge using focused ethnography, and in particular, conducting an ethnography study without doing participant observation. Finally, proposing the use of an Intersectionality Model of Postpartum Care in rural Kenya to address the complex drivers of health inequities and power relations at both individual and structural levels.

There are three limitations to this research study. First, although generalizability was not a guiding principle for my study, as a qualitative study with a small participant sample of 23 nurses and midwives from nine health centers and Kapsabet County hospital in Nandi County, the findings from the study may not be generalizable. However, the rich description provided in this thesis report will help future research to transfer some aspects of the research process into their own work. Second, because the nurses and midwives were participating in a national strike

during data collection, this could have interfered with their responses during the individual interviews. Third, this study included nurses and midwives who worked in the public sector only. In looking back, although the study findings have generated rich information regarding the experiences of nurses and midwives in rural Kenya, it may be beneficial to include nurses and midwives working in the private sector in order to get their perspectives on postpartum care. I should have also included nursing and midwifery supervisors as well as other healthcare staff who provide postpartum care. These particular health care providers will be considered in future studies.

7.3 Conclusion

In general, the work of the nurses and midwives in rural Kenyan communities was influenced by several socio-economic, gender, cultural, and political factors. Hence, information about their knowledge and engagement with local communities while providing holistic family-centered and culturally appropriate postpartum care, is necessary in order to determine their experiences in providing that care.

Understanding nurses' and midwives' experiences will inform future program development and the preparation of future nurse leaders and administrators especially in rural communities. This understanding will also enhance the training and deployment of the health care workforce, foster interprofessional collaboration and a team approach, make better use of communication technologies to disseminate best practices, and improve strategic planning and coordination of MNCH services.

In this study, I have shown how gender and power relations may be influencing the perinatal care services that nurses and midwives provide to the women and infants in rural Kenya. Hence the need to integrate gender perspectives into the policies and programs affecting postpartum care. It also sheds light onto how maternal and infant health may be influenced by power, politics, and policies. Those who have power can play the political game of lobbying for politics that favor their interest. Ill-advisedly, nurses and midwives are very low on the list of those who are powerful and politically astute at policy tables.

Being the largest team of healthcare professionals and working closely with women and infants in rural health facilities, nurses and midwives could have collective power within the healthcare system. While nurses and midwives working in rural Kenya have created a space for trusted, safe, and skilled postpartum health services, there remains a gap in terms of optimal

postpartum care that would have significant impact in improving maternal and newborn health outcomes. Unfortunately, their ability to advocate for necessary resources is compromised by structural oppression, as evident in the social, political, and socioeconomic issues that continue to negatively impact on nursing and midwifery work. This calls for nurses and midwives to become more politically savvy, in order to take their rightful place in the decision-making arena.

The use of critical theory and Foucault's power and knowledge lens to examine the work life of nurses and midwives providing perinatal health in rural Kenya illuminated the power dynamics within the healthcare sector. This calls for need to create an environment of empowerment that might lead towards positive changes within the health sector. This is a necessary step in meaningfully engaging nurses and midwives in healthcare design and policy decisions, which will ultimately lead to improvements in the health outcomes of women and their families, especially in the rural areas of low-resource countries like Kenya.

Intersectionality lens could promote the integration of issues of gender, social, cultural, geography, level of education, religion, and economic status, into the policies and programs related to postpartum care in rural Kenya. This integration requires the support of political leaders, as well as health organization leaders in the implementation and ensuring inclusion in the day- to- day work for nurses and midwives providing postpartum care in rural Kenya.

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Appendix I - Kenya National Guidelines for Quality Obstetrics and Perinatal Care
(MOH, 2014a)

Timing	Mother	Baby
Within 24 - 48 hours*	<ul style="list-style-type: none"> a) Mental status assessment b) Physical assessment (Pallor, Temperature, Blood Pressure, uterine involution, Inspection of the Caesarean wounds for bleeding, lochia assessment, and breast examination for establishment of lactation, calf tenderness) c) Record in Postnatal Care (PNC) register and Mother Infant booklet (MCB). d) Provide Pain management as needed. e) Screening for TB and treat as appropriate f) Provide Vitamin A (200,000 iu), Iron/folic acid supplements g) Treat or refer if any complications are detected h) Provide appropriate family planning (FP) method i) If HIV positive give ARV's for prophylaxis or treatment j) Counsel on: HIV Counselling and testing /re-testing, k) FP Counselling (healthy Timing & spacing of pregnancy) l) Advice on: Danger signs for mother, personal hygiene and hand washing, breast care, exercises, care of the perineum, harmful practices, maternal nutrition, use of Insecticide Treated Nets (ITN). m) Provide mother with a return date 	<ul style="list-style-type: none"> 1. Assess Apgar scoring 2. Perform physical assessment (temperature, take and record birth weight, and head to toe examination. 3. Assess for danger signs for baby 4. Observe breast feeding 5. Record in PNC register and MCB 6. Ensure warmth and put hat on baby 7. Delay baby's first bath for the first 24 hours 8. If pre term encourage skin-to-skin care 9. Encourage early initiation of, and exclusive breastfeeding 10. Administer Tetracycline eye ointment 1%, Vitamin K 11. Administer Immunization (BCG & birth Polio) 12. Infant prophylaxis for HIV as indicated 13. Treat or refer the infant if any complications are detected 14. Encourage and facilitate birth registration 15. Counsel on: Cord care, hand washing for care givers 16. Provide a return date for baby
Within 1-2 weeks	<ul style="list-style-type: none"> 1. Mental status assessment 2. Physical assessment (Pallor, Temperature, Blood Pressure, uterine involution, Inspection of the Caesarean wounds for 	<ul style="list-style-type: none"> 1. Assess for growth monitoring, weight, head to toe examination 2. Assess for danger signs for baby

	<p>bleeding, lochia assessment, and breast examination for establishment of lactation, calf tenderness</p> <ol style="list-style-type: none"> 3. Uterine involution 4. Observe a breast feed, Record in PNC register and Mother Infant booklet 5. Provide Vitamin A supplementation (if not yet given) 6. Treatment for any complications detected Referral as appropriate 7. Counsel on: Danger signs for mother, HIV, FP, maternal nutrition, personal hygiene and hand washing for caregiver, breast care and exclusive breast feeding, harmful practices, cervical cancer screening 8. Provide a return date 	<ol style="list-style-type: none"> 3. Check eyes for discharge 4. Immunisation status 5. Observe a breast feed 6. Record in PNC register and MCB 7. Provide: Vitamin A if not yet given, immunisations if not yet started, 8. INH prophylaxis as appropriate treatment of any complications detected 9. Referral as appropriate 10. Birth registration if not yet done 11. Counsel mother on: Danger signs for baby, exclusive breast feeding, hand washing for caregiver, keeping baby warm, cord care Adherence to ARV prophylaxis as appropriate 12. Provide a return date
4-6 Weeks	<ol style="list-style-type: none"> 1. Assess mother's general condition, mental status, blood pressure, weight, temperature, uterine involution, lochia (amount /colour), observe a breast-feeding record in PNC register and MCB. 2. Provide: FP method of choice, HIV Screening, cervical cancer screening, clinical breast examination, screening for Sexually Transmitted Infections (STI), Respiratory Tract Infection (RTI), screen for Tuberculosis (TB) and treatment for any complications detected Referral as appropriate 3. Counsel on: Danger signs for the mother, exclusive breast feeding and breast care, FP, maternal nutrition, harmful practices, personal hygiene and hand washing for the caregiver 4. Provide a return date 	<ol style="list-style-type: none"> 1. Assess for growth monitoring, weight, head to toe examination 2. Assess for danger signs for baby 3. Check eyes for discharge 4. Immunisation status 5. Observe a breast feed 6. Record in PNC register and MCB 7. Provide: Vitamin A if not yet given, immunisations if not yet started, 8. INH prophylaxis as appropriate treatment of any complications detected 9. Referral as appropriate Early infant diagnosis (EID) for HIV management of HIV positive infant, birth registration if not yet done 10. counsel mother on: Danger signs for baby, exclusive breast feeding, hand washing

		<p>for caregiver, keeping baby warm, cord care Adherence to ARV prophylaxis as appropriate</p> <p>11. Provide a return date</p>
4-6 months	<ol style="list-style-type: none"> 1. Assess mother's general condition, mental status, blood pressure, weight, temperature, uterine involution, lochia (amount /colour), observe a breast-feeding record in PNC register and MCB. 2. Provide: FP method of choice, HIV Screening, cervical cancer screening, clinical breast examination, screening for Sexually Transmitted Infections (STI), Respiratory Tract Infection (RTI), screen for Tuberculosis (TB) and treatment for any complications detected Referral as appropriate 3. Counsel on: Danger signs for the mother, exclusive breast feeding and breast care, FP, maternal nutrition, harmful practices, personal hygiene and hand washing for the caregiver 	<ol style="list-style-type: none"> 1. Assess for growth monitoring, weight, head to toe examination 2. Assess for danger signs for baby 3. Check eyes for discharge 4. Immunisation status 5. Observe a breast feed 6. Record in PNC register and MCB 7. Provide: Vitamin A if not yet given, immunisations if not yet started, 8. INH prophylaxis as appropriate treatment of any complications detected 9. Referral as appropriate Early infant diagnosis (EID) for HIV management of HIV positive infant, birth registration if not yet done 10. Counsel mother on: Danger signs for baby, exclusive breast feeding, hand washing for caregiver, keeping baby warm, cord care Adherence to ARV prophylaxis as appropriate 11. Provide a return date

*The first assessment should be carried as soon as possible after deliver. If facility birth, the mother and baby should be checked at 1 hr, 6 hrs and again before discharge. If home delivery, refer to health facility as soon as possible within 24/48 hours.

Appendix III - Information Letter-Interview

Title of the Study: Experiences of Nurses and Midwives Regarding Postpartum Care in Rural Kenyan Communities



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Research Team:

Principal Researcher: Janet Kemei, BScN, MHA, PhD Student, School of Nursing, Faculty of Health Sciences, University of Ottawa.

Supervisor: Dr. Josephine Etowa, PhD, RN, Full Professor, School of Nursing, Faculty of Health Sciences, University of Ottawa.

Introduction: You are being invited to voluntarily participate in a study led by Janet Kemei. Janet is an experienced Registered Nurse (RN) who holds a Bachelor's degree in Nursing from Baraton University, Kenya. The study is entitled: *Experiences of Nurses and Midwives Regarding Postpartum Care in Rural Kenyan Communities*. This study is part of the requirements that Janet must complete to be granted a PhD degree from the University of Ottawa, Canada.

Participation: If you agree to participate in this study, Janet will conduct an interview with you that will last about 60 minutes, and will invite you to participate in one focus group with other nurses and midwives. The focus group will last about 90 minutes. With your permission, the interview and the focus group sessions will be audio-recorded.

Risks: There are minimal risks to the study. The researcher will take every effort to minimize any risks such as assigning an interview record number instead of using your name on the document. Quotes will be anonymous, although there is a possibility that someone may identify you from the quote.

Benefits: There are no direct benefits to you from the research. However, the research findings will be shared with relevant stakeholders with the goal of addressing maternal health policies to enhance nurses and midwives' quality of care. This will in turn create

positive maternal health outcomes.

Conservation of data: All information collected during research (audio-recordings, interview transcripts and field notes) will be kept under lock and key with the researcher's supervisor at the University of Ottawa.

Compensation: There will be a monetary compensation of five hundred (500) Kenya Shillings for your participation in each interview and focus group session. If you choose to

withdraw from the study, you will still be eligible to receive the full compensation amount of five hundred (500) Kenyan Shillings.

Voluntary participation: You are under no obligation to participate. You may choose to participate in only the interview or only the focus group. If you choose to participate, you can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw after the completion of the interview, you will be given the option of also withdrawing your data. Kindly note that because of the inter-dependent nature of focus group data, individual data shared during the focus group cannot be withdrawn.

Contact persons for participants: If you have further questions regarding the study, please feel free to contact Janet Kemei or Dr. Josephine Etowa through email or phone.

This study has received ethics approval from the University of Ottawa Research Ethics Board, The Institutional Research and Ethics Committee (IREC) at the Moi Teaching and Referral Hospital, and Kapsabet County Hospital Medical Superintendent. If you have any questions about the contact of this study or your rights as a research participant, you may contact any of the following:

The Administrator, IREC, Email- irec@mtrh.or.ke. The Medical Superintendent, Kapsabet Referral Hospital, Email- medsupkapsabetrvp@yahoo.com

OR

Protocol Officer for Ethics in Research

University of Ottawa, Tabaret Hall

550 Cumberland Street, Room 154

Ottawa, Ontario, Canada, K1N6N5

Email- ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep and the other one to be kept by the researcher under lock and key and separate from the data.

Tear-off sheet: If you are interested in participating in this research on Experiences of Nurses and Midwives Regarding Postpartum Care in Rural Kenyan Communities, please tear off this part and put it in an envelope and seal the envelope. The researcher will come pick the envelopes from the facility. You can also call the researcher on her mobile number

I accept to participate: Yes _____ No _____

Name (*optional if you do not accept*): _____

Phone no (*optional if you do not accept*). _____

Appendix IV- Individual Interview Consent Form

File # _____



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Title of the Study: Experiences of Nurses and Midwives Regarding Postpartum Care in Rural Kenyan Communities: How have the nurses and midwives contributed to the reduction and prevention of maternal and newborn mortalities in Kenya.

❖ I have read and understood the information on the “Information Letter”. I have been given the opportunity to discuss any questions and they have been answered to my satisfaction. I hereby consent to participate in the study and I understand the information in this Consent Form.

Yes

NO

❖ I give my permission to be contacted within 12 weeks for a focus group meeting that will be conducted following the interview. I also agree to be conducted via telephone on the following number _____ if the researcher requires to arrange for a follow up interview to clarify items raised during the initial interview.

Yes

NO

❖ I agree to allow my interview to be audio-recorded. I agree for my information to be in this study and I am aware that all personally identifying information shall be removed to protect my anonymity. I also understand that I may request for the recorder to be turned off if there are answers to the questions that I do not wish to be recorded. I give my permission to be observed during the interview

Yes

NO

There are two copies of the consent form, one of which is mine to keep in a sealed envelope under lock and key, separated from other study data. Please sign and date both copies.

Participant's signature: _____ **Date:** _____

Researcher's signature: _____ **Date:** _____

Appendix V - Demographic Questionnaire

File # _____

The information collected in this form shall only be used for the purposes of this study.
This information will be kept under lock and key with Dr. Etowa at the University of Ottawa.

Place of interview _____

Date of interview _____

Starting time _____

Ending time _____

Results of the interview 1. Completed

2. Not completed

Reasons for incomplete interview

1. To be continued on _____

2. Withdrawn from the study _____

1. Name: _____

2. Age: _____

3. Gender: _____

4. Marital status Married _____ Single _____

5. Are you originally from the Nandi County? Yes _____ No _____

6. What language(s) do you speak? _____

7. Level of Education: Certificate, Diploma, Degree, Graduate, Post-graduate, Other

8. What is your current title: _____

9. What are your regular shifts of work? _____

10. How long have you worked as a nurse/midwife? _____

11. How long have you worked at this health facility: Years _____ Months _____

12. What are your previous nursing and midwifery experiences: _____

13. Have you received post-basic nursing /midwifery training? Yes _____ No _____

14. If yes, what training have you received? _____

15. Are you planning on leaving your current job? Yes _____ No _____

16. If yes, to where? _____



Appendix VI - Interview Guide

File _____



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The Interview Guide

Objective 1: To describe how the sociopolitical and cultural contexts of the health care influence the provision of postpartum care by nurses and midwives.

1.1 How would you describe the general population of mothers seeking postpartum care in your facility? (Probe: ethnic background, age, literacy level).

1.2 Are there any other healthcare staff working in this facility besides nurses and midwives?

1.2.1 If yes, what postpartum care services do they provide?

1.2.2 Are they consistently available to provide these services?

1.3 As a nurse and a midwife how would you describe the care mothers and their families receive from you during the postpartum period?

1.4 In general, did the women in your unit receive good postpartum care within 48 hours of the baby being born? Please explain.

1.5 Have you found any problems with mother and baby during postpartum visits?

1.5.1 If yes, what was the problem?

1.5.2 How was the problem resolved?

1.6 Please explain how the referral systems of maternal services work in your facility? (Probe: Do you receive any referrals at this facility? Do you refer mothers and/newborns to other facilities?).

1.7 What are some of the cultural postpartum practices that may have negative influence on mothers' and newborn's health outcomes during the postpartum period? (Probe: based on participant's response).

1.8 How would you describe the government's political will to promote maternal health and postpartum care?

1.9 In your opinion, what is the current situation of postpartum care utilization?

Objective 2: To identify facilitators influencing nurses' and midwives' ability to competently provide postpartum care.

2.1 Please describe any specific resources that have helped you to adequately accomplish your tasks at work (e.g. equipment, management support).

2.2 What training and educational opportunities do you have to enhance your ability to provide effective postpartum care services?

2.3 What opportunities do you have to provide input into postpartum care policy development and dissemination? (e.g. management, policy makers).

2.4 Are there other facilitators (or factors) that help you to do your work or to provide postpartum care to mothers and babies?

2.4.1 What are these facilitators (or factors)?

2.4.2 Out of the facilitators (or factors) that you have just mentioned, which one is the most important or the most useful? Please explain.

Objective 3: To identify barriers influencing nurses' and midwives' ability to competently provide postpartum care.

3.1 How many nurses are normally scheduled to work on each shift in your facility?

3.2 In your opinion, is this adequate staffing?

3.3 What support networks are available for nurses and midwives in your facility?

3.3.1 If available, how useful do you find these networks in your work place?

3.3.2 If no, how do you envision having a support network in your work place?

3.4 Are there other barriers that hinder or prevent you from doing your work or from providing postpartum care to mothers and babies?

3.4.1 What are these barriers?

3.4.2 Out of the barriers that you have just mentioned, which one is the most challenging at this moment in time? Please explain.

3.4.3 According to you, what is (or are) the solution (or solutions) to handle this barrier?

Objective 4: To explicate nurses' and midwives' current knowledge regarding best practices in postpartum care.

4.1 Please describe the current postpartum guidelines used in this facility (prob. Ask about

the postpartum guideline).

4.2 Are these developed by nurses/midwives or by other healthcare professionals?

4.3 What do best practices mean to you?

4.4 Would you say you utilize best practices in your current practice?

4.4.1 If yes, how do you utilize them?

4.5 Do you have a separate protocol for HIV positive mothers and mothers with sexually transmitted diseases? Please explain.

4.6 Are these protocols developed by nurses/midwives or other healthcare professionals?

4.7 What kind of information do you provide mothers during the postpartum period?

4.8 Please explain how you have provided breastfeeding support to mothers (Prob. Ask about breastfeeding behaviours, difficulties with breastfeeding)

4.9 How do you screen the mother for Tuberculosis during postpartum visit?

4.10 How do you assess mental health in new mothers?

4.11 Do you provide family planning to mothers?

4.11.1 If yes, what kind?

4.11.2 At what point do you provide the mothers with family planning?

4.12 What are your thoughts regarding best practices and postpartum care guidelines?

Thank you for your participation.

Appendix VII - Recruitment Poster

Recruitment Poster

Nursing and Midwifery Research



Experiences of Nurses and Midwives Regarding Postpartum Care in Rural Kenyan Communities

Are you maternity nurse or midwife working in the Nandi County
Communities?

If so, I would like to hear from you.

I am conducting a study to examine how nurses and midwives provide postpartum care in rural communities in Nandi, Kenya. All nurses and midwives who provided postpartum care in Nandi County health care facilities for a minimum of two years are invited to participate in the study population.

If you meet these criteria and are interested in participating in this important study, please contact

Janet Kemei

If you agree to participate in this study, you will be asked to participate in an individual interview and a focus group with other participants. Please note participants will be selected on a first come-first served basis.

THANK YOU

Appendix VIII - Receipt for Gift Card/Honorarium

File # _____

Title of Study: Experiences of Nurses and Midwives Regarding Postpartum Care in Rural Kenyan Communities

Thank you for participating in the research project. As a sign of our appreciation for your time and support of this research study we offer you a small gift of 500 Kenyan Shillings.

For audit purposes I must keep a record of individuals who have received an honorarium. Please sign your name in the places indicated below.

Name:

Signature:

Signature of Researcher:



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Appendix IX - Information Letter-Focus Group

File # _____



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Title of the Study: Experiences of Nurses and Midwives Regarding Postpartum Care in Rural Kenyan Communities

Research Team:

Principal Researcher: Janet Kemei, BScN, MHA, PhD Student, School of Nursing, Faculty of Health Sciences, University of Ottawa.

Supervisor: Dr. Josephine Etowa, PhD, RN, Full Professor, School of Nursing, Faculty of Health Sciences, University of Ottawa.

Introduction: You are being invited to voluntarily participate in a study led by Janet Kemei. Janet is an experienced Registered Nurse (RN) who holds a Bachelor's degree in Nursing from Baraton University, Kenya. The study is entitled: *Experiences of Nurses and Midwives Regarding Postpartum Care in Rural Kenyan Communities*. This study is part of the requirements that Janet must complete to be granted a PhD degree from the University of Ottawa, Canada.

Purpose of the study: The proposed study will explore the nurses' and midwives' experiences in delivery of postpartum services in Kenya. The study will highlight current knowledge of postpartum care by nurses and midwives especially in low-resources countries like Kenya to establish the significance of the study. This understanding will provide nurses, midwives and policy makers with valuable information that may contribute improvement of evidenced based nursing care during postpartum and subsequent reduction in maternal mortality.

Participation: You were asked earlier to participate in an interview as part of data collection for this study. You are now being invited to participate in one of the focus groups with other nurses and midwives. Participants will be recruited on a first come, first-served basis. The focus group will last about 90 minutes. With your permission, the focus group sessions will be audio-recorded.

Risks: There are minimal risks to the study. I will take every effort to minimize any risks such as assigning an interview record number instead of using your name on the document.

Benefits: There are no direct benefits to you from the research. However, the research findings will be shared with

relevant stakeholders with the goal of addressing maternal health policies to enhance nurses and midwives' quality of care. This will in turn create positive maternal health outcomes.

Conservation of data: All information collected during research (audio-recordings, interview transcripts and field notes) will be kept under lock and key with the researcher's supervisor at the University of Ottawa.

Compensation: There will be a monetary compensation of five hundred (500) Kenya Shillings for your participation in each of the focus group sessions.

Voluntary participation: You are under no obligation to participate. If you choose to participate, you can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw from the study, you will still be paid full compensation of five hundred (500) Kenyan Shillings. Kindly note that because of the inter-dependent nature of focus group data, individual data shared during the focus group cannot be withdrawn.

Limits on confidentiality: Since this meeting involves a number of participants, confidentiality cannot be absolutely guaranteed. Confidentiality is kept only when all of us agree to keep everything that is shared in this room confidential and not share any information with anyone outside of this group discussion. To protect your confidentiality, we encourage you to think through and decide what you will and will not share in a group setting. To protect everyone's privacy, we will ask each of you to sign the agreement to confidentiality at the bottom of the consent form. You are also encouraged to use a made-up name while taking part in the consultation meeting to enhance your privacy.

Contact persons for participants: If you have further questions regarding the study, please feel free to contact Janet Kemei or Dr. Josephine Etowa through email or phone.

This study has received ethics approval from the University of Ottawa Research Ethics Board, The Institutional Research and Ethics Committee (IREC), and Kapsabet County Hospital Medical Superintendent. If you have any questions about the contact of this study or your rights as a research participant, you may contact:

The Administrator, IREC, Email- irec@mtrh.or.ke

The Medical Superintendent, Kapsabet Referral Hospital, medsupkapsabetrvp@yahoo.com

OR

Protocol Officer for Ethics in Research

University of Ottawa, Tabaret Hall

550 Cumberland Street, Room 154

Ottawa, Ontario, Canada, K1N6N5

Phone- +1613-562-5837

There are two copies of the consent form, one of which is mine to keep and the other one to be kept by the researcher under lock and key and separate from the data.

Appendix X - Focus Group Consent Form

File # _____

Title of the Study: Experiences of Nurses and Midwives Regarding Postpartum Care in Rural Kenyan Communities: How have the nurses and midwives contributed to the reduction and prevention of maternal and newborn mortalities in Kenya.



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I have read and understood the information on the "Information Letter". I have been given the opportunity to discuss any questions and they have been answered to my satisfaction. I hereby consent to participate in the study and I understand the information in this Consent Form. I understand that participants will be recruited on a first come, first-served basis.

Yes**NO**

I agree to the focus group to be audio-recorded. I agree for my information to be in this study and I am aware that all personally identifying information shall be removed to protect my anonymity. I also understand that I may request for the recorder to be turned off if there are answers to the questions that I do not wish to be recorded. I give my permission to be observed during the interview. However, all data from within the focus group will be kept confidential. Since this is a focus group, we ask you to please keep the information that is being shared confidential. Since the other participants will know who participated in the focus group, anonymity cannot be fully guaranteed by the researcher. You are under no obligation to participate. If you choose to participate, you can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw from the study, you will still be paid full compensation of five hundred (500) Kenyan Shillings. I understand that, because of the inter-dependent nature of focus group data, individual data shared during the focus group cannot be withdrawn.

Yes**NO**

There are two copies of the consent form, one of which is mine to keep in a sealed envelope under lock and key, separated from other study data. Please sign and date both copies.

Participant's signature: _____ **Date:** _____

Researcher's signature: _____ **Date:** _____

I agree to keep the information that is being shared at the focus group confidential.

Participant's signature: _____ **Date:** _____

Appendix XI - Interview Guide for Focus Group



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1. Let us do a quick round of introductions. Can each of you tell the group your name, and where you are currently working?
2. You have all participated in the interview. What are your thoughts regarding postpartum care since that time?
3. In general, how would you describe the current postpartum care service in rural Kenyan facilities?
 - a. Do you feel that you are providing adequate postpartum care to the mothers and the infants? Please explain.
 - b. What resources do you have to help you provide adequate postpartum care?
 - c. What additional resources would help you provide better postpartum care services?
4. What are your current career goals?
 - a. Are you planning to leave your job?
 - b. If yes, why? Or if no, why not?
 - c. If you are thinking of leaving your job, what would make you stay in your current job?
5. Now imagine that you are part of a group that makes healthcare policies pertaining to postpartum care.
 - a. What are the factors that you will make sure your committee considers in designing these policies or improving those that already exist?
6. Is there anything else we have not discussed that you think is important for postpartum care services in Kenya?

Thank you so much for your participation.

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Appendix XII - Confidentiality Agreement



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I Janet Kemei, the Principal researcher, agree to:

1. Keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g., disks, tapes, transcripts, photographs) with anyone other than my thesis supervisor *Prof. J. Etowa*.
2. Keep all research information in any form or format (e.g., disks, tapes, transcripts) secure while it is in my possession.
3. Return all research information in any form or format (e.g., disks, tapes, transcripts) to my thesis supervisor *Prof. J. Etowa* when I have completed the research tasks.
4. After consulting with erase or destroy all research information in any form or format regarding this research project that is not returnable to *Prof. J. Etowa* (e.g., information stored on computer hard drive, memory cards, etc.).
5. All documentation contained with the shared drive shall remain confidential and will not be distributed, photocopied or reproduced without the permission of *Prof. J. Etowa*.

_____ (Print Name) _____ (Signature)

(Date) _____

Researcher(s)

(Print

Name) _____

613 562-5473
613 562-5443
451 Smyth
Ottawa ON K1H 8M5 Canada
www.uOttawa.ca

(Signature) _____

(Date) _____

451 rue Smyth
Ottawa (Ontario) K1H
8M5 Canada

451 Smyth Rd
Ottawa, Ontario K1H 8M5
Canada

Appendix XIII - Focus group invitation for nurse/midwife in-charge



*Experiences of Nurses and Midwives Regarding
Postpartum Care in Rural Kenyan Communities*

Are you a nurse/midwife in-charge, Physician, or clinical officer
working in the Nandi County Communities?

If so, I would like to hear from you.

I am conducting a study to examine how nurses and midwives
provide postpartum care in rural communities in Nandi, Kenya. You are
invited to a focused group as part of this study.

If you meet these criteria and are interested in participating in this important
study, please contact

Janet Kemei

Please note participants will be selected on a first come-first served
basis.

THANK YOU

Appendix XIV - REB Ethics approval certificate

File Number: H02-17-18

Date (mm/dd/yyyy): 06/21/2017



Université d'Ottawa **University of Ottawa**
 Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Ethics Approval Notice
Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Josephine	Etowa	Health Sciences / Nursing	Supervisor
Janet	Kemei	Health Sciences / Nursing	Student Researcher

File Number: H02-17-18

Type of Project: PhD Thesis

Title: Experiences of Nurses and Midwives Regarding Postpartum Care in Rural Kenyan Communities

<u>Approval Date (mm/dd/yyyy)</u>	<u>Expiry Date (mm/dd/yyyy)</u>	<u>Approval Type</u>
06/21/2017	06/20/2018	Approval

Special Conditions / Comments:
 N/A

1

Appendix XV - IREC Letter of Approval



MOI TEACHING AND REFERRAL HOSPITAL
 P.O. BOX 3
 ELDORET
 Tel: 23471213
 Reference: IREC/2017/39



MOI UNIVERSITY
 SCHOOL OF MEDICINE
 P.O. BOX 4616
 ELDORET
 26th May, 2017

INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE (IREC)

Janet Kemei,
 University of Ottawa,
 Faculty of Health Sciences,
 School of Nursing,
CANADA.

Dear Ms. Kemei,



RE: PROVISIONAL APPROVAL

The Institutional Research and Ethics Committee has reviewed your research proposal titled: -

"Experiences of Nurses and Midwives Regarding Postpartum Care in Rural Kenyan Communities."

Your proposal has been granted **one-month provisional approval** from 26th May, 2017 subject to ratification by IREC Full Board. Note that this is a preliminary approval and you are only allowed to set-up in readiness for the study but no recruitment should take place within this period until formal approval is granted.

Sincerely



PROF. E. WERE
 CHAIRMAN
INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE

cc	CEO - MTRH	Dean - SOP	Dean - SOM
	Principal - CHS	Dean - SON	Dean - SOD

Appendix XVI - Letter of Approval from Medical Superintendent, Kapsabet County Hospital



Telephone: MEDICAL
 Telephone: 0208153623
 Email: info@keph.go.ke

The Medical Superintendent
 Kapsabet County Referral Hospital,
 P.O. Box 5 - 30260
 E.G.S 40017

Ref. No. R. /VOL. /17/250

31/05/2017

TO WHOM IT MAY CONCERN

RE: RESEARCH AUTHORIZATION: JANET JERUTO KEMUI

Following your request to conduct a research in our facility on "experiences of nurses and midwives regarding postpartum care in rural Keaya communities" your request was accepted to conduct the same during the period of one year.

It's expected that you observe the ethics of research.

Accord her necessary assistance.



for  **DR. S. K. KEMEI**
MEDICAL SUPERINTENDENT
KAPSABET COUNTY REFERRAL HOSPITAL

Appendix XVII - Letter of Approval, County Director of Health, Nandi County

COUNTY GOVERNMENT OF KAPSABET



DEPARTMENT OF HEALTH

Telephone 053 52223
When replying -
Please quote

County Director of Health,
Nandi County
P.O. Box 5
KAPSABET

RE: INCIDENT/AUTHOR.S/VOL.1/66

28/6/2017

The Medical Superintendent
Kapsabet County Referral Hospital

RE: RESEARCH AUTHORIZATION.
MS. JANET KEMEL

The above person is hereby granted authority to carry out data collection on "Experiences of Nurses and Midwives Regarding Postpartum Care in Rural Kenyan Communities"

She is to undertake her research in Kapsabet County Referral Hospital and Health Centers in Nandi County

Please accord her necessary assistance.

Thank you:

COUNTY DIRECTOR OF HEALTH
NANDI COUNTY

9th JUN 2017

DR DANIEL K. KEMBOI
COUNTY DIRECTOR OF HEALTH
NANDI COUNTY.

Appendix XVIII - Panel on Research Ethics (TCPS 2: CORE) Certificate of Completion

