

TRUST IN MATERNITY CARE: A CONTEXTUAL EXPLORATION OF MEANING
AND DETERMINANTS IN PERI-URBAN KENYA

by

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Abstract

Background: Trust in providers and health facilities is important to care-seeking and to health system quality and accountability. In Kenya, *trust* has been little-explored. ‘Trust’ is a multidimensional concept offering a distinctive lens on facility responsiveness during labor and delivery. This study explores the meaning and determinants of trust, and potential trust-building avenues, in the maternity setting.

Methods: A theoretically-driven qualitative approach was used to study trust from a range of local perspectives. Focus groups (n=8, N=70) with recently delivered women (RDW), pregnant women, and male partners and in-depth-interviews (n=33) with RDW, providers, management, and community health workers (CHWs), were conducted in and around a public sub-county-level hospital in peri-urban Central Kenya. Interviews were audio-recorded, transcribed, and translated. Textual analysis consisted of inductive and deductive coding of themes and memo writing.

Results: Chapter IV describes the meaning and types of trust in maternity care reported across all participants. Trust in the maternity setting is nested within understandings of institutional and societal trust and can be analyzed into relational types. Content areas of trust include confidence, communication, integrity, mutual respect, competence, fairness, confidentiality, and systems trust. Overlap of trust content areas across relationship types suggests a shared understanding of trust across hierarchical perspectives: women and communities (use care/least power), CHWs (facilitate accessing care/low-medium power), providers (deliver care/medium-high power), and management (affect care/high power). Chapters V and VI describe a multi-faceted determinants framework for trust in the maternity setting clustered around patient/individual, provider, health facility, community, accountability, and structural factors. Chapter VII shows that building trust in maternity care requires a multi-faceted effort by various actors. This chapter presents cross-perspective evidence that critical trust-building mechanisms center on users, provider-patient interactions, provider-management

interactions, facility environments, community-facility relationships, and supportive socio-political commitments.

Conclusions: Trust is contextually relevant to maternity care in Kenya. This study's findings about the multidimensionality of trust contribute to a growing body of global and regional trust research. In particular, the study highlights the multi-faceted clustering of trust determinants and recognizes the importance of perspective and socio-political context in understanding and building trust.

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List of Terms and Abbreviations

AI	Appreciative Inquiry
ANC	Antenatal Care
CHU	Community health unit
CHW	Community health worker
CRR	Center for Reproductive Rights
D&A	Disrespect and Abuse
DPHO	District Public Health Officer
EmONC	Emergency Obstetric and Newborn Care
FGD	Focus Group Discussion
FIDA	Federation of Women Lawyers-Kenya
HFMT	Health facility management team
Heshima	Kiswahili word for “respect” or “dignity”
IDI	In-depth Interview
IE	Institutional Ethnography
KDHS	Kenya Demographic and Health Survey
KEMRI	Kenya Medical Research Institute
LMIC	Low and Middle Income Country
MDGs	Millennium Development Goals
MOH	Ministry of Health, Kenya
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
NNAK	National Nursing Association of Kenya
NUDSS	National Urban Demographic Surveillance System
NHIF	National Hospital Insurance Funds
PC	Population Council
RA	Research Assistant
RDW	Recently Delivered Women
RMC	Respectful Maternity Care
SBA	Skilled Birth Attendant
TRAction	Translating Research into Action
UN	United Nations
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	White Ribbon Alliance

I. Introduction

Trust: conceptual background and rationale

Trust reflects a belief that an individual's expectation will be met favorably by another individual or system (Gilson, 2003; Goudge & Gilson, 2005; Mechanic, 1998). Definitions of trust are generally situated in a time and context. They range from risk-based calculations of external conditions, viable alternatives, and past experiences (Gambetta, 1988; Zaner, 1991); to notions of hope and confidence (Giddens, 1990; Luhmann, 1988); to a sense of 'affect' or 'instinct' (Coulson, 1998; Gilson, 2003). An instinctual sense of trust may be rooted in cultural and social normative perspectives in a society as it reflects cooperative attitudes, mutual understanding, and the 'social fabric' of a community (Kohn, 2008).

Trust manifests itself in a variety of interpersonal and impersonal relationships. Interpersonal trust refers to the trust between persons. In the context of health facility-based relationships, interpersonal trust may occur between a patient and provider, between a provider and supervisor, or between other intermediaries in the care-delivery process. Impersonal trust refers to 'trust in strangers' or a social system that has embedded structures for operating in a particular way; in the context of health, this could be the care delivery system as a whole (Giddens, 1990; Gilson, 2003). The notion of impersonal trust emerges from the sociological idea that trust underlies many modern social institutions (e.g. health institutions) and often lacks clarity compared to interpersonal trust. Institutions, as symbolic tokens and expert systems, motivate impersonal trust so far as they show themselves to be committed to the public interest. The "faith" individuals have in these structures is derived from experience and through people's perception of the authority's competence and authenticity (Giddens, 1990). Giddens posits impersonality as key to understanding trust in settings like health systems, where information flow and behaviors commingle in complex ways: for instance, through structural and institutional policies such as professional and ethical codes, health policies and regulations, procurement mechanisms, and facility protocols. Furthermore, the diffusion of

information (as through conversation) across different types of relationships - between patients and providers, amongst providers in the workplace or between a community and facility – may elicit variable trusting or non-trusting attitudes. In health delivery systems, it is further critical to draw attention to how trust is ‘impersonally’ influenced by professional norms and power dynamics between nurses, doctors and others working in the institution (Gilbert, 2005). The quality of interactions then becomes central to understanding trust in a health system, as trusting relationships have been posited to increase the legitimacy and social value of the health system itself (Gilson, 2007). Given the complexity of health systems, often ‘unavoidable trust’ must be placed in interpersonal interactions as well as social and political structures of clinics and hospitals (Pellegrino, 1991). Health system trust thus covers a range of spanning interpersonal and impersonal relationships.

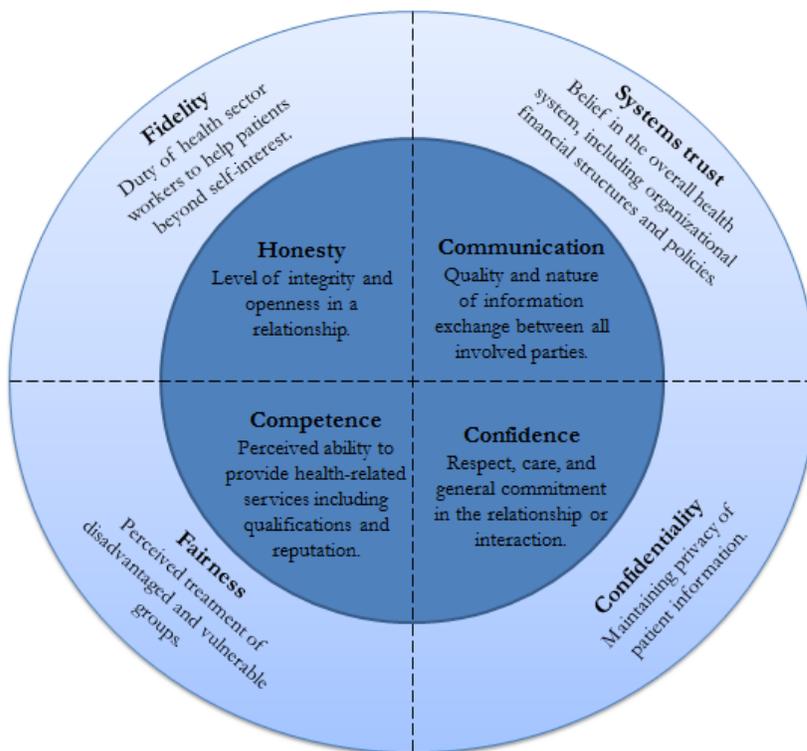
Health systems trust: measurement, multidimensionality and value

Health systems trust is a multidimensional concept, as described in a systematic review of the existing measurement literature (Sachiko Ozawa & Sripad, 2013). The review identified 45 trust measures that varied in terms of length (4-59 items), rigor of development and testing, and type of trust relationship measured within a health setting. Despite conceptual challenges and measurement issues associated with defining and operationalizing trust, there have been significant strides in efforts to quantify it (Bova et al., 2012; Gilson, 2006; Goold, 2002; M. A. Hall et al., 2001; Mechanic & Meyer, 2000). Scholars involved in trust work express hesitance around the transferability of trust measures in low and middle income country (LMIC) settings and in lower resource settings, given that the majority of trust measures originate in high income country contexts (Gopichandran & Chetlapalli, 2013; Goudge & Gilson, 2005; Sachiko Ozawa & Sripad, 2013). The fact, however, that congruencies appear in how researchers across settings have attempted to understand and measure trust in the health system suggests that overarching dimensions of trust may be transferrable. Trust scholars agree that in order to validate instruments in LMIC settings, developing conceptual clarity for unique health areas and in sub-Saharan Africa is critical (Goudge & Gilson, 2005; Hupcey et al., 2001; Østergaard, 2015). Given that trust reflects socio-cultural norms (Kohn, 2008) and is an

underexplored concept in an emerging regional debate around health service demand (Østergaard, 2015), its unique manifestations merit exploration. This dissertation contributes to these broader discussions of trust through eliciting meaning of the multidimensional concept of health systems trust from local perspectives in Kenya. In particular, the qualitative approach taken by this study may provide a basis for informing future development of quantitative measures in sub-Saharan Africa.

The Health Systems Trust: Content Area Framework (*Figure 1*) maps out a global perspective of the range of content areas covered by the existing literature. Systematic review and focused deliberation of trust measures (e.g. scales and indices) allowed for the abstraction of the categories of honesty, communication, confidence, competence, fidelity, system trust, confidentiality, and fairness (Sachiko Ozawa & Sripad, 2013).

Figure 1. Health Systems Trust: Content Area Framework



Source: Ozawa & Sripad, 2103

The overarching nature of this framework as a lens to navigate various types of trust as well as its applicability to various domains within health systems enables researchers to explore the

manifestations of these content areas in different settings. This dissertation utilizes the framework as a starting point for exploration of types and meaning of trust in a maternity context in East Africa. Understanding these content areas in an underserved context, such as a peri-urban county in Kenya, advances the literature surrounding local perspectives on trust, and allows for elaboration on the transferability of the framework. In doing so, it contributes to discussions on the value of health systems trust through the lens of health equity.

Value

Health systems trust has both intrinsic and instrumental value, and is particularly important to explore in socially disadvantaged contexts. Intrinsically, trust underlies the fiduciary¹ nature of relationships and interactions at the health systems interface in a way that directly impacts health status through service access, self-esteem, and agency (Gilson, 2003; Zaner, 1991). Instrumentally, health systems trust relates to enhancing accountability, promoting quality of care, and motivating care seeking (Emanuel & Emanuel, 1996; Mechanic, 1998; Musa et al., 2009; Siddiqi et al., 2009). The inherent vulnerability associated with the patient perspective underlies the intrinsic value of health systems trust (Gilson, 2003), while its associations with related constructs (e.g. satisfaction, care-seeking agency) illustrate trust's instrumental value. How the value of trust is understood or how it operates instrumentally may vary by social class (Riewpaiboon et al., 2005). Given that trust barriers fall on socially disadvantaged groups – including those living in under-resourced settings in low and middle income countries (LMICs) – it is critical to understand how health systems trust is comprehended from these perspectives (Armstrong et al., 2012; Gilson, 2003, 2007; M. A. Hall et al., 2001; Moskowitz et al., 2011; O'Malley et al., 2004; S. Ozawa & Walker, 2009; Thompson et al., 2004). Disadvantaged populations often experience sub-par quality of care and tend to bring up notions of trust (or failures of trust) in providers and the larger health system while recounting their

¹ Fiduciary relationships are special relationships subject to a set of professional ethics linked to expert judgment and action within a field, encompassing and going beyond that of what human beings owe to one another.

past facility experiences (Armstrong et al., 2008; Gilson, 2006; McMahon et al., 2014). Trust (or mistrust) is likely to manifest itself in different ways and may have varied attitudinal and behavioral consequences (M. A. Hall et al., 2001). Since the value of health systems trust as a concept is tied closely to perspective and relationship type, this study focuses on eliciting meaning from underrepresented perspectives as well as from different standpoints around the same interactional interface.

Contextual exploration

Despite concurrence around the content areas of health systems trust, scholars repeatedly advocate for situating trust in a particular context as its conceptual role and manifestations derive from culturally distinct definitions and determinants (Gilson, 2006; Goudge & Gilson, 2005; M. A. Hall et al., 2001; Mechanic & Meyer, 2000). Contextual explanations focus on features of social or physical environment that influence the health or service access of those exposed to it. Things that fall under this purview include sociocultural features, personal histories, levels of integration, as well as the norms and values of a community (MacIntyre & Ellaway, 2000). For the purpose of this study, the emphasis of contextual explanation is on the relational (experienced interaction between patients and providers), social (social and community norms), institutional (e.g. health facility) and structural (policy and political) environments. The relational emphasis between providers and patients and amongst providers in the maternity care setting involves distinctive interpersonal behavioral norms that may be affected by various impersonal factors such as facility policies and resources, labor and delivery training and practices, and supply chains and other material resources (see Chapter II for specific Kenyan context). These institutional factors are likely intertwined with national policies and health reforms that have specific implications for maternity care (see Chapter II). Contextual features are often explored through theoretical lenses that draw upon organizational and critical theory; open-ended discussions around trust across hierarchical perspectives (i.e. positions that situationally hold differential power, e.g. providers have higher power compared to patients); and by investigating

individual and collective viewpoints to elicit social norms and networks surrounding trust in the maternity setting.

Social norms refer to customary rules of behavior for those living in a community. Norms operate in complex ways, can be thought of as collective or perceived, and are pertinent to understanding health systems trust. Collective norms refer to group level norms that emerge through shared interaction among members of a social group, implying an important role for communication and information transmission. Perceived norms operate at the individual level and emerge from a psychological perspective of interpreting the collective norms of a community (Lapinski & Rimal, 2005). Social norms have been linked to ‘trust’ or ‘a culture of trust’ through their association with communication. Coulson posits that trust and its determinants within a culture are reinforced by norms of a community and the social system (Coulson, 1998). Accordingly, this study considers the notion of community and organizational norms (via group-normative and hierarchical perspectives in maternity setting) in its analytic process.

Individual and group trust in a health system may reflect a set of preconditions or contextual factors, including socio-political or historical factors that have been codified into norms that operate at collective levels (e.g. community groups, provider cadres). For instance, it is plausible that collective and perceived norms around trust in the context of maternity care may be in part driven by communication between women and their immediate social networks (families and friends). Sharing delivery experiences may influence normative understandings of trust (or lack thereof) in the health system. Alternatively, community perceptions may influence an individual’s trust in the health system. Tight socially derived interpersonal trust (Boyer et al., 2012; Rutenberg & Watkins, 1997) in Kenya renders normative views integral to understanding health systems trust in maternity care. Situating trust and its meaning in a community-oriented culture may elevate the salience of contextual determinants compared to studying the same concept in individually-oriented society where personal experience may comprise the dominant influence.

Communication and trust

The conceptual link between communication and trust is pertinent given the cultural norm of conversation and informal social network strength in Kenya. Information flow within a community is closely, and dialectically, related to trust in that community (Coleman, 1990; Thiede, 2005). Coleman discusses how, in systems involving trust, changes in information flow may lead to expansion or contraction of trust. Thiede draws largely on a communitarian approach and proposes that generalized trust environments may drive willingness and ability to communicate, thereby potentially propagating norms around community expectations of a health system. In contrast, environments with less network trust may lead to either a propagation of mistrust and dissatisfaction with a health system or non-propagation of any message. Moreover, Thiede argues that trust in a health system context can vary by type (i.e. in provider vs. facility vs. system) and may not necessarily align with general societal trust. He posits that precursors of trust include the provision of technically accountable and ‘culturally secure’ medical care, greater transparency in communication, enhanced communicative action, the existence of ethical institutional relationships, and patient-side autonomy. Different facets of interaction between the community and facility are included in this study, thereby contributing to the understanding of contextual effects of communication (e.g. information channels) that relate to trust in a peri-urban maternity setting. The range of interactions surrounding a woman’s maternity experience is interrelated with and communicated through her socioeconomic, political and cultural context. Group-based methods offer a participatory approach to observe patterns in communication and identify group-normative perspectives. They additionally allow for exploration of information-transmitting and ritual communication, the latter of which represents a group’s culture, norms, and values among those engaging in discussion (Carey, 2009).

Trust, power and gender

Inherent in contextual exploration of trust’s meaning and determinants in a maternity context is also the parallel understanding of organizational hierarchies and gender that illustrate varying degrees of micro-level power dynamics in health facilities. Trust from the patient perspective is necessary for fiduciary relationships (e.g. provider-patient) to function optimally (Zaner, 1991). Such

a relationship is characterized by a distinct power imbalance and explicit vulnerability on one side, thus demanding a deeper complex understanding of trust that goes beyond competence toward dimensions such as honesty, fidelity, and non-exploitation (Pellegrino, 1991). However, trust may not reflect an isolated interpersonal exchange (e.g. power imbalance); rather, it may draw on the trustworthiness of the power-laden environment in which it occurs.

“The reality is that relationships are complicated, and embedded in the histories and cultures of different groups and organization. It is unhelpful, if not downright misleading, to advocate trust without also considering the realities of power.” (Coulson, 1998)

As such, advocating trust without considering the political realities of an organization is simplistic – particularly in health systems where asymmetries between management, providers and patients are often masked by medical neutrality (Grimen, 2009). Part of this hesitance relates to the challenge of distinguishing trust from trustworthiness – where trustworthiness describes the level of commitment to meeting expectations by persons or institutions in question and is embedded in social contracts and histories of service delivery settings (R. Hardin, 2002). Implicit in trustworthiness is a moral grounding of institutional (or personal) commitments to a group (e.g. health facilities or providers are rendered worthy of trust based on good practices or fiduciary roles), while trust reflects the psychosocial cognitive reflection of those experientially engaging in an interaction (Russell Hardin, 2006). When an institution is highly trustworthy and those who utilize its services feel a sense of trust in it, power imbalances are likely to be less of a concern. Given the reality of imbalances in health care institutions, power becomes a larger concern in how it may relate to trust. The need for thick description of these broader institutional and social dynamics as they affect trust relations thus becomes a key motivator for interpretive empirical work (Dimitriadis, 2011). This type of work is rooted in attempts to understand how individuals and groups (e.g. delivering women, their communities) ascribe meaning to their experiences of care.

Social scientists and participatory action researchers have long considered the dynamics of power and structural forces through discourse on knowledge and power as well as through feminist critiques that broadly define gender as a cross-cutting institutional effect on particular groups in

society who because of their position are rendered voiceless (Gaventa & Cornwell, 2006; Maguire, 2006; Park, 2006). In maternity care, gender and power operate in different ways. For instance, gender norms around topic (i.e. reproductive health as traditionally a woman's issue), household and other decision-making (e.g. maternity care-seeking, or midwives' career selection and power), and ability to speak up to health providers exemplify how structured norms maintain power-laden relationships between 'men and women', 'providers and patients', and 'facilities and communities'. In Kenya, gendered systems are complex, have gone through a number of transitional phases (pre-colonial, colonial, independence and post-colonial), and intersect with a number of other social categories (e.g. ethnic group, socioeconomic status) – rendering power dynamics a fluid and ever-changing aspect of women's lives (Nasong'o & Ayot, 2007). These dynamics cut across various relational interfaces for the same person – for example, nurse-midwives may operate both as those in power (e.g. with patient) and as low level health workers affected by power structures in the facility (e.g. managers, institutional factors). In some African settings, midwives, despite their position of power as health providers, may remain socially disempowered in their non-professional life because of gendered roles and societal norms (N. Warren et al., 2012). Whether or not these sociocultural gendered structures spill over into a midwife's professional functioning through her treatment of her patients in maternity care (i.e. transference of oppressions), which may potentially further silence her patients, is less clear, but the question may trouble the midwife-patient relationship (Freire, 1970; Jewkes et al., 1998). Additionally, public discourses and actions – such as social policies and civil society activities – add to the complexity of how community power is balanced with that of medical experts in a particular context.

In the realm of facility-based maternity care, female patients may simultaneously experience sociocultural disadvantage, the burden of childbearing norms, and the social process of care delivery within a power-laden health system. Childbirth is considered a 'special event' that requires sensitivity and attention in light of historical, social, and culturally prescribed roles that women assume as child-bearers in many societies, including Kenya (Hossain & Hoque, 2005; Mwaniki et al., 2002; Nasong'o

& Ayot, 2007). In the Kenyan context, sociocultural disadvantage based on a woman's position in her family and her degree of reliance on male partner facilitation, coupled with her normatively prescribed role, affects her access to maternal health care (Muckle et al., 2013). Nurse-midwives are often primary providers of skilled maternity care (Adegoke et al., 2012; UNFPA, 2014). Though there are male nurse-midwives, the majority of these workers are female – particularly in the case of the peri-urban study context (see Chapter II). Thus, in contrast to other settings where gendered social processes of male providers and female patients have implications for the care experience of female patients, it may be a lesser concern in the specific study context (J. A. Hall & Roter, 2002). While nurse-midwives and lower level health cadres working in mixed-gender facility settings may experience compounding of institutional and social norms, women's trust may be more related to their perception of the patient-provider and facility hierarchies.

This study accounts for institutional power hierarchies in its design as a way to capture a fuller context of trust in the maternity setting. It also utilizes theoretical lenses that aspire to bring out underrepresented voices (e.g. those of women & communities; nurse-midwives in a peri-urban area where inequality is high), enabling a discussion on gendered notions that may play out in distinct forms during facility-based maternity care. In the form of both group and individual interviews, the study builds on sets of perspectives that provide unique 'quotidian' experiences for relevant stakeholders as way of dialoguing across hierarchies and contextualizing trust in a maternity setting.

Trust in maternity care

'Maternity care' is a particular situation where health systems trust calls for exploration from health, equity, ethical and social perspectives. In this study, it refers to and is exchangeable with the 'labor and delivery' phase of maternal care. It is a critical period in pregnancy and childbirth that has a distinctive relational interface with health systems for women and their families; it demands pointed attention given the importance of skilled birth attendance and access to emergency obstetric and newborn care (EmONC) for the prevention of maternal and infant mortality and morbidity (Koblinsky et al., 2006). Inequities in access to maternity care are complex; for example, although women living

in urban settings more frequently deliver in medical facilities, those living in poverty or with lower socioeconomic status often fail to seek and obtain high-quality facility-based care (Say & Raine, 2007). This study is the first to focus on health systems trust in a similar context where quality may not track high access to care.

From an ethical perspective, women's dependence on health systems during childbirth elevates the fiduciary relationship to a high level. The conditions of urgency (e.g. complications, pain associated with labor), unpredictability (e.g. onset of labor, complications), vulnerability (i.e. condition-specific, social, familial, gendered, structural), and intimacy (e.g. invasive nature of EmONC procedures such as the vaginal exam), and to an extent, unavoidability (e.g. care-seeking decision) of facility-based interactions during maternity care constitute a "state of dependence" and imply a need for trust in health systems (Pellegrino, 1991). This state of dependence warrants exploring the quality of interactions that enable safe delivery. A woman's placement of trust in the context of maternity care is likely to be affected by her perceptions of and interactions with physicians, nurses, community health workers, referral processes, and facility resources and equipment for safe and timely provision of EmONC. One trust study in Thailand emphasized the need to look at patients' perceptions and feelings about the interactions and relationships with various actors in the maternity care delivery system (Riewpaiboon et al., 2005). A trust relationship reflects a balance between the actual care provided and the values underlying facility-based interactions. Broadly speaking, this means giving weight to both objective processes that provide safe delivery as well as culturally-derived perceptions of respect and dignity that render care acceptable (Brock, 1991; Pellegrino, 1991; Thiede, 2005).

Health systems trust in the context of maternity care is relatively unexplored, globally and in the sub-Saharan African context. Besides a recent pilot study in post-conflict Liberia that validated a scale looking at workplace trust between maternal care workers working in the community and health facilities (Lori et al., 2013), none of the quantitative measures reviewed to develop the Health Systems Trust: Content Area Framework focused on maternity care (Sachiko Ozawa & Sripad, 2013).

Existing trust literature in Africa is predominantly qualitative and comes from South Africa, Zambia, Uganda, Tanzania, Ethiopia, Mali, Rwanda and Kenya (Birungi, 1998; Gilson et al., 2005; Østergaard, 2015); only a minority of the regional trust work centers around maternity care. A growing number of qualitative maternity care-focused studies in various contexts, including the United States, Serbia, Macedonia, Tanzania, and Thailand, describe the emergence of trust as a key concept to explore further for various instrumental and intrinsic reasons (Baldwin et al., 2005; Janevic et al., 2011; McMahon et al., 2014; Lilian Mselle et al., 2013; O'Malley et al., 2004; Riewpaiboon et al., 2005; Sheppard et al., 2004). These studies represent a start to understanding obstetric care through presentation of conceptual frameworks that tease out the complexities of determinants of trust in the maternity setting. Other studies recognize implicit notions of trust when drawing attention to perceived quality of care and behavior (Hulton et al., 2007; Miller et al., 2003; Ziraba et al., 2009b), but lack in-depth analysis of the construct's multidimensional nature.

With the exception of one study in Thailand (Riewpaiboon et al., 2005), there is a lack of studies exploring the meaning of trust in maternity care as relates to the broader social context. The setting of the Thai study is unique in being set in a tertiary facility that explicitly offers both private and public obstetric practice, which may not be the case in similar LMIC hospitals. The study collected information on general perceptions on pregnancy and childbirth, past birth experiences, demographics, decision-making, and psychosocial factors related to obstetric care and outcomes. Researchers found that risks and uncertainty associated with childbirth, expectations of care, patient autonomy, and experience of care quality were related to trust and return to care of a particular provider (private vs. public). The study suggested that socioeconomic class plays an underlying moderating role in terms of what factors may influence interpersonal and impersonal trust in maternity care (Riewpaiboon et al., 2005).

Trust and perceived quality

Trust and perceived quality in the context of maternity care affect care-seeking and exhibit conceptual overlap in the literature. A recent review of facilitators and barriers to facility-based

maternity care utilization in LMICs suggests that perceived quality of care is important in motivating (or, if low, deterring) care-seeking (Bohren et al., 2014) and intrinsically to the health system after access is promoted (Pitchforth et al., 2006). Perceptions of quality were defined as the standard of care experienced and described by users (not objective quality of medical protocol and management). In their definitions of perceived quality, users often contrast care provided by traditional birth attendants (TBAs) to facility-based care. Negative interactions at facilities, including disrespectful and abusive practices of providers, feelings of neglect and delayed response, as well as under-resourced facilities, all appeared to affect perceptions of quality and accountability of facilities (Abuya et al., 2015; Bohren et al., 2014; Bowser & Hill, 2010; d'Oliveira et al., 2002; HRW, 2009; Miller et al., 2003; Respectful Maternity Care Advisory Council, 2011). Many of these same elements are often related (explicitly in surveys or implicitly in qualitative narratives) to the conceptualization of trust in health systems in African settings (Ng et al., 2014; Østergaard, 2015). Though conceptual overlap exists between the perceived quality and trust literatures, the social-cognitive processing and relational dimensions central to trust draw upon additional factors beyond that of perceived experience; that is, they may be grounded in community norms or local sociopolitical understandings of what institutions owe users of care. For instance, there may be scenarios in which, despite negatively perceived quality of maternity care felt by a woman interacting with a single provider, that perception does not affect her overall trust of the health facility or system. This study posits trust to have a broader definition and considers its link to community and structural factors.

Problem statement

Implicit in discussions around maternity experiences, including those related to quality of care, accountability, and respectful or non-abusive treatment at facilities, is the underlying broader notion of trust in health systems. This relational notion is highly relevant in the health sector where a range of interpersonal and systemic relations operate in distinct ways. Despite a growing concern around perceived quality and implications for care-seeking and accountability structures in a number

of African countries (Moyer et al., 2014; Lilian Mselle et al., 2013), and a growing recognition of health systems trust literature in the region (Østergaard, 2015), there is limited understanding of how trust operates and is conceptualized in maternity care. In particular, given a growing concern in Kenya around disrespect and abuse in maternity facilities from global and local public health and human rights perspectives (CRR/FIDA, 2007; Charlotte Warren et al., 2013), there is a need to explore the intrinsic value of trust as well as how it relates to facility-based maternity experiences in the psychosocial pathway to care-seeking.

Exploring trust as a distinctive lens for understanding relationships and interactions in the maternity setting in Kenya addresses this gap. The Health Systems Trust: Content Area Framework offers a flexible set of content areas that have yet to be explored in the African context. The term health system in this study refers to the structured service delivery system that provides maternity care (among other services) and is comprised of a range of actors and processes that are supposed to ensure safe delivery (e.g. facilities, community health structure). This system is nested in, and may be affected by, broader structural factors such as national policies concerning reproductive and maternal health. Given the variety of interactions and associations in the maternity setting, regulatory standards, and actual care processes in facilities, trust can be understood from multiple perspectives, and likely reflects both interpersonal and impersonal relationships. Understanding how trust is built or undermined in the context of maternity care necessitates exploring its determinants from different hierarchical perspectives and the socio-political settings in question. In drawing together trust, socio-political and cultural norms, and care-seeking literatures, this study aspires to elucidate how trust is contextually understood and determined with respect to a maternity setting as well as reflect on its mediating role as a psychosocial construct effecting behavioral intent. The research objective, specific aims, and conceptual framework are presented below.

Research Objective and Specific Aims

The research objective of this dissertation is to contextually explore, across hierarchical perspectives, features of trust in a facility-based maternity setting and propose potential avenues for building trust in a peri-urban county in Kenya. The study is broken down into four specific aims:

Aim 1. To explore individual and collective perceptions of the meaning and types of trust embedded in facility-based maternity care settings.

Aim 2. To explore what determines trust in a maternity setting through the perspectives of women and the communities in which they live.

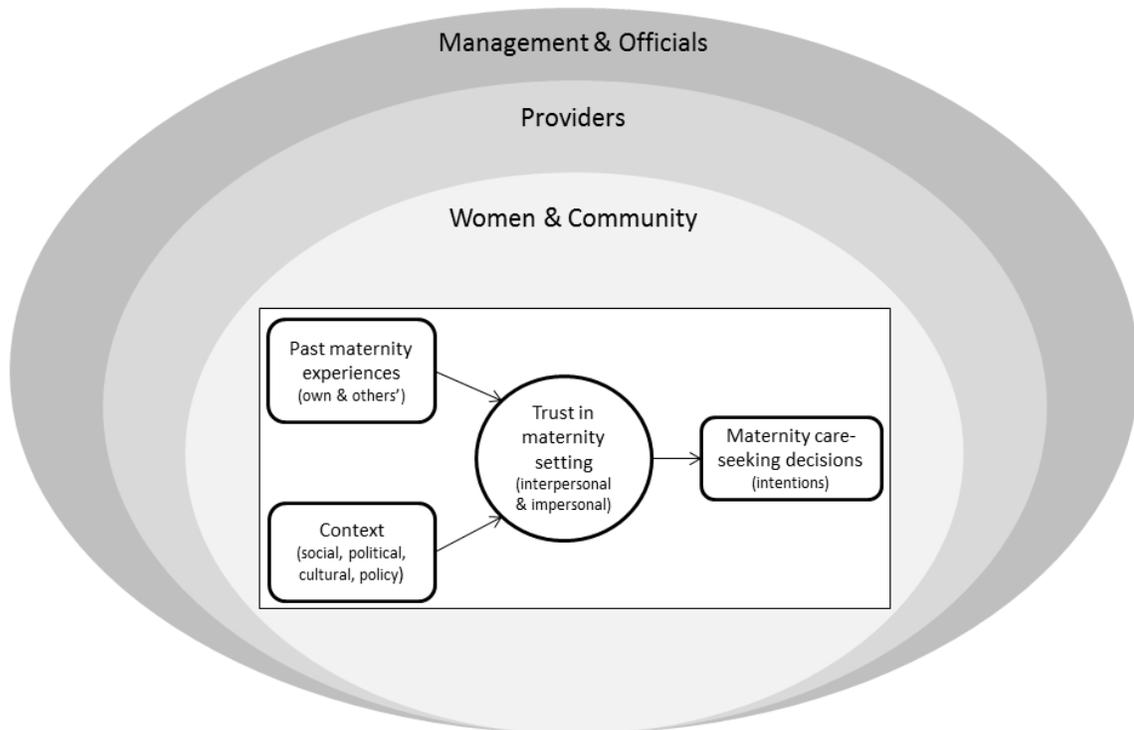
Aim 3. To explore what determines trust in a maternity setting through the perspectives of health facility providers and management.

Aim 4. To identify potential trust-building mechanisms for the delivery and receipt of facility-based maternity care in peri-urban Kenya.

Conceptual Framework

The conceptual framework (*Figure 2*) for organizing this dissertation's structure draws on prior frameworks of trust in the maternity setting (Riewpaiboon et al., 2005), layered trust relationships in the South African context (Gilson, et al., 2005), and the Health Systems Trust: Content Area Framework that encompasses both interpersonal and impersonal trust relationships (Ozawa & Sripad, 2013). The central focus of the study is to explore the features of trust in the maternity setting. In particular, the specific aims cover the exploration of the concept's meaning and the influence of past maternity experiences, as well as social, political, cultural, and policy affectors of trust. The framework also displays the recognition that in addition to the intrinsic value of trust, the concept possesses an instrumental capacity to promote maternity care-seeking intentions in the future.

Figure 2. Conceptual framework



Finally, the subjective nature of trust demands an incorporation of perspective; the concentric ovals represent the hierarchical perspectives of focus in this study, starting from the users of maternity care, to the providers of care, and finally to the management level actors that oversee and influence the maternity care environment through their political and functional capacity.

Dissertation Structure

This dissertation is organized in eight chapters. Chapter I, the present chapter, provides a detailed introduction to the psychosocial concept of trust, its relevance to health systems and maternity settings, and the public health problem of disrespect and abuse in Kenyan maternity settings that this study seeks to address by elucidating the meaning and determinants of trust. Chapter II describes the background and context for the study in Kenya, elaborating on a brief history, basic demographic and health indicators, and key aspects of the social and political environment. Chapter III describes the study methodology, including theoretical orientation and design, immersion in the context, and methods of data collection and analysis. Chapters IV, V, VI, and VII present the dissertation findings (results and interpretation) by specific aim. Chapter IV describes the meaning

and types of trust in maternity care from hierarchical perspectives. Chapters V and VI describe determinants of trust in the maternity setting from different standpoints, leading to the creation of a multilevel determinants framework. Chapter VII describes a range of trust-building mechanisms for peri-urban maternity settings that reflect the multilevel determinant clusters from the prior chapters. Chapter VIII summarizes findings from the prior four chapters, comments on the strengths and limitations of the study, provides policy recommendations for Kenya, and discusses the implications of this body of work for global health research and practice. Reference materials and additional information cited in the text of the dissertation can be found in the Bibliography and Appendices 1-7.

Significance of research

This research contributes to the growing body of literature on trust and health care in the sub-Saharan African region. Understanding the concept of trust in maternity care as it relates to negative (or positive) experiences at facilities is an essential part of developing appropriate health systems interventions and policy to improve standards of quality in maternity care and ethically promote care-seeking. It has implications for generating a positive environment in which respectful maternity care can be sought and received. Given the culture of communication and normative influence with respect to care-seeking in Kenya (Rutenberg & Watkins, 1997), it is useful to gain insight into how facility-based interactions shape women's experiences and how the sharing of experiences in the communities where they live affects trust. In offering a contextualized view, the study further situates trust in the maternity setting within a unique phase of the country's political history as it undergoes structural change that affects public health systems. Understanding the nature of trust relationships that emerge at the health facility interface between providers, nurses, women, and communities, from multiple perspectives, can inform more nuanced policy and programming around the provision of dignified care in Kenya.

II. The Kenyan Context

Brief socio-political history and basic indicators

Kenya, a low- transitioning to middle-income country, is situated in East Africa bordering Somalia to its northeast, Ethiopia and South Sudan to its north, Uganda to its west, Tanzania to its south, and the Indian Ocean to its east. Kenya has a complex social and political history of participation and activism, which thrived as an undercurrent to the neoliberal economic development agenda and sustained dominance of a bureaucratic elite that influenced that country's post-colonial, Cold War and early 21st century trajectory (Branch, 2011; Cooper, 1997; Nasong'o, 2007). After gaining independence from the British in 1963 through the Mau Mau movement – which began with power struggles and uprisings in the Central highlands around the land tenure system, the nation's populace embraced the notion of 'uhuru' (Kiswahili word for 'freedom') into their vocabulary and spirit (Kanyinga, 2009). During the independence and post-independence eras, political, ethnic, and ideological divisions were sequestered – in rhetoric rather than in practice – for the larger purpose of presenting to both the country and the global community a unified Kenya (Branch, 2011).

The presidencies of Jomo Kenyatta and Daniel Arap Moi inherited and upheld the policies of their former colonizers and the broader dominant international institutional paradigms of promoting economic growth through open markets (Branch, 2011). Irrespective of an ethnically and ideologically diverse set of elite politicians influenced by United States, Britain, and communist powers in the East, both presidents pushed forward a production-centered economic model. This bolstered agricultural and other exports, upheld property rights of 'whites' in the highlands, encouraged foreign investment, and maintained a highly centralized governance structure. Aspirations of social justice and redistribution (of land, wealth, social services, etc.) upon independence that had been hoped for amongst non-elite (majority) Kenyans and poor farmers (from Central Province) who fought in Mau Mau took a back seat. As a result, inequality and frustration grew across the provinces both within and between ethnic groups. As party politics amongst the elites over policies and interpersonal power-struggles escalated into violent crimes, leaders' actions resulted in the

resurfacing of ethnic tensions. A culture of impunity between the 1960s-1990s, fostered by powerful inner circles, led to silencing of certain individuals and ethnic groups over others. This led to large-scale targeted violent uprisings in various provinces (e.g. Rift Valley, Central, Nairobi, Northern Coast), which were particularly detrimental to internal-migrant populations and ethnic minorities (Branch, 2011; Makoloo, 2005).

During this period, a multi-party system developed, based partially on ethnic lines. In the late 1980s and 1990s, a confluence of growing internal civil society, private sector actors and internationally-influenced discourses around human rights, devolution, and constitutional reform entered political and economic debate in Kenya (Branch, 2011). These debates, in light of the nation's economic challenges (e.g. high sensitivity to the global economy and natural swings in agricultural exports), increasing poverty, and growing inequality, condemned the growing corruption (e.g. police state of 1980s) in the central government and necessitated policy change. In addition to churches, which represented a 'moral' voice in the context of the Moi police state, non-religious civil society, including women and community rights' lobbies (e.g. Federation of Women's Lawyers Association), experienced growth in the 1990s and pushed for constitutional reform (Nasong'o & Ayot, 2007). Despite the change-rhetoric, political compromise of two-party governance in 2002 under the reign of President Mwai Kibaki (prime minister: Odinga Odinga), and drafting of amendments, the Kenyan majority were once again disappointed in terms of failure of leadership to actualize reform (Kramon & Posner, 2011; Kimenyi & Shughart, 2010). The violence that erupted in the aftermath of the 2007 national election, in which corruption in the form of 'electioneering' resulted in widespread physical and sexual violence, death, property destruction, and disruption of social life, destabilized the country's 'order' (Branch, 2011). This led to a breakdown of citizens' trust in Kenyan public institutions.

Constitutional reform: a new discourse

After almost a decade of efforts to develop and draft amendments, following the internationally brokered peace-keeping force of the United Nations (UN) in 2008 and a two-party

balance manifested through joint appointments to ministries and public offices, constitutional reform finally moved forward. The new constitution, established in 2010, was based on reevaluating and repositioning institutional structures to address the shortcomings of various corrupt and non-redistributive practices of country's past. It builds, instead, on values of freedom, protection, diffusion of power from central leadership, promotion of anti-corruption, human rights, and enhanced accountability of institutions to the Kenyan people (Ghai & Ghai, 2011; Kimenyi & Shughart, 2010; Kramon & Posner, 2011). With the new constitution in place and a peaceful general election in 2013 – the first of many that did not see widespread violence – a glimmer of hope arose amongst Kenyans that the coming years may see increased transparency and the realization of human rights through more active participation. The central topic of this study – the notion of trust – be it between people (given the ethnic polarization and elite domination of the past) or between communities and social institutions (e.g. elites, administrators, police) – is particularly salient at this turning point in the country's social and political discourse.

Demographics, socioeconomic, and basic health indicators

Kenya's basic demographic, socioeconomic, and health indicators are presented (*Table 1*) for national and sub-national levels that are particularly relevant to this study setting in the Central province. According to the last Census (2009), Kenya's population of about 38.9 million, is steadily growing (total fertility rate of 4.6 births per woman) and relatively young in age - 43% of total population are under 15 years (Bureau, 2011). Though the majority live in rural areas, the urban population has been growing over the last decade, which has led to higher population density in urban and peri-urban areas. The Demographic and Health Survey (2008-09) showed that although the majority Kenyans (~80%) have some primary education, completion rates for primary and secondary school vary somewhat by sex, and significantly by provinces, urban-rural status, and wealth quintile (Macro, 2010).

*Table 1. Demographic, socioeconomic, health indicators at data collection time: national, capital and provincial level**

	<i>Kenya</i>	<i>Nairobi</i>	<i>Central</i>
Population (millions)	38.9	3.1	4.4
Under 15 population (%)	42.9	30.3	36
Fertility rate (births per woman)	4.6	2.8	3.4
Population density (per square km)	66	4515	333
Percent urban (%)	21		
Life expectancy at birth (years)	58.9		
Education			
Completed Primary (%)	17	17.8	25.3
Completed Secondary (%)	8.7	20.5	11.2
Wealth quintile			
Lowest (%)	20	0	2.2
Second (%)	20	0	11.1
Middle (%)	20	0	29.2
Fourth (%)	19.9	4.2	36
Highest (%)	20	95.5	21.4
GNI per capita in 2012 (USD)**	938.6		
Under 5 mortality (per 1000 live births)	74	64	51
Unmet need for family planning (% among married women)	25.6	15.1	15.6

*Data sources: Demographic and Health Survey 2008-09, Population Reference Bureau 2011

**Data source: United Nations Statistics Division website

The unmet need for family planning, like education, varies by wealth quintile – the poorest are least likely to have access to any spacing or limiting method.

Socio-demographically, Kenya is comprised of a Christian majority (Protestant, Catholic, or other); minority religions include Islam, Buddhism, Hinduism, and traditional African religions (Makoloo, 2005). Additionally, as mentioned above in the socio-political history sub-section, the country is home to a range of ethnic groups with unique languages and traditions. The larger groups include Kikuyu, Luo, Kalenjin, Luhya, Kamba, Kisii, Mijikenda, Somali, and Meru; however there are sub-sects throughout the country. Many of these ethnic groups residentially cluster in particular provinces or parts of the country (e.g. those living in Central are likely Kikuyu); however, the capital (Nairobi) and major cities tend toward heterogeneous populations. The political elite referred to in the socio-political history sub-section primarily included representation from Kikuyu, Luo, and Kalenjin communities. Additionally, non-African ethnic groups – Kenyan nationals – include Europeans,

Arabs, and Kenyan Asians (South Asian ethnicity). Though the national language is Kiswahili, Kenya inherited English as its official business and government language from its colonizers (Macro, 2010; Makoloo, 2005).

Maternal health in Kenya

Kenya's maternal mortality ratio is estimated at 488 deaths per 100,000 live births according to the previous Kenya Demographic and Health Survey (KDHS) 2008-09 (compared to 414 in 2003), indicating slow progress toward the reduction in MMR over the last decade (Macro, 2010; WHO/UNICEF, 2010). This average ratio masks within-country disparities in maternal health indicators and underestimates the burden of maternal mortality and morbidity in various geographic areas and populations. The general expectation that maternal health access is likely higher and MMRs are likely lower in urban areas is not upheld consistently for all populations residing in such locales. For instance, in urban slum areas in Kenya, MMRs hover around approximately 706 deaths/100,000 live births, suggesting urban populations face distinctive problems other than factors such as physical distance to services, a barrier in many high-MMR rural settings (Ziraba et al., 2009a). The Ziraba study, which uses the National Urban Demographic Surveillance System (NUDSS) and health facility survey data to assess the distributions of death in urban poor populations, suggests that the majority of maternal deaths occur in facilities. One can thus infer that maternal deaths in said populations may be a result of both delayed care seeking and low quality of care for urban poor populations. Moreover, the fact that maternal mortality in Kenya remains high despite attempts by national efforts to increase access to skilled care at delivery is troubling ("The Kenya Health Sector Strategic and Investment Plan (KHSSP) July 2012-June 2017,"). Though, on average, the national antenatal care coverage is high (91%), only 44% of women had a skilled birth attendant (SBA) at delivery, 43% delivered in facilities, and 53% received no postnatal care (Macro, 2010). The increase in MMR between 1989 and 2008/9 paralleled the decrease in the proportion of women who delivered with SBA from 50% to 44%. This reduction opposes regional trends of increasing SBA coverage experienced by countries such as Tanzania, Uganda, and Rwanda (WHO/UNICEF, 2010). Kenya's lack of progress on the

millennium development goal (MDG)-5, improving maternal health, poses the question: why it is that maternity care is not being utilized?

Although supply-side programs increase availability of service points, expand and distribute SBAs, and ensure supply-chains and equipment required for obstetric complications and post-abortive care, the literature suggests a need to address demand-side perspectives (Borghi et al., 2006; UNDP-Kenya, 2005). Informal and formal costs associated with care, distance (time) to facilities, family dynamics, gender norms and autonomy around care-seeking decisions, and poor quality comprise reasons for non-utilization of maternity care (Essendi et al., 2010; Fotso et al., 2009b; Macro, 2010; Mwaniki et al., 2002). Kenya's recent employment of a demand-side financing voucher and hospital accreditation scheme demonstrates an effort to reduce health inequities by providing incentives to poor women to increase uptake of reproductive health services and utilization of health facilities for labor and delivery (Bellows et al., 2012; C. Warren et al., 2011). Though this scheme begins to address cost concerns for the poor, its evaluation continues and calls for more attention to the quality of care. Attention is particularly warranted in urban and peri-urban settings, where quality of care (defined in terms of both technical EmONC capacity and such factors as (un)friendliness of providers, 'cumbersome' facility requirements, inadequate resources, and lack of referrals) is an integral component in motivating demand (Essendi et al., 2010; Fotso et al., 2009a). In Kenya's peri-urban and urban areas, inequalities in maternal health care quality and outcomes are inequities because they systematically burden the poor (Childress et al., 2002). These inequities are complex; they emerge not only from negative experiences motivating women to seek alternative sources of care, but also are compounded by poverty status and social and physical environments (Izugbara & Ngilangwa, 2010).

Disrespect and abuse as a growing issue

Increasingly, literature points to the importance of understanding mechanisms around compromised quality of maternal care as relates to abuse, disrespect, and trusting (or mistrusting) relationships where facility or health sector interactions are high (Das & Hammer, 2007; Honikman et al., 2015; Hossain & Hoque, 2005; Hulton et al., 2007; Janevic et al., 2011; Miller et al., 2003;

Pitchforth et al., 2006; Z et al., 2005; Ziraba et al., 2009b). Disrespectful and abusive practices in Kenyan facilities manifest through physical abuse, non-consented care, non-confidential care, non-dignified care, abandonment/neglect, and inappropriate demands for payment in health facilities (Abuya et al., 2015). In Kenyan facilities, these negative maternity care experiences may have psychological consequences for women and their decisions regarding use of care (CRR/FIDA, 2007). Psychosocial pathways influencing care-seeking are particularly apparent in urban and peri-urban settings where the frequency of facility-interactions is high simply because of the proximate availability of facilities (Ziraba et al., 2009b). Given that 43% of births in Kenya occur in facilities and women living in urban areas are more likely than those living in rural areas to deliver at facilities (Essendi et al., 2010; Macro, 2010), this study focuses in-depth on a peri-urban setting to capture a range of women's and community experiences with facility-based maternity care as it relates to their trust.

Health system in Kenya

It is critical to understand the health system's broader operational structure before describing relationships between health facilities and communities with respect to maternity care. The Kenyan system emerged out of a post-colonial history, which propagated a public system of care; (Macro, 2010). Since then, there has been a growth of private facilities that are often operated by faith-based non-profit organizations (CRR/FIDA, 2007). The institutional service delivery mix includes public (47%), private for-profit (21%) and private non-profit/faith-based (30%) facilities (Luoma et al., 2010). Facilities and human resources are unevenly distributed across the country with the highest levels of coverage in Nairobi, Central, Eastern, and Coast provinces compared to the lowest in the North Eastern province (Wamai, 2009). Facility-based maternity care is provided through skilled birth attendants (SBAs) across both public and private sectors, primarily through nurse-midwives (normal deliveries) and medical and clinical officers (cesarean sections). Though maternity care is sought and delivered in both public and private (e.g. faith-based and for-profit) facilities, the primary

source of health services for the poor remains the government. Private and faith-based facilities are not obligated to and do not, in practice, provide free care to the poor in Kenya.

The Ministry of Public Health and Sanitation (MOPHS) and the Ministry of Medical Services (MOMS) are the national level governance and stewardship bodies for the public health system in Kenya. Public facilities follow a tiered system where the first level of care is provided through community health workers (via community health units); the second at dispensaries and clinics; the third at health centers and sub-district hospitals; and the fourth, at district and provincial general hospitals ((MoH), 2006). According to the national health sector strategic and investment plan following the 2010 Constitution, the largest gaps in health care fall at the community level as evident from *Table 2*.

Table 2. Kenya’s public health infrastructure coverage by care level

	Hospitals			Primary Care Units		Community Units
	Tertiary (level VI) referral hospital	Secondary (level V) referral hospital	Primary (level IV) hospital	Health Centre (level III) services	Dispensary (level II) services	
Catchment populations	5,000,000	1,000,000	100,000	30,000	10,000	5,000
Numbers required	9	44	440	1,468	4,404	8,808
Existing facilities	9	44	554	1,064	3,676	439

Source: Kenya Health Sector Strategic Investment Plan (KHSSP) July 2012-June 2017

In the case of maternity care, capacity and referral at these various levels are critical to promoting access to delivering women. Referral hospitals such as Kenyatta National Hospital, a major tertiary center in Nairobi, and Pumwani Maternity Hospital (PMH), the largest national maternity hospital, draw patients from across the country in addition to local patients from Nairobi and the Central Province (Macro, 2010). Sub-county hospitals, such as the site for this study, are classified as primary (level IV) hospitals. Though level IV facilities are supposed to provide comprehensive emergency obstetric and newborn care (EmONC), many lack a separate maternity theatre and have a limited number of doctors (e.g. it’s likely that a doctor trained in general surgery – not an ObGyn – conducts cesarean sections). Only 7% of facilities offer EmONC, which includes all basic procedures (antibiotics, oxytocics, anticonvulsants, manual removal of placenta, assisted vaginal delivery) and advanced functions (blood transfusion and Cesarean section) (Bureau, 2011). This average varies

across districts ranging from 2% in the Western compared to 14% in Nairobi (7% coverage in Central).

In addition to the geographically uneven coverage and service placement, access to care and actual utilization both vary throughout the country; this reflects cost-centric and non-financial demand-side factors (Wamai, 2009; Wanjira et al., 2011). Though there is a small tax base for health care (~7%), about 30% of health services expenditures are financed through out-of-pocket payments (Chuma & Okungu, 2011); these OPP payments disproportionately burden the urban poor as these households pay three times the per capita OPP (~\$9.2 USD) compared to their rural counterparts (~\$3.1 USD). Lack of funding in public facilities is related to quality of care as it affects the adequacy of human resources, staff stress and morale, and inadequate supplies and equipment. The congested wards and long waits in public facilities alongside high costs at private facilities result in concentrations of poor women seeking government services. Moreover, informal and formal user fees (i.e. bribes or cost of items like cotton wool, drugs, etc.) in facilities discriminate against poor women (Say & Raine, 2007; Sharma et al., 2005). User fees in district hospitals increased between 2003 and 2009 (Chuma & Okungu, 2011). Generally, government facilities have longer lines and are more congested and less hygienic, while the unregulated and variable private sector is not always accountable to those who cannot afford it. Though fee waivers for the poor exist on the books, awareness, implementation, and protection of these exemptions is relatively non-existent in public facilities (Sharma et al, 2005). The plethora of health system factors described foster a culture of delayed care-seeking in this population (CRR/FIDA, 2007). Such delays are particularly problematic in the context of maternity care, where complications often require immediate attention to prevent morbidity and mortality.

Political and policy environment affect maternity care

Devolution of Power

Devolution structurally affects maternity care in Kenya and the framing of this dissertation. The idea of devolution, which resurfaces a number of times in Kenya's post-colonial history (Branch,

2011), only recently manifests as reality in accordance with the new Kenyan Constitution of 2010 that restructures governing bodies (Ghai & Ghai, 2011; Kimenyi & Shughart, 2010; Kramon & Posner, 2011). The constitution upholds the right to health (including reproductive health) and establishes a new set of guidelines around devolution of powers (administrative, financial, and procedural) to the county level that affects health system structure and function ((FACT), 2013; Kenya, 2010). In the devolved system, the overall policy goal for the health sector is to “better health in a responsive manner”; achieving this goal builds on principles of people-centeredness, equity, participation, multi-sectoral effort, efficiency, social accountability, and with particular objectives centered on “quality and access”.

In 2013 (the data collection period for this dissertation), deliberations and planning for health sector devolution at the central level was finalized and county leadership appointments were in progress. Though official documents delineate distinct and linking roles between county, central governments, and health systems stakeholders (e.g. facilities, community health units, civil society, etc.) with respect to (a) stewardship and oversight roles, (b) management and resource structures, (c) accountability mechanisms, and (d) procedural guidelines, operationalization of the new system remained ambiguous at the time this research was conducted ((FACT), 2013). For example, terminology around the structure of national-provincial-district-sub-district governance, which affects decision making about public health facility management and community health strategy, shifted to ‘county-level’ vocabulary. In addition to semantics, this shift left a number of district officials uncertain about their trajectories and role in the devolved system following the commencement of county appointments by the newly elected government. Study findings are sensitive to and influenced by the prevailing discourse of devolution and institutional rhetoric that shapes how maternity care is provided and experienced. Moreover, general discussions around accountability, responsiveness, and fairness – all critical to health systems and associated with trust (Emanuel & Emanuel, 1996; Gilson, 2007)– render this study timely and relevant.

Free maternity care

In addition to the shifting political environment of devolution, the March 2013 general election of President Uhuru Kenyatta, followed by his inauguration in April 2013, introduced a policy mandate that affected delivery and receipt of maternity care in Kenya, i.e. ‘Free Maternity Care’ (H.E. Hon. Uhuru Kenyatta, 2013). The President’s mandate, which called for the immediate effect of universally free maternity (labor and delivery) services to be provided to women in all public health facilities, pushed forward one of his campaign platforms within his first 100 days of office. The policy did not obligate private and faith-based facilities to provide free maternity care. The policy sought to address growing concerns around falling short of the MDG-5 and to capture the ethos of the health sector’s goal under the devolved government structure of improving on reproductive, maternal, and newborn health ((FACT), 2013; Bourbonnais, 2013). It was highly publicized through the national media and led almost overnight to maternity ward saturation (Muraya, 2013). Facilities that previously detained women post-delivery for inability to pay were prohibited from continuing these practices. The mixed response to this policy – as rhetorically positive but burdening an overwhelmed health delivery system suffering from a shortage of material and human resources to meet demand – is observed in, and congruent with, other sub-Saharan African country experiences (e.g. Ghana) of removing user fees for maternity care (Bourbonnais, 2013; Ganle, 2014). The timing of this dissertation’s data collection immediately following the free maternity announcement, because the study is an exploration of trust in the maternity setting, was affected by a hyper-sensitized and vocal public.

Study Setting

The choice of research setting for this study was informed by a range of interests and concerns around maternity care, devolution and shifting county health structures, peri-urban population needs, and the researcher’s involvement in concurrent Respectful Maternity Care (RMC) work in Kenya. The Heshima (‘respect’ or ‘dignity’) Project is coordinated by the Population Council and emerged out of a multi-sectoral movement to understand and address disrespect and abuse

(D&A) experienced by women during childbirth globally. The global multi-sectoral movement includes researchers across a number of institutions (including the Population Council), advocates led by the White Ribbon Alliance (WRA), and maternal health program implementing agencies. As a part of this effort, USAID's Translating Research into Action (TRAction) initiative funded two studies in Kenya and Tanzania intended to measure D&A and, through partnership with local partners and with community input, to develop multi-faceted intervention strategies for promoting RMC. In Kenya, the implementing partner consortium includes the Population Council (PC), the Federation of Women Lawyers-Kenya (FIDA), and National Nursing Association of Kenya (NNAK). PC's Heshima Project is a highly participatory iterative process of understanding from a range of perspectives (women, communities, providers in community and facility settings, facility and county management) what drives D&A during childbirth, and actively responding to these root drivers through multi-faceted interventions developed through consultative dialogues with the MOH, professional associations, civil society, and numerous other stakeholders.

This dissertation is nested as a sub-study within the Heshima Project (study) in that it contributes to the understanding of facility-based maternity experiences and their repercussions through the lens of trust. The parent study followed a quasi-experimental participatory design with a baseline and endline evaluation; the dissertation study was situated about 6 months prior to the endline as the multi-faced interventions were being rolled out. Interventions include a series of trainings, orientations, and multisectoral efforts to elevate RMC as a priority at the national policy, facility, and community levels. The Heshima study spanned five counties (including the capital city of Nairobi) in Central and Western Kenya, covered facilities their surrounding communities, and traversed urban, rural, and peri-urban areas (Charlotte Warren et al., 2013). Given its link to a larger reproductive health voucher study (C. Warren et al., 2011), the Heshima's study population of women and communities were predominantly of lower socioeconomic status. After review of baseline data from all counties through her work with the PC on the Heshima Project, the researcher noted trust as an emergent issue in the context of maternity care. The researcher focused her sub-study in one

socioeconomically unequal county in Central Kenya. The study county had less intervention exposure and uptake particularly at the facility level (i.e. time and number of activities) compared to the other counties in the study. The researcher further selected the main public sub-district hospital (with surgical capacity) and its surrounding peri-urban area as a setting for the dissertation research, in order to ensure coverage of a range of facility-based maternity interactions. In order to carry out dissertation research, the researcher solicited support of those involved with implementing or coordinating Heshima intervention activities both at the facility and community levels. Community health extension workers (CHEWs) and community health workers (CHWs) involved in community-centric interventions promoting RMC were particularly instrumental in understanding and carrying out the sub-study in this particular peri-urban county setting.

Peri-urban county setting

The peri-urban setting in Central Kenya around a sub-county hospital is best characterized as a small town with easy highway access to Nairobi, the capital city. The majority ethnic group is Kikuyu and study population reflects the underserved (non-elite) groups. The county shares a provincial history of involvement in politics, participation in Mau Mau, and skepticism around ‘western foreigner’ influence and motive (e.g. land rights and domination). The county’s economy is rooted primarily in agriculture – mainly coffee and tea plantations – though there are local shops, businesses, and small-scale commercial ventures operating in villages and epicenters of town. County infrastructure includes a few paved roads that lead towards the town center accompanied by graveled lanes and dirt roads that comprise the narrower diversions. Access to financial resources varies tremendously – despite a wealthy few, the majority population (study population) would find it difficult to spend ~\$10 on a family member for required treatment if he or she fell ill. Housing styles range from shanty dwellings and poor-quality cement multistory buildings (slum-like) in the areas close to the town center, to basic mud-and-cement structures in the farther-out villages, to lush countryside homes. The study population covered the former two groups. The sub-county hospital,

located in the town center, sprawled out with an administrative wing (facility management and county health offices), a number of outpatient and inpatient wards, and an operating theater (general surgery, including cesarean sections). The maternity ward, comprised of two wards – the first, for laboring women with the delivery area for vaginal births, and the second, a postpartum ward – are geographically separate from the operating theater and the gynecology ward. About 15% of facility deliveries were cesarean sections as shown in the monthly returns between 2011 and 2013. This typifies the peri-urban facility and community environment in which the study is situated.

III. Methodology

This dissertation adopts a qualitative approach to explore, in depth, the nature of interactions and relationships surrounding the meaning and determinants of health systems trust in the context of maternity care. Data collection is nested within a larger study around disrespect and abuse in maternity care (Charlotte Warren et al., 2013). Baseline data from the parent study suggest the emergence of trust as a potential linking concept between perceptions of facility-based maternity experiences and care-seeking. The sub-study grew out of the impetus to better understand the salience of trust in maternity care, how trust is shaped, and the nuances in relationships and interactions that influence trust. A qualitative approach allows for contextual explanation within a peri-urban setting, eliciting meaning from participant perspectives and describing processes (Maxwell, 2005). The present study seeks to achieve this by drawing on individual and normative perspectives and exploring how trust is enhanced and undermined.

The researcher chose a qualitative design given the relatively new substantive area of inquiry, the sensitivity of the research topic, and the nature of the overall objective. Literature on health systems trust recognizes the need for both qualitative and quantitative methods and recommends qualitative exploration of the concept in any context (Goudge & Gilson, 2005). This methodology is best suited to assess socio-cultural resonance of the construct and identify trusting relationships across maternity care interactions. Moreover, interpretive methods are integral to studying a concept like trust that possesses an undercurrent of inherent power-imbalance in social interactions in the maternity setting. Given the goal of developing a contextual understanding of trust, the researcher selected methods most attuned to capturing a range of perceptions – both across individuals (in-depth interviews) and collectives (focus group discussions).

Theoretical orientation and design

The epistemological orientation for this body of work is social constructivist. Social constructivism embraces multiple realities and assumes that knowledge is co-created as a result of the

interaction between researcher and researched (Creswell, 2007). In such an orientation, it is important for researchers to be reflexive about their relationship to the study topic, participants, context and findings. In this study, the qualitative researcher's understanding of trust certainly affected the lens through which the data were collected and analyzed; moreover the research is influenced by how research assistants perceived and probed on various aspects of health systems trust. As a female American student of South Asian ethnicity conducting research in Kenya, a country where South Asians have resided for generations, the qualitative researcher played the role of a familiar-looking outsider whose affiliation with a respected NGO allowed for congenial researcher-researched interactions that motivated the sharing of personal experiences. This openness – facilitated additionally by sensitive research assistants and amenable interviewing environments – allowed for the co-creation of knowledge to be rooted in local perspectives.

Two theoretical orientations that serve distinct complementary purposes in influencing this dissertation's design and data collection include appreciative inquiry and the critical lens of institutional ethnography. Appreciative inquiry (AI) is an action-research approach that is applied to inspire organizational transformation through positive practices and aspirations within a particular societal context (Ludema et al., 2006). AI emerged from grounded theory methodology (described later in this chapter's discussion of analytic approach), yet leans toward goals of advocating changes to particular systems (Grant & Humphries, 2006). The process of appreciating, envisioning, co-constructing and sustaining a 'positive topic' resonates with this dissertation's objective of exploring the notion of trust and its determinants. The philosophy of AI is appropriate given the parent project's participatory nature and acknowledges that people carry forth past notions of realities to influence future change; it understands the importance of incorporating peoples' values into any system improvement effort (Duncan & Ridley-Duff, 2014; Hammond, 1998). The spirit of this type of inquiry was particularly helpful in tool creation and developing probes to better understand trust within the context of facility-based maternity care experiences for 'what they are', 'what they could be', and 'what they should be'. For example, the study team probed respondents to elaborate on

discrepancies between their ideal and actual maternity experiences. Moreover, posing similar questions across different types of respondents offers the ability to link the different methods and perspectives in an action-oriented way around how to build women's and community trust in the maternity setting. Recognizing some of the critiques regarding AI's use - namely, its lack of accounting for implicit power relations and consideration of salient 'negative stories' (Bushe, 2011; Grant & Humphries, 2006) - both of which likely have implications for trust in maternity care, the qualitative researcher drew additionally on principles of a critical approach.

Critical theory has a rich history in the social sciences with respect to studying hierarchical relations, identifying institutional shortcomings, and proposing alternative ways of thinking (Kemmis, 2006; Kincheloe et al., 2011; Madison, 2005). These theories embrace the idea that inherent power relations affect how societies function, how institutions operate, and how disciplines conduct research – all of which can either oppress or emancipate – thereby warranting the need for engaging voices less heard (Foucault, 1991; Freire, 1970). Institutional ethnography (IE), in particular, builds upon the actualities of women's lives, probes on the political nature of these realities and describes the social processes surrounding particular standpoints to unearth the way discourses are created and potentially identify points for change (Campbell, 2006; DeVault & McCoy, 2006; D. Smith, 2006). IE is motivated by feminist theory and provides a useful lens for understanding gender power dynamics in the context of specific interactions (e.g. with health facility). In the words of Dorothy Smith,

“It is not meant as a way of discovering the world as such but looking beyond the everyday to discover how it came to happen as it does.”(D. Smith, 2006)

This theoretical lens bears in mind the role of the institutional networks and processes by studying human experiences and linking them to dominant discourses (e.g. maternity experiences and trust in maternity care). Beyond description of experiences, Lisa McCoy elaborates on the contribution of IE to a broader advocacy agenda in the context of health care, saying that it possesses

“...an institutional focus that keeps attention oriented toward the organization of health service delivery (what is being evaluated) and prevents it from stalling at a typology of evaluative criteria (studying participants).” (McCoy, 2006)

As such, this lens encourages the asking of critical questions around experiences (e.g. what breaks trust in maternity care) and the social processes surrounding those experiences (e.g. relations and interactions) to glean better understanding of institutional norms and discourses that have implications for trust. In particular, this study draws on the critical theory's emphasis on analyzing upward and downward (within the hierarchical structure) to fully explore a topic (i.e. trust) using texts and multiple standpoints (McCoy, 2006). For example, critical theory influenced the design choice to elicit community group-normative perspectives of maternity experiences through focus groups discussions (FGDs) before exploring individual perspectives through in-depth interviews (IDIs) of women, community health workers, nurses, doctors, and managers to understand the social processes surrounding maternity care that affect trust. Additionally, IE guided the analytic choice to develop a narrative across standpoints of women and community (Chapter VI), provider and management (Chapter VII), overall determinants of trust, and recommendations for building trust (Chapter VIII).

Underlying the rationale for drawing on the philosophies of AI and IE is that in addition to their complementarity, they both fall under social constructivist traditions and are well suited to exploring an inherently relational and politically laden topic like trust. Moreover, they both resonate with the action-oriented parent study focused on promoting respectful maternity care (RMC) through a people-informed complex multi-faceted intervention (Charlotte Warren et al., 2013). Both orientations encourage 'emergent design' that facilitates an iterative process of design, data collection, and preliminary analysis.

Study site & population

Given the goal of achieving an in-depth contextual understanding of a range of perspectives of trust and its determinants, the doctoral student decided, jointly with the Population Council (an organization working toward promoting RMC) to focus the research site within communities residing near a sub-county hospital in a peri-urban county in Central Kenya. The county is located about 30-40 minutes outside the capital city of Nairobi and has a population of about 1,673,785, of which 60% reside in urban areas (Data, 2011). In addition to its inclusion in the Heshima study, this location is

selected for a few other reasons. First, to be able to capture the range of facility-delivery interactions and positive and negative experiences of women who sought maternity care for their most recent delivery, it is appropriate to focus on an area where these interactions are frequent; a sub-county hospital in a peri-urban setting (not rural, but under-resourced compared to urban centers like Nairobi) meets this criterion. Second, both individual and group-normative perspectives are made richer and strengthened by integrating and linking thematic relationships around trust if it is explored in the same county. Third, contextual explanations need to be bounded in some way – in our case, within a county – so that interpretation and policy and program implications are practically meaningful.

The study populations of interest include recently delivered women (RDW), first time pregnant women, male partners of RDW, health facility providers, and key informants working to address D&A in the Kenyan context. These groups are of interest because of their ability to provide rich information on their perceptions and feelings about health systems trust as related to women's maternity care experiences; they are content experts based on their life experience or professional work. Multiple viewpoints were drawn upon in order to triangulate findings across perspective, method, and chapter (Maxwell, 2005). Moreover, the use of multiple viewpoints supports the development of a contextualized explanation or model of how trust is conceptualized, is created or undermined, and operates with respect to maternity care.

Immersion and Context

Prior to data collection, the South Asian American qualitative researcher spent about a month familiarizing herself with the geography, norms, local culture and organizational structures involved in the delivery and receipt of maternity care in this particular county. Her South Asian ethnicity rendered her somewhat of an insider in the Kenyan context, as she was often told in conversations with her supervisor and co-workers at PC, and felt through encounters in her Nairobi neighborhood and experiences in the field (e.g. locals often started conversations in Kiswahili). Initially, the qualitative researcher was concerned that her ethnicity might be a potential barrier to participants'

willingness to share information, given the complex post-colonial relationships between Kenyan Asians and Africans (Anand & Kaul, 2011; McCann, 2010; Vandenberg, 2006). However, she soon discovered that most participants, if recruited through appropriate channels (see *data collection*), were put at ease through initial conversation and opened up freely as they considered the IDI or FGD as a real opportunity to have their voices heard. This may have been in part due to her disclosing clearly who she is, describing the study purpose, and exchanging basic greetings in Kiswahili before proceeding in English. Additionally, despite being American – or a westerner – which has historically strained relations in the Central region (Kanyinga, 2009) - working as a research intern with the Population Council’s Heshima Study (comprised of a predominantly Kenyan African team) offered a unique cross-cultural scenario that privileged the qualitative researcher as an insider-outsider.

Given the study’s central topic of trust (of those holding varying amounts of institutional power), it is important to consider any potential limitations associated with participants’ willingness to engage in open discussion with the research team. Women and communities may not have been as open or critical if a formal health provider (e.g. nurse or doctor) had administered the IDI or FGD, if the interviewers spoke only English, or if they were more comfortable speaking Kikuyu (vs. Kiswahili). A language gap may lead to simplistic, uncritical response to understanding trust and its determinants. Providers and management, on the other hand, may have limited their own criticism if they felt that the interviewer would reveal their complaints in an identifiable way to their supervisors or if candor would threaten their professional practice. Across all participants, mistrust of the researcher for any reason (e.g. sociocultural, fear of disclosure) would likely result in an understanding of trust that lacks nuance and depth.

The qualitative researcher’s work with the Population Council enabled her to establish contacts with gatekeepers to both community health and health facility workers involved in shaping or understanding maternity experiences, as well as providing legitimate access to speak with communities residing in the surrounding areas. During this time, visits to community empowerment

sessions in various county sub-settings – some more rural-like and others more urban – allowed for the qualitative researcher to gain a glimpse into the willingness of women and men in the community to share their perspectives on the process of maternity care-seeking, the labor and delivery experience, and the quality of care received at the sub-county facility. These community visits provided time and space for the qualitative researcher to build rapport with CHWs and familiarize herself with contacts at the health facility and become an accustomed face to providers in the maternity wing. Moreover it allowed for understanding the norms of social interaction in a community setting as well as etiquette and conversational style in the facility setting. The qualitative researcher's presence both in the community and facility allowed for garnering support and buy-in for the study.

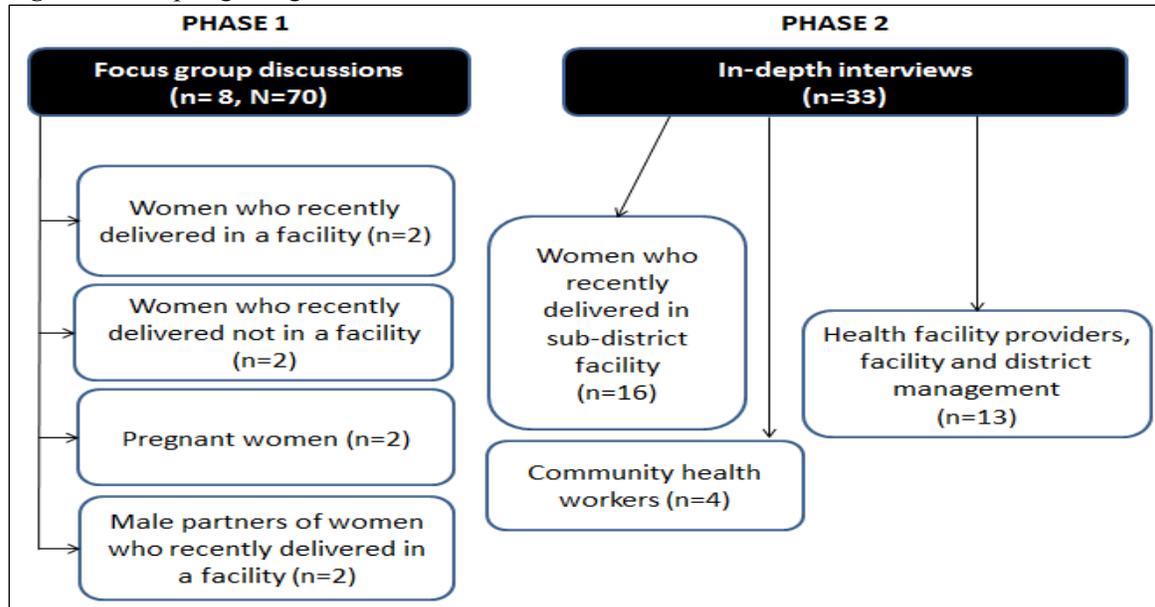
This initial stage of developing substantive working relationships with the community and facility, particularly in the shadow of the recently announced 'free maternity' policy, informed the development of interview guides (e.g. emergent design accommodates asking about 'free maternity') and acknowledged the larger social and political changes that rendered the topic of interest particularly salient. Establishing legitimacy with some of the upper level management and bureaucrats was also integral to carrying out study logistics.

Sampling strategy

This study uses a purposive sampling strategy that covers a range of hierarchical perspectives in one peri-urban context, from women and communities, to health providers, to facility and county level management (see *Figure 3*). This sampling method allows for informed selection of participants based on the nature of the research problems, process, or phenomenon being explored (Creswell, 2007). Sampling is theoretically driven to explore and reach saturation on the construct of trust in the context of maternity care (Creswell, 2007). The data were collected during June and July 2013 over two phases, the FGDs preceding the IDIs. The first phase focused on eliciting group-normative community perspectives while the second sought to build upon preliminary findings and probe more in-depth on individual perspectives at various levels of receipt and delivery of maternity care. As per

emergent design, the qualitative researcher decided – based on preliminary FGD findings – to include CHWs as study participants given their linking role in the patient-provider-facility management hierarchy. Sampling focused within the geographic bounds of one county and generally fell within a 5-10 km radius of one sub-county public hospital that had a high volume of patients to ensure maximal individual and community exposure to facility-based maternity interactions.

Figure 3. Sampling design



In phase one, researchers conducted FGDs (n=8) with a total of 70 participants first to gain an understanding from a community or group-normative perspective of the meaning and determinants of health systems trust around maternity care. Participants included recently delivered women (RDW) who delivered in and out of the facility in the last year (n=4), pregnant women (including first pregnancy) (n=2), and male partners of women who had delivered in facilities within the last few years (n=2). These particular groups were selected given their vested attention to and proximity of maternity care intentions, experience and potentially varied perspectives on health systems trust. For example, it may be that notions of trust vary by stage of pregnancy (first-time pregnant women may have more or less trust in the health system compared to those who've delivered), experience of delivery (facility vs. not) or as an integral family member/third-party overseeing and influencing the care-seeking process. Group participants were further purposively selected based on geographical

distance to the facility, covering both those living ‘closer’ to and ‘farther’ from the facility. For instance, one of the RDW in a facility FGDs was held with women who lived ‘closer’ to the sub-county facility (<5km), while the other was held with a group that lived farther away (>5km).

In phase two, a total of 33 IDIs were conducted with the purpose of further understanding the same concepts from the individual’s perspective. The multiple perspectives explored included recently delivered women (RDW) in facilities within the last 6 months (n=16), different cadres of health workers in facilities (n=11), community health workers (CHWs) (n=4) and management level key informants (n=2). RDW participants generally lived within 6 km of the sub-county hospitals County Hospital and were drawn from 7 slum-villages in the county. The health facility workers interviewed included nurse-midwives, doctors (clinical and medical officers) and the nursing in-charge of maternity. The facility matron (senior nursing officer) and county public health officer were also interviewed in the administrative wing of the facility premises. Within each participant type, researchers aspired to diverse sampling of delivery experiences amongst women, professional cadres and experience in maternity, and across gender in supervisory, health facility worker, CHW roles. The study team purposively sampled two male and two female CHWs to interview as key informants to get a balanced view across gender, which the qualitative researcher thought important given the nature of maternity care as a women’s health issue.

Theoretical Saturation

The concept of saturation guided the final sample size. Theoretical saturation refers to the sampling process during which the researcher collects data to elaborate on theoretical categories related to the central topic (e.g. trust) until ‘no new properties’ emerge (Charmaz, 2006). Prior qualitative studies that used theoretical saturation to guide data collection suggest that approximately 25-30 IDIs and 2-3 FGDs per group type, each with 8-10 participants per group are sufficient (Mason, 2010; Morgan, 1997). In this study, the research team discussed emergent themes during the data collection phases based on fieldnotes and reflections, which led to consensus around theoretical saturation on the concept of trust in the maternity setting. The final sample size was additionally

influenced by the qualitative researcher's constraint to remain within funding allocations for research and living expenses in Kenya.

Data collection

Recruitment

Recruitment for FGDs was carried out by CHWs residing in this peri-urban setting who held community rapport and respect because of their social engagement and work empowering and educating men and women on health and well-being. CHWs also interacted with local leaders and elders and had a history of working with the Heshima project. CHW recruiters ensured that women and community respondents were not influenced by (through direct participation in) the Heshima community-level intervention activities in the county. In the case of the IDIs, RDW in the last 6 months were identified through record review at the sub-county hospital by qualitative researcher and the nursing in-charge deputy of maternity at the facility. After obtaining a listing, women were contacted and recruited by CHWs working in the nearby areas to limit any suspicion of being directly approached by outsiders— a skeptical attitude shared by many living in the area. Health provider and upper level management recruitment occurred jointly by qualitative researcher, the nurse in-charge, and her deputy. After the study had been introduced to the maternity unit as a whole, volunteers were called upon from different cadres of workers. The qualitative researcher conducted interviews with these individuals at their convenience - during breaks in their schedules or lulls in patient load.

Research team and pre-data collection training activities

The qualitative researcher and four research assistants (RAs) comprised the data collection team. Data collectors were all female, held diplomas in the social sciences, were fluent in Kiswahili (one was fluent in Kikuyu, the dominant language in the Central Province), and had experience collecting qualitative data in various parts of the country. Prior to the start of fieldwork, the qualitative researcher conducted a 4-day training with 2 research assistants that covered FGD methodology, conceptual background, study objectives, and protocol. The training period included a

collective effort to finalize translations of the discussion guides and questionnaires as well as a pre-test in a Nairobi slum. The pre-test helped to identify areas requiring a bit more explanation, modify or exclude questions deemed problematic, and assess any stigma associated with in the language being used (e.g. we found that it may not be hurtful to ask women in a group setting about potentially distressing maternity experiences). The research team learned that the topic was timely given the recent free-maternity mandate and that women were open in speaking about their maternity experience in an intimate space with others from their community (who had similar life experiences) and the research team (who put them at ease), provided that a community liaison facilitated an introduction. For Phase 2, a 1-day intensive training on IDI methodology, protocol, instrument translation, and practice was conducted with 2 research assistants. To allow for practicing interviewing technique, RAs conducted mock interviews with Population Council staff and interns and debriefed with the qualitative researcher. The trainings emphasized the importance of taking fieldnotes and engaging in daily discussion with the qualitative researcher about how findings were complementing, confirming, and disconfirming emerging themes around trust.

Language, process and interview environment

FGDs were conducted in Kiswahili and IDIs were conducted in Kiswahili, English, or a combination based on respondent preference, and lasted about 1-2 hours. FGDs' length was fairly consistent - between 1.3 hours to 2 hours (average: 1.5 hours); IDIs ranged from 35 min to about 2 hours (average around 1 hour). In the case of FGDs, CHWs introduced the moderator, note-taker, and observer/listener (the qualitative researcher) to the participants as a way to set up a comfortable atmosphere – this was done through a brief introduction and a prayer, as that was the norm for many community meetings in the county. CHWs thereafter left the room and allowed for the research team to explain the study details and obtain written informed consent before starting the groups. A similar process was followed for IDIs with respect to study introduction and consent. At the end of the FGD or IDI, each participant also filled in (with a research assistant's help, if needed) a brief questionnaire that helped characterize the socio-demographic background and maternity-care preferences (e.g. age,

education, occupation, parity, delivery location preference, provider characteristics) of respondents and contextualize each perspective (see Appendix 3 for full questionnaire).

Interview location varied by type of respondent: IDIs of managers, supervisors, and CHWs were conducted in their office or field setting; IDIs of health workers were conducted in a small private back office of the maternity ward (which doubled as a storage area for files and smaller equipment); and RDWs were interviewed in a place of their preference (their home or a friend's home). The research team conducted FGDs in community settings or homes – if distance posed a real challenge, the study team provided additional support for transportation. Settings included schoolrooms, outdoor gathering spaces, living rooms in the homes of centrally located participants, and in the case of one male partner FGD, a small community meeting room attached to the county chief's office. In all cases (IDIs and FGDs), we made a conscious effort to select venues that were private, convenient, and comfortable for the participants, given the intimate nature of some of the questions. Furthermore, the compositional design of the FGDs accounted for power imbalances that might have stifled conversation or induced social unease in mixed groups. For instance, male and female groups were held separately; first time pregnant mothers were interviewed as a separate group to avoid often dominating views of higher-parity women in the community discussion contexts. The moderator emphasized that the discussion environment was a safe space for everyone to learn from each other's experiences and contributions.

Instrument development

The interview guides were informed by the literature and research questions and evolved over the course of inquiry. This is characteristic of 'emergent design', by which data collection and some level of analysis will be simultaneously conducted and instruments altered (Maxwell, 2005). In both data collection phases, we allowed for continuous honing, re-phrasing, and re-orienting of interview questions from one interview to the next to fully understand the topic at hand. Participants were probed on their experiences to elicit emic descriptions of the meaning, relevance, and determinants of health systems trust. The qualitative researcher and research assistant team engaged in a process of

asking different groups about what they thought trust looked like and how it was created in different relationships – spanning from patient-provider, to patient-facility, to those involving community health workers, and the more broadly to social institutions in the county. The theoretical lens of appreciative inquiry was particularly useful here in asking questions around ‘ideal’ versus ‘actual’ experience – and, moreover, for probing respondents about how they felt trust could be built in the context of various interpersonal (patient-provider, inter-provider) and impersonal (patient-facility) relationships. Over the course of asking these questions, we also realized it was more effective to ask what particular groups (i.e. community, providers, facility management, and government) could do toward achieving this goal. In the application of the bottom-up approach in institutional ethnography, we asked different levels of participants (community, facility, & upper management) about their understanding of the trust relationships at the lower levels on the hierarchy in addition to their own thoughts. The study team encouraged critical perspectives by probing on negative aspects of maternity interactions, asking participants to provide examples of experiences where there was little or no trust.

The study team drew upon defined content areas in the Health Systems Trust: Content Area Framework (*Figure 1*) to develop interview guides, as the qualitative researcher sought to assess whether these global understandings would resonate with a local interpretation of trust (Sachiko Ozawa & Sripad, 2013). For example, the team asked questions such as “How do you know your provider is being *honest* with you?” or “What makes you *confident* enough to deliver in a facility?” The ‘context’ in which the proposed study explores the derivation of meaning spans multiple sub-contexts including the ‘facility-based maternity care’ health space, the geographical bounds of communities within specified radius of facilities in a peri-urban area, and the socio-cultural norms within communities in this Kenyan county – emic perspectives were sought to achieve this understanding.

Interview guides included realist² questions with some instrumentalist³ probes to ensure coverage of the central topic (Maxwell, 2005). Iterations of the instruments, practice interviews, and debriefing sessions were all ways in which the research team took care to minimize leading questions, by focusing on process as opposed to variance. Examples of realist questions include “please describe how you felt about your last experience delivering in a health facility”, “please explain how you know that you can trust your provider”, or “how do you think we can build trust between patients and the health facility?” The semi-structured guide used as many open-ended questions as possible in order to elicit narrative accounts. The guides were further revised through a deliberative process with PC, data collectors and pretesting. Pre-testing ensured, to the degree possible, comprehension of instruments and sought to correct inconsistencies in language, assure readability/interpretability, recognize and change any stigmatizing questions, and identify leading items.

Table 4 lists a range of sample questions, by topic, covered in the interview guides; the full semi-structured guides (including probes and alternative ways brainstormed to ask questions) can be referenced in Appendices 1 and 2. Questionnaires administered for contextualization purposes asked about socio-demographics (age, marital status, religion, education, occupation, and parity), delivery place preference, maternal health decision-making, and the role of feedback mechanisms (Appendix 3).

Table 4. Sample questions from interview guides

<i>Topic</i>	<i>Sample question</i>
Meaning and types of trust	<ul style="list-style-type: none"> - What do you think of when you hear the word trust? - What social institutions do you trust and why? - How do you know you can trust someone?* - Tell me about a maternity experience (your own or someone you know) where there was very little or no trust in the health system?† - Describe to me an instance where you may trust the facility but not the provider? - How do you know your provider is being honest with you?‡ - What makes you confident enough to deliver in a facility?*‡

² Realist questions stem from the perspective that unobserved data (e.g. perceptions) are the “real phenomena” of interest

³ Instrumentalist questions refer to questions based on observable/measurable data of interest

Determinants of trust	<ul style="list-style-type: none"> - Why did you feel you could trust (or mistrust) your doctor/nurse/CHEW/TBA? - How might this trusting/mistrusting attitude change?[†] - How do you know you can trust the health system?* - Why do you think some women may trust the providers more than others?[†] - Describe how you felt about your last experience delivering in a health facility?* - Describe what an ideal maternity care experience would be like for you?* - How does your experience with ANC relate to your trust in the health system? - What do you think of ‘free maternity care’?
Building trust	<ul style="list-style-type: none"> - How do you think we can build trust between patients and providers?* - How do you think we can build trust between communities and the health system overall? - How do you think we can build trust between cadres of providers?* - How do you feel ethical or professional codes could be changed? *[†]

*Appreciative inquiry lens

[†]Critical questions/Institutional ethnography lens

[‡]Health systems trust: content area framework-informed

One challenge faced at an early stage in the process of FGD and IDI guide development revolved around translation. After an initial round of translations of the FGDs, the research team (during the RA training) felt that some of the concepts were not captured as accurately – i.e. literal translation (translator was given a brief background of project, but not in-depth training) did not do justice to the ethos of the questions. In back translating (orally) some of the questions, the RAs and qualitative researcher noted the discrepancy. Moreover, given one of the RA’s familiarity with the Kikuyu language and both RAs’ field experience in the Central Region, the qualitative researcher decided to defer to their expertise. The team subsequently re-worked translations during the weeklong preparation for fieldwork. Pre-testing these versions further honed our instruments and helped with translation of the IDIs.

In the spirit of emergent design, appreciative inquiry and institutional ethnography, phase 2’s instruments (IDIs) contained items similar to the FGDs (particularly those with RDWs) and further explored the topics of providers, managers and supervisors, and CHWs. Additionally, adaptive tools enabled probing on initial community responses from FGDs.

Data management and analysis

Data management

FGDs and IDIs were audio-recorded using digital recorders, transcribed, and translated into English. At least two people looked at each transcript to ensure quality translation of text for

meaning, tone, and non-verbal cues. Any discrepancies or unclear audio segments were replayed and discussed with the qualitative researcher and PC context specialist (fluent Kiswahili and Kikuyu) to ensure accurate representation of the data. Research assistants and doctoral student conducting IDIs and FGDs briefly commented – in writing – on their impressions from each interview and wrote summary field notes on their perception of the interview quality, a description of the location and atmosphere, and any circumstances that may have affected the conversations being held. Both transcript data and summary reflections contributed to the qualitative researchers' writing expanded fieldnotes of both phases to provide detailed accounts of data collection processes and fieldwork challenges.

Data analysis

Data analysis for the overall study draws on social constructivist paradigm, AI and IE principles, and specific grounded theory analytic techniques. Chapter IV uses a mixed analytic approach to understanding meaning and types of trust in the Kenyan context of maternity care; the qualitative researcher coded deductively for the trust construct using the Health Systems Trust: Content Area Framework as a guide, as well as inductively for new themes and content areas of trust in maternity care in Kenya that organically materialized from the data. Chapters V and VI apply a purely inductive approach to conceptualize and explore the determinants of trust in a maternity setting from the perspectives of (a) women and community and (b) health providers and management. Chapter VII solicits AI and IE philosophies to further explore across the hierarchical perspectives from Chapters V and VI, and explore potential trust-building mechanisms in maternity settings in peri-urban Kenya.

Constant comparison method

The qualitative researcher applied the 'constant comparison method' to learn more about the meaning and determinants of trust. Using this method, the data collection and analysis follow an iterative process of informing each other and building on prior knowledge on the research topic in an adaptive way (Glaser & Strauss, 1967). This approach has been shown to be useful in health services

and systems research (Bradley et al., 2007; Janevic et al., 2011). To help facilitate the constant comparison method, the qualitative researcher applied memo-writing – both during and after data collection – as a method to facilitate thinking and stimulate analytic insights about the data (Charmaz, 2006; Creswell, 2007; Maxwell, 2005). Initial analysis, interspersed with data collection, occurred in the form of rigorous note-taking during debrief sessions with RAs, writing process and status memos, and writing expanded fieldnotes. This reflexivity⁴ influenced subsequent data collection by guiding exploration of newly emerging ideas, themes or thematic links. In particular, it helped determine new probes to ask in subsequent IDIs or FGDs, reflect on how the substantive themes relate to one another, and gauge a level of theoretical saturation. For example, it enabled the qualitative researcher to consider initial FGD findings as they informed a priori content areas as well as new understandings of trust – which were later explored further in the IDIs. Memos further allowed for concurrent exploration of themes across standpoints (women, community, providers, and management) in initial and latter stages of analysis. In latter stages, these provisional excerpts allowed the qualitative researcher to apply the constant comparison method as well as think freely based on her experience collecting and categorizing data to synthesize findings. Memo-writing alongside coding allowed for understanding how probing on different types of trust across multiple perspectives enabled the researcher to ascertain a comprehensive view of the construct in this particular context.

Textual analysis and theme emergence

The qualitative researcher conducted textual analysis through coding of data using Atlas.ti, referring to fieldnotes to place the findings in context, memo writing to develop themes, and engaging in a deliberative process with those on PC staff and thesis committee around emergent themes in the data. Coding served as a way to manage and categorize the large amount of text into thematically cogent areas, a process informed by grounded theory (Charmaz, 2006). After initially reading through all the transcripts and taking notes, the qualitative researcher coded the FGDs first as

⁴ Reflexivity refers to the writer/researcher's consciousness of the biases, values, and experiences that he or she brings to the study.

a step for building an overall code structure, after which she applied the extensive version to the IDIs. During this process, the researcher added some new codes, but primarily filled in the explanations of the prior codes, noted them as individual perceptions, and reflected on how themes were described at different hierarchical perspectives. This was reflected in summary documents and outlines/diagrams of themes. The extensive codebook includes 135 open and focused codes, which reflect both content and process, are often relational, and operate at multiple levels (e.g. ‘nature of communication’: patient-provider, patient-CHW, provider-management, patient-community member, etc.). In the case of FGDs, coding additionally focused on the nature and patterns of conversation as well as the saliency of topics as exemplifying what meanings most valued in a group (Morgan, 1997).

Thematic areas pertain to research questions and organically arising themes that characterize the meaning and determinants of trust (Appendix 4). Specifically, Appendix 4 shows how particular questions gave rise to a range of codes that helped to develop themes presented across chapters. As evident from the expansive scope of data, memo-writing served an integral role in developing codes and themes, evaluating linkages between themes, and generating trust conceptualizations in each chapter. For example, this process allowed for analyzing agreement and disagreement between members in FGDs to generate ‘collective’ (i.e. social normative) perspectives. Specifically, non-verbal cues such as tone, shared laughter, nods, and the way in which women or men finished each other’s sentences allowed for assessment of agreement, while the shaking of heads and looks of skepticism suggested disagreement in the group. Memo-writing linked these cues to participant quotations in a way enabled the researcher to assess consensus in the FGDs. Later, the same process allowed for assessing how collective and individual perspectives trust tended to overlap. Overall, memo-writing enabled a way of dialoguing with the coded text and operationalizing the constant comparison method.

Ethical considerations for human subjects’ protection

This study received ethical approval from the Population Council IRB as well as the ethics review committee of the Kenyan Medical Research Institute (KEMRI). The Johns Hopkins

Bloomberg School of Public Health IRB deferred to the Population Council IRB based upon required documentation provided by the qualitative researcher. Though this study is minimal risk, the study team took care to select interview locations that ensured privacy to the greatest extent possible. During each FGD, it was reiterated to the group to please keep confidential all group proceedings.

The research aspires to benefit the groups and participants from whom data are collected, particularly given its placement within a larger participatory research-action project to develop multi-level interventions addressing disrespect and abuse in maternity facilities in Kenya. It likely contributes to increasing awareness of RDW or pregnant women around the quality of facility experiences by engaging in discussions about health systems trust. Given the possibility of increasing information exchange in a community about negative facility-experiences, there could be unintended consequences of reduced care-seeking or forms of resistance to health care service delivery. To mitigate such consequences, it was helpful for data collectors to recognize the dynamics of power and potentially different interests of those seeking and those providing care, for instance, by adopting the appreciative inquiry lens to motivate systems improvement without incurring blame on specific individuals.

Voluntary Participation

Participation in this study was on a voluntary basis; researchers did their best to assure voluntariness by familiarizing CHWs involved in recruitment of RDW and community groups with ethical standards for research. Moreover, during the FGD sessions, the study team took care to reaffirm the willingness of each participant to participate and made it clear that participants had the right to withdraw from the study at any point. Similar procedures were used during the IDI phase. The study team provided a nominal monetary compensation of 200 KSH (~2.50 USD) to cover either transportation cost or refreshment to all RDW and community members. Providers and management were offered the equivalent amount for refreshment, though not all accepted it.

Informed Consent

The research team required participants to provide written informed consent before beginning the FGD or IDI. The data collector explained in detail the goals and nature of the study, described any associated risks and benefits to one's participation, assured confidentiality, and explained that responses would be de-identified, collated, and presented together in a report or publication. Data collectors also asked permission to audio-record the sessions in order to be able to capture everything that was discussed during the FGD or IDI.

Data storage and protection

To ensure confidentiality and anonymity, participants' personal information was not connected with their interview audio or text files (informed consents were stored separately) and de-identified audio and text files were stored on password protected computers (the qualitative researcher's and the PC Nairobi office data manager's). The data were managed by the qualitative researcher. The research team renamed transcript files using an agreed-upon scheme to keep track of relevant descriptors for the analysis (i.e. participant type, interview type) and to be able to reference to questionnaire data.

IV. Meaning and types of trust in maternity care

Sample and Method

This chapter explores individual and collective perceptions of the meaning and types of trust embedded in the context of maternity care. Descriptive characteristics of respondents (*Table 5*) show that community (female and male) and RDW participants' age ranged between 18 and 37 years; though men were slightly older, the average age falls in the mid-to-late twenties. Participants were relatively well educated with a large proportion reporting that they had completed secondary or higher education. It appears from FGD participants that men have greater access to higher education (59%) than women (30%); however RDWs with whom IDIs were conducted form a comparatively highly educated group. This discrepancy is partially explained by the heterogeneity in the FGD population (e.g. women who delivered both in and out of facilities, first time pregnant mothers) compared to the IDIs (e.g. purposively selected women who had delivered in the facility).

Table 5. Descriptive characteristics of community and RDW participants

	<i>Focus Group Discussions</i>		<i>In-Depth Interviews</i>
	Women	Men	RDW
Total Number	53	17	16
Mean age (range) years	26 (18-37)	28 (18-37)	25 (20-30)
Secondary or higher education	16 (30%)	10 (59%)	12 (75%)
Married	33(62%)	17 (100%)	15 (94%)
Protestant	23 (43%)	11 (65%)	10 (63%)
Currently pregnant	15 (28%)	n/a	
1 child only	13(25%)	9 (53%)	9 (56%)
Occupation			
Homemaker	12 (23%)		7 (44%)
Small business	11(20%)	3 (18%)	4 (25%)
Casual labor	12(23%)	5 (29%)	
Other employed	12 (23%)	9 (53%)	5 (31%)
Not employed	6 (11%)		

The majority of our respondents were married – of those that were not, most were single (never married) and one IDI respondent was separated. Participants were all of Christian faith (Catholic, Protestant or other denomination) - representative of the county's religious majority. Parity across respondents ranged from no children – 15% of our sample were first time pregnant mothers - to 6

children. More women in FGDs than those interviewed in IDIs had more than one child, though there was considerably more heterogeneity in the community setting. Participants reported a range of occupations including homemaking, small business, casual labor, and other employment. As described by community health workers, casual or ‘informal’ labor for women referred predominantly to domestic support jobs, while for men it referred to agriculture and farming support on tea and coffee plantations. ‘Other employment’ for women included self-employment, teaching, farming, working at a beauty salon, or secretarial work; one woman also described herself as a student. For men, the same category referred to self-employment or *bota bota* driving. In the absence of explicit income information, the study team inferred – based on the living conditions of recruited participants – that the respondent sample likely fell into a lower income bracket (the bottom two quintiles). Community, RDW, and CHW respondents’ homes visited during fieldwork were comprised of basic cement structures or mud dwellings, or were constructed using tin sheets and other cheap materials; none had more than one bedroom.

Health facility providers, certified by the Ministry of Health, worked primarily at the public sub-county hospital and had varied years of experience working at their current job (7 months to 30 years). The nurse-midwives generally held more years of experience compared to the doctors who were younger and new to the field. The head of the maternity department held a postgraduate degree in epidemiology in addition to her nurse-midwifery qualification. The two management level key informants, the matron of the facility and the district public health official (DPHO), had >3 and >5 years of management experience, respectively, including and prior to their current posting. Finally, the CHWs were formally trained about 5 years ago by the government and have since been taking part voluntarily in the community health strategy. The CHWs work toward linking communities with the facility as needed and they provide ‘level 1’ health services, meaning basic preventative and curative care across a variety of areas including maternal and reproductive health. In the institutional ethnographic sense of standpoints, CHWs provided an intermediary perspective between (a) women and communities and (b) providers and management.

This chapter was guided methodologically by the global content areas described in the Health Systems Trust: Content Area Framework. The researcher sought to understand, from local perspectives, the meaning of health systems trust and particular types of trust that manifested in the maternity setting. Questions were both open-ended (e.g. What do you think of when you hear the word trust? Describe people you trust? Describe social institutions you trust? How is trust in the health system different from in other institutions? How are facility doctors and nurses different from traditional birth attendants?) and framework informed (How do you know your provider is being honest with you? How do you know your provider is being fair to you? Do they treat you differently because of your age, parity, ethnic group, poverty status? What makes you confident that the provider has your best interest at heart?). Further probes that served as follow up questions included exploration of trust's variability, its dynamic nature, and its relevance in maternity care.

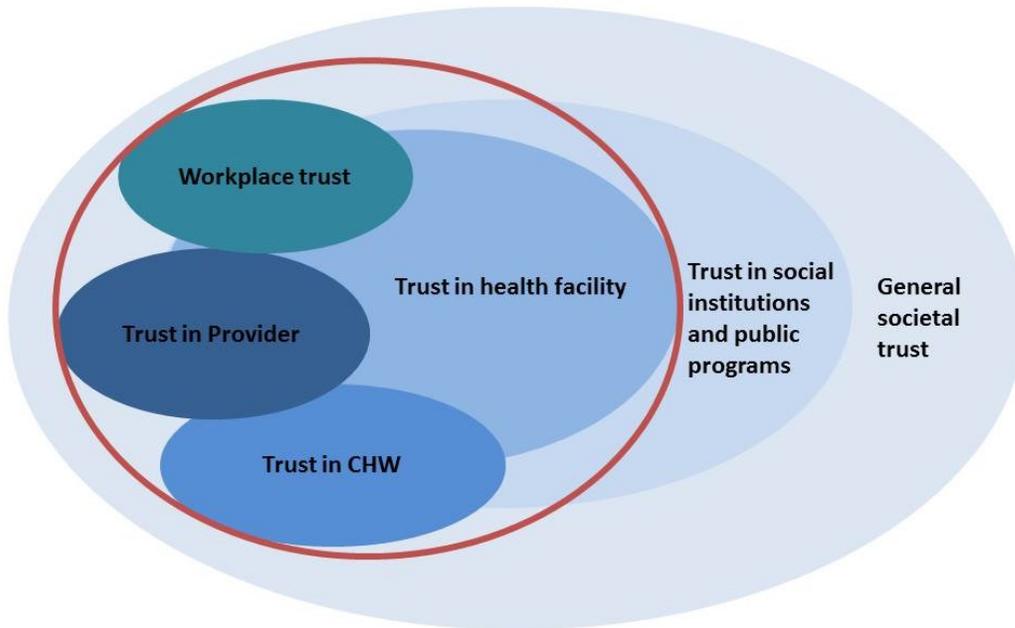
Results

Key themes and representative quotations from the data are presented in Tables 2-4 and Figure 2; first the complexity of health systems trust seen through types and perspectives, followed by the exploration of its multidimensional content areas, the uneven distribution of content areas across relationship type and perspective, the dynamic and mutable nature of trust, and finally, the particular relevance of trust in providers and health facility in maternity care.

Types of trust in maternity care

What emerged from the data is that health systems trust in maternity care can be categorized into four general types that capture both interpersonal and impersonal trust: (1) trust in providers; (2) trust in the health facility; (3) trust in community health workers; and (4) workplace trust. The manifestations of these types of trust may be distinct yet they remain interrelated and nested as shown in *Figure 4*.

Figure 4. Types of trust described in maternity setting



Women’s and community trust in providers is often embedded in their trust in the facility (but not always, as discussed later), as well as their understandings of trust in social institutions and programs, and general societal trust at large. Trust in CHWs falls within that of social institutions and general societal trust, also through their link to the health facility. Workplace trust, though nested primarily within the health facility, also exists amongst the diffuse community health workforce; in both cases, this type falls broadly under institutional and general societal trust. Cross-type examples illustrate how trust is understood and is thought to operate by multiple respondents in maternity care.

Meaning of ‘health systems trust’ in maternity care context

Health systems trust in the peri-urban Kenyan context includes notions of confidence, open communication, integrity, mutual respect, competence, confidence, fairness, confidentiality, and systems trust (Table 6). The majority of these content areas emerged organically from the questions asked while a few, such as fairness, necessitated focused probing.

Confidence

Confidence reflects the dependability of one party to the other, which in the case of maternity care manifests in the provider to the patient, the health facility to the patient, community health

worker to the laboring women in the community, or the providers to each other (*Table 6*). All participants describe this content area using terms such as ‘faith’ and ‘belief’ - it captured a positive belief in the context of implicit vulnerability and uncertainty. They describe confidence as both ex ante and ex post of their facility experience. This notion is most commonly articulated in the context of ‘trust in providers or the health facility’. Women and communities often spoke of providers and care processes leading to either loss or inspiration of hope. Some women (and a few providers reflecting on patient trust) explained confidence in providers using spiritual language, namely that doctors and nurses with ‘good hearts’ acted as agents of God (or ‘angels from heaven’) to guide patients through labor and delivery. This language did not resonate in the three other trust types. Confidence in workplace trust amongst providers and CHWs reflects a faith in the role and responsibility of each cadre and individual to complete allocated tasks in the best interest of a patient.

Communication

Communication appeared as a key component giving rise to and following from trust in the maternity setting (*Table 6*). Accounts of verbal and non-verbal interactions of laboring and delivering women with providers, community health workers and other staff encountered in the facility over the course of their maternity experiences varied in nature and frequency. Communication quality determined how trusting patients were of providers and the extent to which workplace trust existed between providers in their coordinated efforts. Patients who felt they were not listened to, who feared to ask questions because of anticipated negligence or disrespect from providers, or who lacked a clear feedback channel for their complaints exhibited lower levels of trust in their providers. Trust in the provider was also reported to lead patients to engage in open discussion and disclosure of necessary information for providers to respond effectively in maternity and related reproductive health care.

Table 6. Health systems trust in maternity care: content areas and supporting quotations

	Content Area	Supporting Quotations	Types of trust*
Interpersonal Trust	Confidence	<p>"It is to believe in something that you have not seen." (RDW not in facility, FGD)</p> <p>"To have faith in the hospital activities and services. Having faith in the doctor's abilities. It's having faith in the services one will get to them when it is highly required." (RDW, IDI)</p> <p>"Like when somebody is on duty and things always go wrong... that will make me not trust the person a lot." (Nurse in-charge, IDI)</p>	1, 2, 3, 4
	Communication	<p>"You know, there is a provider you can just look at and feel scared, and walk away. There is another... the way he just talks to you...how he asks questions when you talk, you just feel you trust him and you tell him how you feel." (RDW not in facility, FGD)</p> <p>"You don't have to be abusive to the patient; you have to encourage this patient, you have to talk to her nicely and you guide her step by step... You know you have to trust whatever the patient is telling you because you will be guided with what the patient is telling you. But sometimes if you notice the patient is lying, you have to talk to her...to counsel her so that she can tell you the truth, so that she can confide in you." (Nurse-midwife, IDI)</p>	1, 2, 3, 4
	Integrity	<p>"It is the providers themselves who know if they are telling the truth. That's why we say doctors are different. There are providers who are ready to assist you and others who are unwilling. Just like teachers, there are those who want to teach and those who just sit in the staff room." (Male partner, FGD)</p> <p>"That will depend on how they approach you, when you go to them as you enter the facility...how they talk, the way they treat you when you go to the labor ward - that is when you can feel that truly this provider has come to work and not just for the money, but to give service to the patients." (RDW not in facility, FGD)</p>	1, 3, 4
	Mutual respect	<p>"I will be open to you since when I speak to you I know you will hear me out and we will come up with an agreement. That means I trust you - there is nothing I cannot tell you. But when there is no faith, I will be afraid of you." (RDW in facility, FGD)</p> <p>"Imagine when you are in pain, someone insults you. That pain could even get into your mind. ... when you feel like you are being bullied, you feel like you are worthless. You felt like you are not needed there. So if only they could change and become friendlier." (RDW, IDI)</p> <p>"Respectful care I think is really treating the women who come to give birth with respect; just assume they're your sisters, don't talk to them rudely... just try to understand them...If you show them respect then they will definitely trust the system." (Medical officer, IDI)</p> <p>"The work in the ward is usually kind of teamwork and there are some things that bring out differences that may lead the system to fail. So you find when there is something that they [nurses] want you to do, they will come talk to you, they will suggest something to do. Now they come and ask for your opinion. Often, we even ask them... then they tell us how they see about it." (Clinical officer, IDI)</p>	1, 3, 4
	Competence	<p>"I found out that the doctors were qualified. They know how to do their work. I was confident with it [for delivery] because it is a government facility and the government mainly works with people who have been trained -those who know their work." (RDW, IDI)</p> <p>"Trust, like that first one is not trustworthy because he/she did something as if he/she is not sure, or just to try. As in, it is kind of she was in a training. At least hospitals, they should not ...people like us they should not give us to people on training...it can change like in that labor ward, they shouldn't always leave it to those who are learning - or training - to serve those mothers. At least there should be one who has the skill. Okay, the one who is on training is observing and still, the one who has the skills is still coming to check on you." (RDW, IDI)</p>	1,2, 3, 4
Fairness	<p>"Let's say we get in there with my wife. You find another lady whose petticoat is hanging below her dress, basically not attractive as she comes in. In a community, we cannot all be the same. Some are dirty, some are clean, but a doctor should be fair, be neutral...You see</p>	1, 2, 3, 4	

		<p><i>as you get in and he sees you are dirty so shouting at you starts, but the one who comes in looking clean and neat, the provider is even afraid of her because she may not know who the patient is." (Male Partner, FGD)</i></p> <p><i>"When you go to the clinic, maybe there is a patient who is well known by the provider and is a wealthy person. They will not queue and will be treated before the rest." (RDW not in facility, FGD)</i></p>	
	Confidentiality & Privacy	<p><i>"When you have a problem, you tell them [providers] and they advise you on what you should do without telling people outside." (Pregnant woman, FGD)</i></p> <p><i>"You will find maybe that some patients are HIV positive and they do not want other people to know. So sometimes it's challenging because as much as you don't want to disclose the information, you also want to protect the husband." (Medical officer, IDI)</i></p> <p><i>"The environment ...if they need some [vaginal] examination or something that needs privacy to that extent, they are taken to that room [points to the room next to us]. But it's also a challenge, because even the others who are coming in - they use the same same room." (Nurse-midwife, IDI)</i></p>	1, 2, 4
Impersonal Trust	Systems trust	<p><i>"They have the ability but are unwilling to work. They are able because they have all the materials they need to do the work....like drugs, injections, gloves. Everything that's needed in the maternity. But when you go there you are asked to go buy them yet they are available." (RDW facility, FGD)</i></p> <p><i>"When they see that the overall supervisor is around, they all treat you well. But immediately after the supervisor leaves, things change for the worst" (Male Partner, FGD)</i></p> <p><i>"The way we were handled by those workers [by the gate] was not bad...They just took us nicely, they showed us where we were supposed to start until we got to the doctor....we found the one who serves at the customer care - it was at night and we did not know where to start. So we went in there and he/she called for us the security man who took us to the maternity." (RDW, IDI)</i></p> <p><i>"[We interact] through giving the reports about the patient... (I: ok). What you have done to the patient, you give a report to your colleagues, the other nurses, and also to the doctors for the special patients -that's patients who need special attention, you also inform the doctor. But for those ones who don't individualize care or those ones you think you can handle, you don't inform the doctor about them....[how?] conversation and also there is documentation part of it written.. It works well because if something was not given orally then somebody is able to check on the report in the documents of the patient." (Nurse-midwife, IDI)</i></p>	2, 3, 4

*1: trust in provider, 2: trust in health facility, 3: trust in CHWs, 4: workplace trust

Integrity

The level of integrity across relationship type emerged as an essential content area of trust for all participants; integrity drew on notions of ‘honesty’ and ‘fidelity’ (*Table 6*). Honesty stemmed from the closeness of those interacting, conversation quality, non-verbal cues of providers (e.g. looking patient in the eye, facial expression, and body language) and management, and, in some cases, cultural background of providers. Women, individually and collectively, elaborate on this closeness by describing providers who spoke about their faith, those with whom patients shared a common language, or those who were socially linked to patients as being more honest or meriting trust. Sustaining informal social connections over time created a sense of honesty in a relationship and emerged as a key component of trust in CHWs, and to a lesser extent, in workplace trust. The level of honesty is often described by participants as related to fidelity. Fidelity involves providers having the patient’s best interest at heart during maternity care. It captures the responsiveness expected by delivering mothers: the expectation that providers and facility management are not misguided by self-interest, but rather by ‘good will’, as articulated by many participants (*Table 6*). In the case of workplace trust, fidelity is closely related to commitment to one’s work irrespective of non-professional pressures and responsibilities. RDW, pregnant women, male partners, CHWs and providers concur on the salience of integrity as a health systems trust component in maternity care.

Mutual Respect

‘Mutual respect’, according to all participants, is seen as a part of interpersonal trust across relationships (*Table 6*). For RDW, this notion encompasses both valuing the expertise of providers involved in their treatments and establishing a real human connection with them. One of the RDW descriptions illustrates the point at which women in labor lose their sense of self-worth as a result of verbal or non-verbal interactions with nurses and doctors as the moment when mutual respect disappears. Collective perspectives of male partners, RDW, and pregnant women agree with this notion of how the mutual respect that gives rise to trust is closely intertwined with interpersonal communication. Provider and management perspectives concur on the salience of mutual respect. In

the case of inter-cadre workplace relationships, this notion played out as having respect for distinct roles and responsibilities of ground staff, nurses, doctors and, consultants to promote safe delivery and the well-being of both mother and baby.

Competence

Competence of providers and the health system to respond to women's needs and provide timely, effective, and appropriate maternity care emerged across all participants as integral to both interpersonal trust of providers and impersonal trust of the facility. In relation to interpersonal trust of providers (by patients as well colleagues), competence was often articulated in terms of skills, qualifications, degree types, and years of experience, while in relation to impersonal trust competence was described more in terms of the systemic capability of the facility (*Table 6*). In particular, trainees – medical and nursing students, who often wore distinct attire from their fully qualified counterparts – were perceived by many women as less competent in the maternity ward. Given the sub-county hospital's role as a teaching facility with a high turnover of trainees, their interactions with women have implications for trust in the maternity setting. Some women described competence of providers in terms extending beyond just a degree to a doctor's or nurse's thoroughness of examination and ability to respond to the unique patient needs. Overall, as suggested in *Table 6*, there was a sense that government facilities hired qualified providers (i.e. those with high competence) compared to private or faith-based facilities where human resource qualifications varied immensely; however, inefficient and delayed quarterly funding cycles often led to systemic shortcomings of infrastructure, space, drug supply and delivery-equipment (in short, the competence of government facilities/health system).

Fairness

Fairness resonated as a content area across all participants with respect to trust in providers and facilities. When asked if they had been treated fairly, many women provided an overarching response about service equivalence ('they [facility providers as a group] treat us [all types of women] the same'). Upon further inquiry and probing, participants revealed various 'unfair' service experiences. There is a general perception amongst women and communities that treatment differs

along the lines of age, wealth, social status, familiarity with providers, and to a lesser extent tribal language – if a preference existed apart from Kikuyu and Kiswahili (regional and national languages, respectively) (*Table 6*). Women who ‘skipped the queue’ because of ‘wealthier’ appearance, used cash payment, or had social connections to specific providers, as well as those who were first time delivering mothers, were less likely to suffer neglect and service delays compared to poorer, voucher or NHIF card users, unconnected, older counterparts, or women with previous deliveries. Providers’ perspectives disagreed with individual and group-normative perspectives from the community setting (e.g. RDW, pregnant women, and male partners, and CHWs) about unfair treatment based on these lines, claiming that ‘preferential’ treatment only occurred based on a woman’s stage of labor. Besides the repeatedly expressed and agreed upon imperative to address urgent maternity cases first, fair treatment was a unanimous aspirational component of the community’s view on health systems trust.

Confidentiality & Privacy

Confidentiality and privacy are components of trust (in providers and the health facility) that emerged predominantly from providers’ perspectives, confidentiality being a challenge precipitated by the lack privacy (*Table 6*). Providers describe difficulty in keeping confidential women’s broader reproductive health concerns around sensitive issues like HIV and STDs over the course of maternity care, given the proximity of beds, overwhelming numbers of women, and bed sharing. Though providers spoke frequently of bringing women with particularly sensitive issues to a separate room for discussion, they commiserated about their inability to maintain the intended privacy of discussion and protection of confidential information. The congestion issue was raised amongst women and the community, though most articulated this more as an infrastructural limitation and personal comfort issue than a confidentiality-concern.

Systems Trust

Infrastructural, physical, organizational, and social environments comprise the overall notion of systems trust (*Table 6*). In maternity, systems trust, from all participant perspectives, breaks down into patient navigability and provider, resource, and management capacity with respect to facility

functioning. Provider capacity, beyond qualifications and skill, includes motivation and other support factors. Facility environment concerns include but are not limited to the presence of materials, supplies, drugs, equipment for safe delivery, space to serve all patients, and provider supervision. The coordinated efforts of all those involved with a woman's care between labor and delivery – starting with the guard at the front gate to the nurses, to other staff members, to doctors and supervisors – influences understandings of systems trust. The salience of systems trust falls mainly within women's and community trust in the health facility, though also resonated in their trust in CHWs and social institutions.

Trust content areas vary across type and perspective

Though all the content areas were covered across trust relationship types, prevailing individual and collective understandings of each type of trust did not necessarily align across perspective (*Table 7*). For instance, the understanding of trust in providers from women's and community perspectives was often described using content areas of confidence, communication, integrity, mutual respect, and competence, while from the provider and management perspective, confidentiality is among the most commonly noted aspects. The CHW perspective fell in-between – though aligned closer to the perspectives of women and communities – highlighting fairness, mutual respect, and communication as integral to patient-provider trust. The considerable overlap suggests that the underlying construct of trust (across types) is contextually understood and shared among groups at the maternity interface. *Table 7* suggests that confidence, communication, mutual respect, and systems trust appear particularly salient across the different trust types and perspectives, while the content areas of fairness and integrity, which may be more interpersonally experienced, appear more perspective-oriented (i.e. women, community and CHWs discuss these components more than providers and management do). Despite divergent perspectives around fairness, the researcher infers some overlap between fairness and confidence and communication. For example, many of the participants - both individually and collectively – describe certain sub-populations (e.g. younger

sexually active and unmarried women, those seeking abortions, or HIV-positive women) as plausibly having lesser trust in providers or the facility compared to the general community.

Table 7. Trust content areas by type and perspective

Types of Trust	Content Areas	Women & Community	Community Health Workers	Providers & Management
Trust in providers	Confidence	x		x
	Communication	x	x	x
	Integrity	x		
	Mutual respect	x	x	
	Competence	x		x
	Fairness		x	
	Confidentiality & Privacy			x
Trust in facility	Confidence	x	x	x
	Communication	x	x	
	Integrity			
	Mutual respect		x	
	Competence	x		x
	Fairness	x	x	
	Confidentiality & Privacy			x
Systems Trust	x	x	x	
Trust in CHWs	Confidence	x	x	x
	Communication	x	x	x
	Integrity	x		
	Mutual respect		x	
	Competence			x
	Fairness			
	Confidentiality & Privacy			
Systems Trust	x	x	x	
Workplace trust	Confidence		x	x
	Communication	x	x	x
	Integrity		x	x
	Mutual respect		x	x
	Competence			x
	Fairness			
	Confidentiality & Privacy			
Systems Trust	x	x	x	

In such cases, issues of fairness may be indirectly manifesting through limited agency in these sub-populations' willingness and ability to communicate openly with providers to receive appropriate care during childbirth (Table 8). Noting the diversity within the broad perspective categories (women &

community, CHWs, and providers & management), *Table 7* reveals how content areas vary across trust type and perspective. As depicted in *Table 7*, CHWs' perspectives fall hierarchically in-between those of women communities on one side and those of providers and management on the other.

Trust types may not always align

Types of trust relate to one another, but do not always align given the variability in how content areas were understood both interpersonally and impersonally. Trust in providers did not always agree with trust in the health facility, though the latter may build to some extent on the former. Trust in providers often reflects a range of issues including objective provider characteristics such as gender, attitude, education/competence levels, and behaviors, as well as patients' perceptions of empathy, respect, dignified treatment, and overall quality of interpersonal interactions. Trust in health facilities stems more from overall reputation and expectation rooted in the trust of professionalism, expertise, resource capacity, and coordination to provide quality services. The first RDW quotation describes how a woman's initial trust in the facility stemmed from her trust in one provider, although her later experience with another doctor at the same facility presented an instance where these two types of trust (in provider and facility) did not align (*Table 8*). Trust in CHWs appeared to be distinct (e.g. high confidence in their community presence) yet plausibly linked to trust in providers and the health facility. CHWs exhibit a conviction that their own trust in the health facility's responsiveness to community needs may directly or indirectly influence women's and community trust in providers and the facility. Additionally, women's trust or mistrust in the health facility may have implications for mistrust of social institutions at large, including but not limited to police, public education, and the government (i.e. CHW and RDW quotations). Trust across types may have an array of determinants. The content areas of confidence, communication, integrity, mutual respect, and systems trust appear particularly transferrable to trust in providers, CHWs, facilities, social institutions, and society generally, as seen in the example quotation regarding "failures to trust" (*Table 8*).

Confidence, integrity, systems trust, and mutual respect emerge as integral to workplace trust: the final nested type. Workplace trust between providers revolves around the willingness and ability

Table 8. Emergent thematic areas: trust variability, dynamics, and relevance

Thematic area	Supporting Quotations	Type of trust
Content areas vary across relationship type and perspective	<p>“Things like abortion in young girls, they never say the truth. We always face so much trouble with all that...the management is different for different things [stages of abortion and labor]. So, when they don't say the truth and we manage the other way, it goes all wrong on you.” (Medical officer, IDI)</p>	Provider, Facility
	<p>“When I first went to the [ANC] clinic, the doctor I found there served me and made me to like the services of that place. She would talk to me politely, she serves you well. But other times, you'd find a different one who insults you at the slightest mistake you make. So you trust their service knowing it's a clinic check-up and you will be treated and be well, But the doctor, no.” (RDW, 27 years, IDI)</p>	Provider, Facility
	<p>“Even when you are unable and have no one, your own people nearby, this person (CHW) will be close by to help you and will see how you can get help [e.g. at facility].” (RDW, 25 years, IDI)</p>	CHW, Facility
Trust types may not always align	<p>“The failure to trust government hospitals has also resulted in the failure to trust all these other government facilities [institutions].” (CHW, male, IDI)</p> <p>“Especially police... there is a lot of corruption. Like you see like you have gone to report something, if it is a certain case at the police, so that they follow up on that thing. You see sometimes they delay, they tell you give me something small I push for you that thing... Sometimes in schools, you may go taking a child...there are many in schools. Let us say you have taken to like class eight or class seven, now there they refuse to take the child. They say you must give them something small maybe so that they admit the child in school. Or offices if you want to be served, maybe something like birth certificate like so, maybe it has a problem, you must follow it up. Somebody tells you to buy them some tea so as to do for you that thing.” (RDW, 30 years, IDI)</p>	Facility, Social institutions
	<p>“It is trusting somebody like a friend because that one you have interacted deeply, you have shared social and personal issues.... but at the place of work, you don't discuss those personal issues with the people. You only discuss about the patient and things that are related to work, nothing else.” (Nurse, 10 years at facility)</p>	Workplace, General societal, Facility
	<p>“We [providers and CHWs] respect each other. The biggest need we have as the CHW's is to be acknowledged by those hospital workers... Many of the staff members don't know us....It is tedious introducing yourself every time when you encounter them....You see, it becomes a problem. It affects the service negatively because you may be with a patient from the community. As CHW's you bring them to the facility so that they can get treatment. It becomes difficult to introduce oneself to every provider and as such, it becomes difficult to assist the community because these providers don't recognize me....One feels like they are being a burden to the provider...The providers don't know you and they don't know the work you do.” (CHW, female, IDI)</p>	Workplace, CHWs, Facility
Dynamic nature of trust across participants and time	<p>“It was just one nurse [spoke rudely]....Because you know if at all I had had a complication from the ward and they didn't attend to me there and then, I would have preferred changing the hospital and going somewhere else. But the way they have served you in the nine months [of pregnancy] and then to the time of delivery...I was happy about it actually.” (RDW, IDI)</p>	Provider, Facility
	<p>“The first childbirth went well and so did the second one. The doctors present were different one for each of the births. So you see, that does say something about that hospital and the doctors working there.” (Male partners, FGD)”</p>	
	<p>“I know that the ones who have delivered from home are not assisted by doctors; they are just assisted by local women. You see the traditional birth attendants will be very patient with you and they don't abuse you. But you have to remember that if you have any complications, you would rather go to the hospital. Personally I felt that it was bearable considering, even though they [facility providers] may abuse you, you will deliver well.” (RDW, IDI)</p>	Provider, Facility, CHW, General societal
	<p>“I think it's a doctor and patient's relationship that builds over time. Because you'll see... like you need couple of consultations before you can actually open up to the doctor or... I think it takes time... In maternity it develops like...because initially when you are treating them, they are not too happy because labor and all that takes time. But as soon as they deliver, they come straight like, 'oooh yaah! Daktari (doctor) you were right!' So I think it just takes time....but other fields like the departments it's a very slow thing. I think when you starting improvement, I think that is when you build that trust and you want to share.” (Medical officer, IDI)</p> <p>“It [trust] is definitely very important. If you are the kind of a doctor who goes on revealing the issues about patients, with time, patients will come to discover - then they will be running away from you. It really even reflects on your image.” (Medical officer, IDI)</p>	Provider

<p>Relevance of Trust</p>	<p><i>“When a woman is pregnant, she carries the lives of so many; her baby, herself and generations. Her life is at the hands of the doctor...because childbirth is painful and a woman is usually feeling so much pain. She needs assistance and so she would love if the doctor understands her state and serves her with utmost patience and good will.”</i> (RDW, IDI, 1 child)</p> <p><i>“If you have trust in those doctors and you are friendly, you can’t even contemplate delivering at home.... I really believed that they wouldn’t leave me with any problem. I just had faith... I just had faith in them.”</i> (RDW, IDI, 1 child)</p> <p><i>“If you don’t trust an institution, you won’t go there for whatever service. Only that if you don’t trust the hospital then it’s really grave because in a hospital it sometimes is between life and death... if every time you think when you take your patient to hospital X, they will die, then you will never take your patient there.”</i> (Medical officer IDI)</p> <p><i>“I think she [patient] sees it is of great importance. Because if she trusts you, she will tell you all her problems, and after telling you, you will be able to help her. And also for you [provider], you will be able to deliver what you are supposed to give to the patient. But if she does not trust you, she will hide some issues from you - that will bring a problem even to the community.”</i> (CHW, IDI)</p>	<p>Provider, Facility, General Societal</p> <p>Provider, Facility</p> <p>Facility, Social institutions</p> <p>Provider</p>
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to collaborate to accomplish the best result for the patient. Its range across health facility worker and CHW perspectives covers both professionalism and personal connectedness (*Table 8*). Distinguishing between workplace trust and deeper trust rooted in interpersonal closeness is one way providers and CHWs express the concept. Others spoke of workplace trust as requiring a more solid interpersonal relationship rooted in mutual understanding that grew over time and could be enhanced by non-professional activities. ‘Workplace trust’ amongst CHWs in their role as educators and liaisons to women is more complex; however the importance of integrity to working at the grassroots level with the community remains an integral manifestation. Mutual respect between facility and CHWs was described by CHWs, in particular, and some facility providers, as integral to providing necessary and timely maternity care (*Table 8*). In a culture where exchanging greetings and pleasantries is embedded in quotidian working relationships (i.e. CHW-provider), the experience of ‘not being recognized’ is demonstrates a lack of mutual respect, a key component of workplace trust.

Dynamic nature of trust across participants and time

The four types of trust were unanimously described as dynamic, though shifts in trust in the health facility – which draws from more of an impersonal space – may have been less mutable compared to trust in particular interpersonal relationships. Participants often agree in trusting the health facility to ‘do a good job’. It appears that this type of trust represents an average attitude that may not increase or decrease after each health facility interaction, but rather develop and sustain itself within individuals and the community over time. For example, a RDW reports that irrespective of a negative experience she had during her delivery, her overall trust in the facility (based on her ANC experience) did not waiver given the competence, confidence, and systems trust of the facility (*Table 8*). This perspective of stability in facility trust was echoed across quite a few women individually and collectively, often out of discussions comparing the facility-based maternity care with the alternative of home-based TBA care as well as commentary on public vs. private care. Trust in facilities reflected a sense of familiarity and systems trust accrued over repeated positive outcomes across pregnancies

as described by a male partner (*Table 8*). Moreover, despite the agreed-upon notion that women's trust takes time to develop interpersonally (both over the course of a single visit and over multiple interactions) – provider perspectives (e.g. medical officer) suggest that interpersonal trust develops rapidly in the maternity setting compared to other departments, as it relates to progression of labor and individual outcomes of the delivery process. While many women and community participants describe 'improving' confidence in facilities, they simultaneously reveal experiential shortcomings with respect to delays or rationalize provider mistreatment (e.g. 'having a bad day'), suggesting that interpersonal dynamics may not always directly affect trust in a facility. Others saw trust in providers and facilities as linked; the medical officer describes instances where trust in providers stem from confidentiality – which, when breached, may influence provider image in the community. Trust in the facility may be more stable over time compared to interpersonal trust, though this proposition invites less support if the content areas of confidence, communication, or systems trust are broken. Findings reveal a complexity in the dynamic nature of trust through the nuances of different interpersonal interactions at the facility interface.

Relevance of trust

Trust– particularly in providers and facilities – was described across all participants (individually and collectively) as intrinsically important in maternity care settings given the “urgency” and “vulnerability” associated with the process of labor and delivery. Respondents describe the underlying positive expectation that the health system (providers and facilities) will treat delivering mothers with respect, dignity, and perceptibly high quality care (*Table 8*). Women's trust in a facility's ability to address obstetric complications in light of a range of care options at public, private, and faith-based facilities (or home-delivery) compelled many to seek care at the sub-county hospital. The representative RDW quotation describes a normalcy around facility delivery that echoed amongst male partners, pregnant women, and even women who did not deliver at the facility for their most recent childbirth. Individual and community trust in providers and facilities encapsulates an

implicit vulnerability and dependency on an expert system (i.e. health workforce) to provide timely, appropriate and acceptable care.

The relevance of trust in providers and the facility is further rooted in its instrumental association with maternity care seeking behavior (*Table 8*). After consideration of distance and cost, respondents often describe their past maternity care experiences related to trust as guiding their choices around whether or not to deliver in a facility. Contrastingly, the fear of mistreatment and negligence or being ‘left alone’ inhibited care-seeking. The relevance of trust stems from the users’ sense that facilities and providers ought to be accountable to individual patients and their communities – just as other institutions ought to provide their mandated services. A medical officer speaks to the high stakes involved in a facility-based maternity setting, implying that trust in a facility is a key part of promoting necessary care-seeking – and, if broken, may lead to avoidance of maternity care in order to save a life (*Table 8*). CHWs elaborate on the value of trust in providers, particularly the content areas of communication and integrity, for promoting medically-appropriate clinical practice. Although collective perspectives on the value of trust as a determinant of care seeking appear mixed, there is consensus across FGDs that trust in providers and the health facility was both instrumentally and intrinsically important in maternity care.

Chapter Summary and Interpretation

Study findings demonstrate that trust in maternity care is complex, multidimensional, and a highly relevant and valued construct (both intrinsically and instrumentally) in the peri-urban Kenyan context. Its complexity lies both in its manifestation (via content areas) in different trust relationship types and resonance across perspectives, and in how it is nested in broader conceptualizations of trust in social institutions and general societal trust. Despite the considerable overlap of trust content areas, particularly in the case of trust in providers and facilities, perspective plays a notable role in understanding the meaning and manifestations of trust, which has implications for its determinants.

The four generalized types of trust in this LMIC context are consistent with relational types in the larger health-focused trust literature (Egede & Ellis, 2008; M. A. Hall et al., 2002; Kelly et al., 2005; Lori et al., 2013; Østergaard, 2015; Zhang et al., 2009), though trust in CHWs has been less formally studied. The nesting of these relationships resonates with ecosocial models of trust in therapeutic sphere from South Africa (Gilson et al., 2005) and perspective-based conceptual models pertaining to dignified maternity care developed in East Africa (Freedman et al., 2014). Ecosocial models conceptually map patient-provider trust and workplace trust as components of health systems trust within a social context, while perspective-based conceptual models emphasize the need to account for layered perspectives in definitions and determinants of a multidimensional concept (e.g. D&A in maternity). Social and institutional environments affect patient and community trust in their immediate health care interactions as well the quality of interactions amongst providers in the facility and the community (i.e. part of what comprises workplace trust) in maternity care (Arnold et al., 2015; Gilson et al., 2005; Lori et al., 2013; McMahon et al., 2014; Riewpaiboon et al., 2005). Though this study did not stratify by socioeconomic status in its sample selection, findings around fairness suggest that perceived (or actual) wealth status is relevant, as in the Thai study, where women's perceptions and feelings about their interactions with various actors and their trust in the maternity care delivery system varied by social class (Riewpaiboon et al., 2005). Discussing trust in maternity often led participants into conversation about trust in other health areas and of the health system broadly. The gravity and intimacy associated with trust at a health facility interface distinguished it to a degree from trust in other social institutions, though consideration of trust often tended toward issues of access, agency, responsiveness and quality in any public service (e.g. police, education). This supports the idea that though trust in the health sector may be somewhat unique, it is understood in a socially patterned and nested way. The nested model is likely transferrable to other similar peri-urban under-resourced settings in Kenya and sub-Saharan Africa, where community trust of public institutions may dialectically influence trust in health systems providing maternity care.

Given the dearth of trust in maternity research, the nested findings suggest that despite some unique features of the maternity setting, the sense of trust may be similar in other medical areas. In particular, the multi-dimensional trust model in maternity care parallels that of other urgent care scenarios (Kelly et al.; 2005), which possess similar circumstances of patient distress, high patient, family, and community expectations for immediate outcomes, high-level coordination, and pressure-laden health service delivery environments. These scenarios necessitate the placement of trust in health professionals much more readily than in primary care (Pellegrino; 1991). In such cases, the stability of trust in the health facility (content area: systems trust) considerably outweighs the stability of trust in a specific provider from women's and community perspectives. This health systems-level trust may resonate particularly for those lower income communities residing in unequal socio-institutional settings as has been shown in experiences of low income African American populations in the U.S.(Shea et al., 2008). Building patient-provider rapport over time – over the duration of one or more pregnancies – reflects a continuity of care across reproductive health trajectories (i.e. ANC, maternity care, postnatal care and routine gynecological care) and suggests that trust in maternity care providers may resemble that of doctors in primary care settings (M. A. Hall et al., 2002). In both highly acute and routine health care settings, the communication-confidence dialectic –in which one reinforces the other – is a critical component of trust relationships (e.g. patient-provider), as seen in this study and in the broader health communication literature (Roter, 2000).

The empirically derived content areas support the transferability of the Health Systems Trust: Content Area framework (Sachiko Ozawa & Sripad, 2013); though in the Kenyan context, mutual respect emerged as particularly important across the different trust types in maternity care. This may be due to concurrent attention to dignity commanded by the Heshima Project and the free maternity mandate, or it may be attributable to the sequencing of questions in the open-ended guide, which asked early on about what respectful maternal care looked like. For example, the Heshima interventions focus on the need to enhance respect and reduce disrespect and abuse and in maternity setting. In the community this was done through mobilization meetings in which RMC rights and

obligations are a focal point of discussion. Though recruiters ensured that sub-study FGD participants had not directly participated in the meetings, there may have been an indirect influence of community trainings. Additionally, given that ‘Heshima’ is the Kiswahili word for dignity, early introduction of this term may have affected responses. The locally derived content area of mutual respect (particularly in, but not limited to, patient-provider and provider-CHW relationships) warrants further exploration and incorporation in trust-monitoring measures. Beyond the applicability and flexibility of the Health Systems Trust: Content Area Framework to specific health areas (e.g. maternity care) in particular contexts (similar peri-urban settings in Kenya), the conceptual similarity of trust content areas to those found in prior studies suggest that there exists a level of cross-cultural commonalities conducive to the adaptation of prior measures (M. A. Hall et al., 2001; McEvily & Tortoriello, 2011). Moreover, given the growing regional interest in trust (Østergaard, 2015), findings from this chapter provide a contextual basis for the development of trust-monitoring measures and a generally shared understanding of the content areas that reflect trust in maternity and trust in the health system more broadly.

Future research

Substantial overlap of content areas across respondents and types of trust suggests that confidence, communication, and systems trust are central in the maternity context and warrant further exploration. The dynamic nature of trust implies that trust can change over time, may change differentially by relationship type (e.g. trust in facilities may more stable than that in providers), and may be sensitive to shortcomings in specific content areas (e.g. confidence). This fragility is evident in other health systems trust work (Gilson, 2003). For example, it may be that certain sets of experiences (e.g. negative outcomes, harsher care, inability of providers to coordinate effectively) are more likely to affect interpersonal trust relationships (e.g. trust in providers, workplace trust) compared to impersonal ones that may align more closely with notions of ‘trust in social institutions’ (e.g. the facility or health system).). The understanding of the dynamic nature of various trust relationships is at a nascent stage and requires attention. Finally, respondent’s concurrence on the

relevance of trust in maternity settings –particularly women and community’s trust in providers and facilities – across hierarchical perspectives suggests a need for further exploration in terms of the determinants of trust and contextually acceptable ways to build it.

V. Determinants of a trusting environment for the maternity care: women's and community perspectives

Standpoint and method

This chapter presents women's and community voices regarding what determines their trust in the health system in the context of maternity care. It draws specifically on collective perspectives from the 8 focus group discussions (FGDs) with recently delivered women (RDW) both in and out of a facility, pregnant women, and male partners of RDW. Additionally, it explores individual perspectives of determinants of trust through 16 in-depth interviews (IDIs) with RDW who delivered in the last 6 months at the sub-county facility as well as 4 IDIs with community health workers (CHWs) – 2 men and 2 women – as representatives of the community who served in a bridging capacity with respect to the formal health delivery system. The institutional ethnography (IE) lens situates CHWs under the community standpoint, but recognizes their unique positioning as intermediaries in the hierarchy of perspectives covered in this dissertation. In accordance with IE, this chapter describes determinants of trust from the standpoint of the users of maternity care.

The socio-demographics of women and community respondents are described in *Table 5* (Chapter IV). Less than half of the FGD sample of women (n=25; 47%) report making maternal health care-seeking decisions on their own; the majority describe it as a joint decision made with their husbands, or as the choice of the husband or another family member. Similarly in the case of IDIs, the majority (n=10; 63%) report maternal health care-seeking decisions to be a shared process with their male partner. Male partners reaffirm that either they make the maternal care-seeking decision (n=10; 59%) or it is a joint decision with their spouse (n=4; 24%). Gender dynamics in the household thus affect maternity and reproductive health seeking decisions and facility-based interactions in this context. Based on the living conditions (described in Chapter IV) from which women and community participants were recruited, it is reasonable to infer that the sample likely fell into a lower income bracket. Women and community participants had been living in the peri-urban area for a significant amount of time ranging from at least 1 year (only 3 were residents for less than a year) to 35 years

(29% have been in the area for over 10 years). The standpoint of women and community reflect a lower-income working class living in a peri-urban Kenyan locale where delivering in a public facility is the general preference (~ 85% report preference to deliver in public facility).

This chapter's findings draw upon the following guiding questions.

- How do you know you can trust someone or an institution?
- How do you know you can trust a health provider or the health system?
- Tell me about a maternity experience (your own or someone you know) where there was a lot of trust in the facility or the health system? Probe: in the provider?
- Tell me about a maternity experience (your own or someone you know) where there was very little or no trust in the health system? In the provider?
- Describe how your last maternity experience met (or did not meet) your expectations?
- Tell me what an ideal maternity experience would be like for you?
- With whom do you discuss your maternity experiences and health care seeking decisions? How much do you value these discussions?
- What do you think about the free maternity mandate?

Determinants

Women's and community perspectives of the determinants of trust in a maternity setting can be classified broadly into five clusters: patient/individual, provider, health facility, community, and accountability factors (*Figure 5*).

Patient/individual factors

Women's and community trust in the maternity setting is affected by prior experiences, perceived risks and harms, and childbirth outcomes in a particular maternity setting.

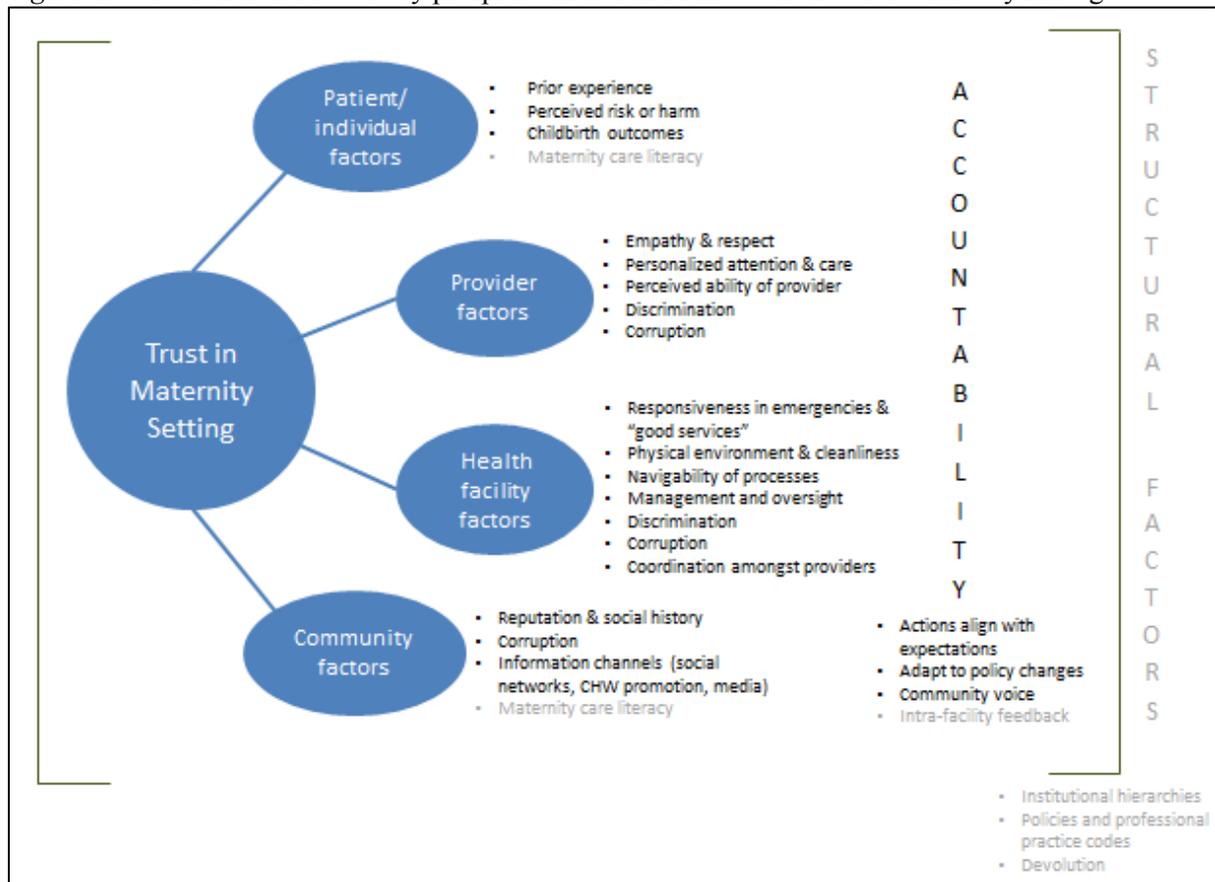
Prior experience

Past experiences determine women's and community trust in the facility. Multiple births at the same facility reflect and positively determine interpersonal and impersonal trust for many RDW and male partners.

"The first childbirth went well and so did the second one. The doctors present were different one for each of the births. So you see, that does say something about that hospital and the doctors working there." (Male partners, FGD)

In contrast, negative experiences and outcomes (mismanagement manifest in poor newborn outcomes) led a few women to feel that their trust had been broken, which consequently deterred their care seeking at the same facility.

Figure 5: Women/s and community perspectives of trust determinants in the maternity setting



Negative prior experience affecting women and their family’s trust may pertain to either the facility or a specific provider; moreover it could occur within a single encounter or multiple facility visits. The example below describes how prior experience affects a woman’s repeated interaction with a provider over the course of single maternity care visit.

“You may ask and find that he may enforce what he had already said even more. So you hold your peace... It will be difficult to ask because even what you are to ask involves him. If he is the one who has offended you, how will you still ask him a question and yet you have no one else to ask? (M: What can he do if you ask?) You don’t even want to know what he will say because he has offended you. You tell yourself that if he offended me without any fault of mine, how will it be if I get in there and ask him a question? It scares you...He might even become more harsh. (RDW in facility, FGD)

Offensive treatment at an earlier point during her stay undermines the woman’s interpersonal trust of her provider, leaving her in a state of fear during the latter stages of labor and delivery.

Perceived risks or harms

Perceived risks or harms associated with delivering in a facility play a role in determining women's and communities' impersonal trust in the facility. Though feared physical and psychosocial harms range from going 'under the knife' (cesarean section) to abuse in facility-based care, women and communities describe perceived risk of infection as particularly salient in affecting trust.

“(R1): In my view, the local midwife may assist the delivery of a child who has health challenges. She (midwife) will not know. (R4): There are also diseases like HIV. When one delivers in hospital, it is not easy for the baby to get infected. Also, they use things like razorblades, and in the process, one may cut themselves and thereby infect the baby. Hospital (delivery) is better than home.” (Male partners, FGD)

As described in the above quotation, perceived risks of infection emerge repeatedly in comparisons between facility-based and home deliveries, across both individual and group-normative perspectives.

Childbirth outcomes

Childbirth outcomes (for mother and newborn) play an important role in creating a collective image of a trustworthy facility. Positive childbirth outcomes that increased trust in maternity settings include the successful management of complications and prognosis of mother, the delivery of a live and healthy baby, and the ability of both mother and infant return home without any health concerns.

“The labor pains came and overwhelmed her and she fainted when the baby was coming. They [providers] took her to the theatre, operated her, and removed the baby and she was okay... You know, they saved her life and that of the baby.” (RDW not in a facility, FGD)

“When you go to the hospital, you trust that you will leave in good health.” (RDW, 24 years, IDI)

Returning home in good health and without much delay was particularly important for some women who describe their needing to return to a range of responsibilities in the home (e.g. other children requiring care, household work, etc.). Gendered perceptions of maternal morbidity may thus influence the understanding of determinants of trust. Underlying individual and collective perspectives concur on the notion that positive outcomes generally elevate trust. Negative childbirth outcomes – often compounded by other patient/individual and provider factors – undermine trust for individuals and those around them (i.e. family, network, community). Common examples of negative outcomes include newborn death, newborn and maternal morbidities (e.g. respiratory conditions/cold and pain/bleeding, respectively). Women tend to discount their own outcomes in deference to their

newborn's ("I have faith... even if you mistreat me...the baby will be well"). Group-normative perspectives concur that poor outcomes may have broader implications for facility reputation through co-occurrence with prior negative experience, jointly undermining trust.

Provider factors

Provider empathy and respect shown toward patients, personalized attention and care (responsiveness), and perceived ability of providers influence women's and communities' trust.

Provider empathy and respect

Participants describe empathy or being treated 'as a human' as an opposing concept to disrespectful and abusive attitudes and behaviors of providers.

"Some people are human and some are not. I felt that there they are very interested in the person, especially when you are there to get a baby. So the way they received me and the services I received I felt that...I really got to trust them." (RDW in facility, FGD)

'The way they received me' is further characterized by respondents as the 'welcoming' nature of providers and staff, general 'kindness', 'courteousness' and 'friendliness'. Often, the social cognitive processing of these attitudes occurs via emotional cues triggered by the way providers first interact with a delivering woman. When questioned about this processing, an RDW responds.

"I think your heart will tell you. Because... I always follow my heart. And again the way the person will attend to you, you just feel comfortable and you end up trusting that person... Like there is someone you can, even before you start what you want to say or do, she is all over you and, "what do you want?" and you are kind of, this person, she's so polite, "how can I help you, good morning", and everything. So you compare the two, the way she will start the whole thing, you will know." (RDW, 30 years, IDI)

Basic courteousness emerges as way of showing respect and facilitating open communication, a key component of trust in the maternity setting (Chapter IV). Participants concur on the trust determinants of empathy and respect, which reflect core elements described in 'actual' and 'ideal' maternity care.

RDW, pregnant women, and male partners further elaborate on the empathetic care using language of "good hearts" and "bad hearts". "Good heart" refers to providers with whom women had repeated congenial interactions with: nurses and aides who responded to queries and treated them like a "daughter" or a "sister". "Bad heart" describes insensitive or "rude" providers who may

intentionally or unintentionally exhibit abuse, ask for bribes to “hasten” services, “chase women away”, or just “do not care about people.” Providers with “good hearts” actively exhibit caring and fair (non-discriminatory) behaviors that enabled greater interpersonal trust in providers.

“That is a good doctor, a doctor who does not discriminate against anybody. Even when you look at her when she is talking to you – or to another person – she does not have a bad heart.” (RDW, 25 years, IDI)

Contrastingly, those with “bad hearts” show limited compassion and concern, are impatient and uncommunicative, and often exhibit verbal, facial or physical abuse.

“They told me nothing. It was just returning me back to the ward. When he told me to take my things and go back to the labor ward -the same provider was the one assisting me in delivery - he is the one who beat me... He just had a bad heart...he was not patient. (I: So he was just beating you and not telling you what was happening..?) Yes. He told me to shut up.” (RDW, IDI)

In addition to the overtly dismissive speech and attitudes of those with “bad hearts,” indirect forms of abuse also affect trust. The quotation below exemplifies an indirect form of abuse in which a woman overhears an apparently degrading conversation between providers and trainees during her stay in the maternity ward.

“They just look at you and laugh. (Probe: how does that make you feel?) (Chorus: bad...afraid). Sometimes they speak in English, assuming that you do not understand and they make you feel very bad. They say some very abusive things...I had taken another lady to deliver and they were saying she is so dusty and they were wondering where she had come from.” (RDW not in facility, FGD)

As this quotation suggests, provider behavior in the facility – even when not directly in contact with the patient – may undermine women’s and communities’ trust in the maternity setting. Background characteristics (age, gender, years of experience, religion) may underpin women’s perceptions of providers with “good hearts” and “bad hearts”. Some respondents describe male providers as having “good hearts” because they exhibit gentle care; others have mixed opinions on how older providers were more or less empathetic. One woman ascribes her provider’s “good heart” to her being a “born again” Christian. Irrespective of background influences on whether or not providers have “good” or “bad” hearts, these local terms elucidate how empathy and respect affect trust.

Personalized attention and care: responsiveness

Personalized attention and care comprise a key determinant of trust for participants as it relates to timely and responsive addressing of unique needs. Women – individually and collectively – describe provider compassion and sensitivity as a reflection of a nurse or doctor’s willingness and ability to limit ‘pain and suffering’ during labor. Provider engagement in dialogic counseling signals a vested interest in their patients, dispels fears around the delivery process, and enables confidence.

“They first came and started counseling me, telling me I should not be afraid - that really encouraged me. When you feel low because of the pain, there is someone there holding you up?” (RDW in facility, FGD)

“They take you in immediately you get there. They examine you to know how close you are to delivery.... And they don’t leave you; they stay around and come quickly when it’s time for you to deliver. They later then make you tea, and show you to a bed with your baby where they cover you. And they keep checking on you frequently till you leave the hospital.” (RDW in facility, FGD)

The continuity of care described above, as well as ancillary and customized care (e.g. providing a basin to women for their use), offer illustrative examples of attentiveness to personal needs in maternity.

“After delivery, you don’t have energy. They [those involved in your care] should therefore help the mother clean up the baby. They should also carry it for you as well as clean it. For example, I have now heard that they offer very tasty food. They give eggs and tea in the morning while at 10:00am they provide porridge. In the sub-county facility, they even clean up the baby when you deliver and dress it up for you. Such things would make more people trust the facilities.” (RDW, 28 years, IDI)

As suggested, provider sensitivity to patient suffering is understood by women and communities through continuous care, open dialogue, and attentiveness throughout the maternity process.

Timeliness and avoidance of neglect emerge as manifestations of personalized attention and care in that they capture provider responsiveness to a woman’s specific needs, queries and complaints. CHWs and women often describe providers not actively listening to laboring women, which discounts patients’ needs, signals disrespect, leads to neglect, and undermines trust.

“I have heard some say that the doctors don’t concentrate when the patient is with them...the doctor just keeps looking at the newspaper as you talk about the health problem...That lack of concentration can make a patient lack trust as they see the doctor has no relation with them... This is something I have witnessed. I have also heard several complaints....There’s no co-operation between you and the doctor. ...One may feel like it is disrespect. Someone feels neglected - you are in pain but they feel nothing. They are insensitive and thus you can lack trust.” (CHW male, IDI)

All participants describe ‘feeling ignored’ at various points in the maternity process; these instances reflect provider delay and non-response to calls for help that led to women known in delivering alone or with the help of other women. Women ascribe non-response to nurses ‘just chatting’, ‘sitting idle’, ‘too busy’, or to doctors refusing to come when called. In some cases, a sense of systemic neglect and lack of timely response stems from witnessing others’ being ignored. To women and their families, such scenarios exemplify a lack of sensitivity and respect for patients’ perceptions of pain as well as responsiveness to individuals’ needs, thereby undermining trust in the maternity setting.

Responsiveness to individual patient needs and concerns is also understood by the community as being related to various health facility factors such as workload and type. In the following example, a CHW with two young children compares personalized attention and care in public and private facilities.

“Like now, my wife does not attend the government hospitals; she attends hospitals that are faith based because in the faith based facilities, there is that one to one connection...The doctor and the patient becomes now, they are somehow connected. Because, they found that, if it is a service, they are served the way they want. They ask questions about the medication they have been given. But in government hospitals, they do not have that one to one connection because there are so many people who are waiting... the doctor does not have much time to talk with his/her patient.” (CHW male, IDI)

The ‘one to one connection’ captures the personalized care that women and communities see as what providers ought to foster with their patients to positively determine trust in the maternity setting.

Perceived ability of provider

Women and communities consider the perceived ability of providers as a key provider-level determinant of trust; this refers to the symbolic role that qualifications and experience play in distinguishing the ‘trustworthiness’ of formal health sector maternity care providers. Participants felt that perceived ability contributed to both interpersonal and impersonal trust (medical education). Statements like “s/he was skilled and knowledgeable”, “he is the one that knows”, “I can’t know... just go there and listen to what they tell you” reflect a cultural deference to medical expertise underlying trust. The following excerpts exemplify how perceived ability of providers emerged in quality-comparisons between provider type, facility worker cadre, and training experience.

“The difference between a TBA and a doctor is... a TBA does not know how to do a caesarian section. So if you are one who delivers by caesarean section, the TBA may not know what to do and maybe she could just keep you there in pain, but if you go to deliver at a facility, the doctor will examine you and know if you will need to go to the theatre.”(RDW in facility, FGD)

“Sometimes you may find doctors and trainees. The doctors don’t bother with you. It is the trainees who attend to you. They may not have the experience the doctors have so they come to practice on you. You can’t walk away; they use you as a guinea pig.” (RDW not in facility, FGD)

Perceived ability thus reflects not just technical competence, but also reflects years of experience and the manner in which providers perform their work. In cases of unpredictable pregnancy complications, facility provider expertise (compared to TBAs) fosters a sense of trustworthiness. Trustworthiness also reflects providers’ ability to discuss (in care settings) risks associated with maternity procedures as well as recognize and disclose personal or professional limitations (if there are any) in handling an individual woman’s case. This openness is seen by some women as positively determining trust.

Health facility factors

Health facility factors that determine trust include the responsiveness of facilities in cases of emergencies and notions of “good services”, physical environment and cleanliness, navigability of facility processes encountered during childbirth, the importance of management and oversight in mitigating corrupt or disrespectful practices, and finally, coordination amongst providers in the ward.

Responsiveness in emergencies and “good services”

Women and communities repeatedly describe the reliability of facilities in delivering “good services” in general and during emergencies as influencing trust in the maternity setting.

“I trust the sub-county hospital because when you are there, no matter the extent of complication, you will be assisted. You know there’re some other small health facilities when you go there, they may lack the service that you need. But that county hospital, there’s nothing that you could lack there.” (RDW, IDI, 27 years)

As the above quotation suggests, larger hospitals (compared to smaller facilities-e.g. clinics) are perceived to possess a comprehensive set of maternity services that enable greater systems trust. The phrase “good services” refers to the overall facility capacity – sufficient numbers of qualified providers as well as adequate material resources to conduct both vaginal and cesarean deliveries.

“Or maybe experienced doctors. If you are undergoing an operation, you will need the big doctor [medical officer or consultant] and maybe he is not in. So you will prefer to go to a place where the doctors are available. Where they are many.” (1st time pregnant woman, FGD)

“Good services” as described above refers to human resource capacity – i.e. ability of health facilities to draw not only on experienced providers (e.g. in maternity, these were generally the nurse-midwives) but also on a range of employees (e.g. nurse-midwives, medical officers, clinical officers, and consultants that can be called upon for specific tasks) to provide medically appropriate care.

Women who did not deliver in a facility describe nuances in how “good services” are understood as a composite of provider and material resources by comparing public and private facilities.

“You can go to a [public] health facility. The doctor you find there talks very badly to you, or he attends to you but he doesn’t attend to you well. So you decide to go to a private hospital. In that private hospital, you find the same doctor, but he treats you well and gives you good service, because that is his own private practice and not a public facility. But if you find him in a public facility, he cannot give you good service.” (RDW not in facility, FGD)

The same doctor working in an under-resourced public setting is unable to provide the “good services” he can in the private (for-profit or faith-based non-profit) facility.

“Good services” also refers to impersonal facility functioning; a steady flow of material resources enabling the delivery of appreciable levels of maternity and ancillary care creates a sense of trust for women and communities. Basic resources (e.g. hot water, electricity and ambulances) and maternity-specific supplies are considered a precondition for “good services.” Examples of maternity supplies and equipment include blood transfusion capacity, an operating theater, drugs, and cotton wool. Typical ancillary care described by women (individually and collectively) includes the provision of warm foods and teas after delivery as well as washing services for soiled clothes.

Stocking sufficient medicines is particularly important.

“Sometimes you go to hospital, then you are told to go buy drugs- where that doctor directs you to buy happens to be his own chemist... Government hospitals should have plenty of drugs. That will increase trust....if we don’t have to go and buy drugs outside the health facilities.” (RDW, not in facility, FGD)

Trust arises when the burden of purchasing drugs does not fall on a delivering woman or her family.

Implicit in the ‘own chemist’ clause is one type of exploitation that occurs when public facility

providers or staff have arrangements with local chemists (pharmacists) to financially benefit from referring patients. This type of explicit exploitation appears in only a few participant accounts; however, the majority describe informal payments as a system-wide concern in determining trust (see *Community factors*).

Physical environment and cleanliness

The physical environment of the wards affects women's and community trust in the maternity setting. Women and communities describe congestion (e.g. women sharing beds), cleanliness, and hygienic conditions (e.g. toilets, bathing area) influencing their sense of trust in the facility.

"They should add more rooms for women at the maternity. There is maternity A and B. At B there is a room for children straight from birth. There are only six beds and the women are many. The children must first get a place to sleep while the mothers keep standing. You cannot stand up for long when you don't have enough energy." (RDW not in facility, FGD)

"I like a clean place. So you can't trust that, "ooo did she clean the equipment well?" You know their cleanliness also matters a lot. From where you will be laid when giving birth, anything that she is handling and everything." (RDW, IDI, 30 years)

Descriptions of the preferred physical environment for childbirth often organically emerge across both collective and individual perspectives through comparisons of facility type and ideal vs. actual experience. How space and infrastructure change over time is critical in determining community trust.

"Facilities have improved. Sometime ago people were sleeping like three-three [in a bed]. And you are mothers who have just delivered sleeping there - three of you with your babies. But nowadays - I hear from those who have got babies that these days a person even sleeps alone [in a bed].... So I build that trust - that those people [providers & management] have started changing... I hear these days that they have brought the modern beds - these ones that are of like plastic, not like those ones of long ago...and bed sheets, those blankets they give are clean nowadays." (CHW, female, IDI)

Interestingly, as suggested in the "I build that trust" clause, the CHW herself is an agent of determining trust in the maternity setting (see *Community factors* section for details).

Navigability of processes

The navigability of processes facing women in the maternity setting – the paperwork, communication across departments and providers, payment and financing, and the frustration of being shuttled around for procedures were described as affecting their trust. Many participants felt the need

to streamline and simplify these processes. For example, a RDW describes how relocating the care-initiation forms would alleviate the stress of shuttling between administrative and maternity wings.

“They send you to go and buy a file. You see the place you are going to buy a file and maybe you are in pain, is a distance. So, what I would say - at least those files should have been within that area of that maternity, that area. Because the place you are going is a place where you will get a line and you must go and lineup, get into the line till they get to you. I was saying now, at least they bring that service nearby.” (RDW, IDI, 30 years)

Similar logistical challenges occur when diagnostic tests are ordered and given in spatially distant locations. One woman who delivered her first child in a facility but refrained from doing so for her most recent delivery attributes this decision to the experience of cumbersome intra-facility referrals. Her experience of being shuttled between different providers (those conducting tests and those monitoring labor progress), combined with a lack of explanation on the part of each individual provider, led to confusion, which reduced both impersonal and interpersonal trust. Women and communities express similar frustration about navigating payment systems and queuing in the facility.

“R4: There is also the system of how payments are made. For example when you go to hospital, they will tell you, go for the card - you will find a queue there. You go to see the doctor or to the maternity if you are taking your wife to deliver, you still have to buy these maternity ward forms. (R3): You have to go back and queue to pay for it. You take the form to her. If your wife was in labor pain, she is given drugs which you have to pay for. After you pay you have to go on another queue to collect those drugs. That system is too long. It would be better if they could shorten those systems.” (Male partners, FGD)

The above example typifies the experience of a male partner or accompanying family member who may be transferred back and forth between payment, procedures, and additional material resource purchases, which subsequently lead to delays in maternity care. The navigability of processes affects notions of “good services” and impersonal trust in the maternity setting.

Management and oversight of providers

Management of providers influences women’s and community trust in the maternity setting (of providers and facility) given the administrative and supervisory power of facilities (as a system) to address staff shortages (particularly on nights and weekends), oversee provider-patient interaction, and reduce corrupt or discriminatory practices. For instance, women and community members

describe how providers appeared burned out, overworked without sufficient breaks, and in need of support.

“(R7): I don’t know if it is that the nurses are overworked and are therefore tired, since they are rude every time you get there. (R1): I think they just don’t love their jobs. It’s as if they are tired of it and just go to work each day as routine.” (RDW in facility, FGD)

Participants posit that staff’s being overworked often translated into rudeness, harsh treatment, or corrupt practices, which reduced trust for patients. Women and communities concur on the need for supervisor presence in the ward as a way of ‘checking up’ on providers, “so that they will be afraid to do those things they do”. The complex multilevel interaction between provider behaviors and facility management appears to influence trust in the maternity setting.

Discrimination

Discrimination across provider and facility clusters (*Figure 6*) undermines trust and affects future maternity care-seeking. Women and community describe experiencing discrimination (unjust differential treatment) on the basis of wealth status, age, and parity. For example, it is ‘common knowledge’ that voucher users (being perceived as poor) experience longer wait times compared to those who pay cash. Though first time mothers generally experience congenial treatment by providers compared to older higher parity women, IDIs reveal that provider prejudices may be nuanced. For instance, such nuances may pertain to judgements regarding women’s fertility and birth spacing.

“We have been getting information of discrimination in the facility and the doctors are angered when you mention of such....They are angered maybe because one is a young girl who is soon to be a mother - they are heard abusing these girls whether it is education they want or to get pregnant.... [or] ... The older women who are getting children also fear going to deliver in the hospital. They might be having close to 5-7 children. When they get to go and deliver their 7th born, they find it very difficult. The doctors ask them questions such as, “are you the one going to be delivering or isn’t it your children’s turn to do so?” Such women weigh their options of delivering in the facilities and they feel it better to get their children at home so as to avoid being embarrassed by such questions from doctors.” (CHW, male, IDI)

When provider attitudes and judgments about the delivering women are conveyed explicitly during childbirth, they enter into public conversation. Propagation of these discriminatory attitudes into the community has implications for trust in maternity settings.

At the facility level, individual and collective memory of discriminatory practices such as detention (prior to free maternity) may undermine trust. A CHW reflects on the vulnerability of detained mothers (e.g. poorer, single) as well as the notion of financial assistance that facilities ought to provide to accommodate those unable to pay.

“In the past women would avoid going to the hospital for delivery so that they are not detained due to lack of money to pay for the maternity services. Now-a-days, they are satisfied with the services... They were afraid of being detained and as a result causing them shame and embarrassment to their fellow villagers.... They would be really scared of the detention as the whole village would learn about their detention due to lack of money. Or worse - that they had not planned for the coming baby. Life is very expensive and where I come from saving up Ksh. 1000 is very hard. Therefore you see someone getting pregnant and when it comes to delivery time, they are jobless and can't save up this much..... Another thing around my area is that most of them are single mothers and very young girls who rent houses but are broke. Some just have enough for food and they don't get any financial assistance from anywhere. Then when it comes to delivery time, you don't have any money to do the basics of delivery. This is why so many of the people in my area got detained.”

The majority of women and male partners concur on prior detention norms and the notoriety of certain facilities as more likely to detain women, ‘misplace’ or ‘exchange’ newborns – all of which had repercussions on trust in facilities. Despite the recent free-maternity policy banning detention in public facilities, a discriminatory past may residually determine trust in this peri-urban context.

Collaboration amongst health providers

Collaboration amongst health providers working in labor and delivery – given that this health area in particular demands a range of skills and cadres of health workers – plays an integral role in creating a trusting environment for maternity care. The individual and collective perspectives of women and the community, as care-users, often revolve around the congruency of efforts witnessed over the course of a woman’s stay in the wards.

“They made me happy because I saw all of them love each other, they talk to each other well, and if your patient has encountered a certain problem... you have a phone you can call the doctor and tell her that a particular patient is like this and this, you can come because I cannot handle, come and help out.” (RDW, 25 years, IDI)

Witnessing discordance or negative tone between providers may affect their confidence in caregivers and the facility. Situations where coordination supports the mother, but not the newborn (e.g. newborn death) were described as undermining trust. Additionally, overhearing conversations of

others' care may lead to fear of the unpredictability of one's own maternity process. The nature of collaboration influences building, maintaining, or – absent or antagonistic – breaking trust.

“You know, when you have trust, you will expect nothing but the best... The doctors also had trust that with their collaboration, I will get better. But if they work with so much division, you will not be treated with the trust that you have.” (RDW, IDI, 24 years)

There was a mixed sense amongst women and communities about whether working together for long periods of time in the maternity ward would enhance or undermine the collaborative spirit. Some felt that familiarity (closeness) gained through consistent interaction would enhance collaboration. Others felt that familiarity leads to a sense of apathy and laxity in care delivery which would mask and lead to ignoring any shortcomings within the collaboration. These groups (a minority of our participants) posit inter-facility rotations as a way of maintaining collaborations that determine trust.

Community factors

Trust in maternity setting, according to individual and group-normative perspectives of women and communities, is shaped by a range of interrelated community factors including facility reputation rooted in social history of childbirth outcomes and experiences, collective understanding of corrupt practices, and information channels such as social networks, CHW promotion, and media that perpetuate the sharing of maternity experiences.

Reputation and social history

The reputation and social history of a facility influences trust in a maternity setting as explained by a shared perspective on health facility trust echoed across all participants.

“Something else would be its history. An experience you or someone else had there that caused you to either trust it or not trust it. Its history.” (Male partner, FGD)

The notion of ‘history’ refers to a social history as participants elaborate on ways in which individual experiences translate back into the community, creating a negative or positive facility image.

“Maybe you have heard that this woman went there, had a complication and the doctors didn't know it. If you hear of two or three such cases, you will fear.” (1st time pregnant woman, FGD)

The frequency and nature of communicating experiences may affect how a reputation is built or broken as well as reflect general trusting or mistrusting attitudes in the community. The power of

social history is particularly important in this peri-urban environment, where men and women value and act on accounts of their families, neighbors and other community members. The contextual salience of reputation also reflects Kenya's political history and current institutional changes.

Corruption

Corruption cuts across provider and facility factors; however, it is most readily understood at the community level given its contextual salience in Kenya and this peri-urban setting. Corruption, occurring most commonly but not exclusively in the form of informal payments, falls within the socio-political norm of offering and accepting bribes as a necessary means to 'getting things done'.

"There is even a man who asks for bribes there. He asks for something so he can hasten things for you...if you give a bribe, they give you [test results] very fast." (RDW not in facility, FGD)

"You have to go back to your pocket and give him [doctor] money. And once you give him money, if he was angry he changes and flashes a smile. Then you know that you are going to get good treatment." (Male partners, FGD)

This sentiment was repeatedly conveyed across individual and collective perspectives of women and communities – often accompanied by nodding, expressive smiles, and shared laughs, all of which signal a level of agreement that bribes in this context reflect a way of life. Despite the commonality of such informal payments in other facets of social and political life, it appeared unsettling, to many participants, in the maternity setting – where women's vulnerability is high. Similar concerns emerge around the use of "social connections or "knowing people with power" to "hasten" things or to ensure "good services" through an influential position. While the use of social connections is considered acceptable in certain non-health realms, women and communities felt it problematic in maternity.

"Say, if I want my patient to be treated better, I will give you something small. For example, I will come in the hospital and you are the one on duty at that time. And I know you. "So, take tea. Take care of my patient." That is very simple. It may be before the treatment or after the treatment.... Just as we are talking here, I will come and tell you, "please take care of my patient very well for me -we shall see each other later." We shall see each other later means I will give you something. And definitely, once you are given something, you will not leave the patient die. But those who are not able to provide anything, you will leave and find them there, no one cares." (CHW female, IDI)

The above example illustrates the subtlety of how corruption manifests in maternity settings and how it often involves persons accompanying a woman for delivery (e.g. family members, CHWs, etc.).

Information channels: social networks

Avenues through which women and communities share information about maternity experiences affect facility reputation and trust in the maternity setting. The most commonly described information channel is that of social networks; namely informal conversations between women, male partners, close family, friends, and neighbors. Women who delivered in facilities share information with others while in the waiting area and communal space in the maternity ward. They often describe these conversations as ways to ‘become wiser’ by learning about which providers are open and which are harsh. Trust gained through informal sharing mediates other future health care-seeking behavior.

“I trusted it because my neighbors had been treated there. They had told me how well they had been attended to there, the services offered there and so I decided to take her there too.” (Male partners, FGD)

“(R1): You get prepared psychologically [from conversations]. You see, if you get a certain feeling while at home, you may not be sure what it is. But not if one who has gone through such a thing has already told you of it. (R2): It helps you to be prepared.” (1st time pregnant women, FGD)

The value of such conversations extends beyond trust to influence maternity care-seeking decisions, birth preparedness, pragmatic management of expectations (e.g. treatment norms), and patient response in a particular facility. These conversations take place in a variety of settings: ANC clinic waiting areas, “chamas” (social and financial support groups), community events, and social gatherings.

Believability of the source may affect the degree to which social network driven information influences individual or a group trust. In some cases, community members consider the source highly reliable; while in others, they do not. If the source in one’s social network has no ulterior motive nor stands to gain from any action taken by a mother (e.g. delivery in facility), then reliability increases. Alternatively, if the broader agenda of the individual providing information does not align with one’s own perspective or background knowledge (i.e. ‘scientific’ vs. traditional), one may be less willing to believe the substance. A woman describes her unwavering trust of the hospital as a place for delivery despite other conflicting messages she gets from “someone”.

“It’s like when someone comes to tell me that – for example, when I was planning to go to the hospital, someone tells me that it is a waste of money. It is throwing away money-that I should just call a woman and deliver from home. Although I know the truth. Things like those are the ones that I don’t trust. Such convincing from people, I don’t trust...For example, there are these traditional beliefs that someone may be told. Let’s just say that they have untrue teachings that I don’t believe.” (RDW, 25 years, IDI)

Finding the right informational source appears distinctly important for first time pregnant women, who may be less familiar with facility processes and are still developing their maternity expectations.

“That’s because sometimes it’s not good to share with friends as sometimes they can give you wrong direction or not be wishing you well. So if you have relatives nearby or a husband at home, then you share with him. Or one of your relatives who is nearby.” (1st time pregnant woman, FGD)

The study sample suggests that this group is younger and may not possess strong familial support systems, rendering them a sub-group potentially vulnerable to internalizing information they “hear” from their social networks (irrespective of message accuracy). Thus, ‘believable’ conversations in this peri-urban context may enhance or undermine trust in a maternity setting.

Information channel: CHW promotion

A second channel affecting trust in the maternity setting includes CHW promotion, in which CHWs serve as readily accessible information sources within the community.

“I have been meeting those who are delivering...and they have been telling me how they are faring on. I think the ones I have talked with are faring on well and they usually tell me they are going to the clinics, and they are doing well... I have been telling them to go and get safe delivery in the hospitals, not to get children at home. They should go and get a safe delivery at the hospital so that they can avoid the risks which can occur when they are delivering back at home.....We are free with them [pregnant women]. We are not enemies and I am able to reach them. Because if you are enemies with them, you cannot be able to reach them. So my relationship is good because I am able to reach them and we are able to talk... They have my number, they can call.” (CHW female, IDI)

Though many of the men and women living in the peri-urban county broadly know and value CHWs in their role as health promoters and advisors, numerous participants admitted an inability to locate and utilize them effectively. FGDs suggested that not all community members – for example, women who did not deliver in a facility – had prior interactions with CHWs in the area till their recruitment for this study (“I have never known CHWs”). Exposure to and familiarity with CHWs and their role may affect the believability of their messages and assistance around maternity care. In general, a CHW’s link to the facility in other health areas and involvement in community life (church, schools

health campaigns, chief's *barazas* [meetings], social rites of passage) renders him or her a reliable information source.

Information channel: media publicity

Women's and community trust in maternity settings draws upon publicity as an information channel, though to a lesser extent than social networks. Media – primarily radio – emerged as a medium for praising or shaming facilities; the nature of media influence on trust varied across a few respondents. Some suggest that media shaming motivates facility management and providers to make changes in their processes and behaviors, thereby enhancing trust in the maternity setting. These participants often referenced shaming by saying that “announcing on Kamame,” a local radio station, led to improvements or “good services”. Others say that media ought to illustrate positive features of a public facility (e.g. sub-county hospital) that promote a trustworthy image of a maternity setting.

“The government should advertise it [sub-county hospital] in the media as is done in other hospitals...But the government doesn't take it upon itself to let people know what is available in their hospital and invite people to come for the services. They just build the facility and do no more....You keep seeing [X private hospital] in the media telling you what they are doing and when you get there, you are able to identify new things happening.” (Male partners, FGD)

The quotation implies that private facilities utilize the media in service promotion; moreover, the subtext suggests that public and private facilities plausibly have differential priorities and publicity norms. Educating the public about changes made at public facilities – via media – may be helpful in building trust, particularly given the ‘improvement in maternities’ that many women and community members agree is occurring. A believability consideration analogous to that of social networks (e.g. informational source) likely applies to media (e.g. radio station), but is beyond this study's scope.

Accountability factors

Women and communities describe the idea of accountability as integral to determining trust in a maternity setting is the idea of accountability, which in the current context manifests in a few distinct ways: (a) the alignment of women and community expectations with provider or facility action, (b) the ability of the health facility to adapt to changes at the policy level (e.g. to free

maternity), and (c) the incorporation of community voice into facility functioning to ensure responsiveness.

Actions align with expectations

Women and communities describe delivering on promises through actions as enhancing trust in health and social institutions in the peri-urban context. For example, participants describe elevated trust when active efforts were put forth toward providing respectful and dignified care in health facilities at community and facility levels (Heshima Project), guaranteeing the safety of children in schools, maintaining sustainable programs (NGO or government), the church keeping promises to address an array of concerns (e.g. feeding orphans or setting up nursery), and government action toward meeting campaign promises. For instance, some describe the newly elected government efforts to address corruption cases, while others reflect on the local chief's efforts to curb criminal activity in the area. The notion of actions meeting expectations to enhance trust across institutions also incorporates effectively utilizing funds in a transparent way.

In facility-based maternity settings, at the patient-provider level, expectations and actions revolve around the quality of interpersonal interactions and responsiveness to patients' needs.

"You see, the patient is never at fault. For example if I fall ill this very moment, am not at fault so you should not shout at me. You should offer me service. So the moment you go there, you are innocent and they should treat you. So we are okay; it's the doctors that have a problem....They are the ones that need to change." (1st time pregnant women, FGD)

This sentiment captures the inherent vulnerability of laboring mothers, recognizes the position of power that nurses and doctors hold, and advocates the notion that women deserve to receive treatment without blame. Though this proposition drew consensus across RDW, pregnant women, male partners, and CHWs as what 'ought to be' standard accountable practice in maternity settings, the underlying tone suggests that this was not always the case in terms of actual experience. Nonetheless, women and community members convey the belief that when patient-provider interactions meet their expectations, there is an elevated sense of accountability and interpersonal trust.

At the facility level, this alignment of expectations with action speaks to multiple expectations: (1) receiving care worth what one pays for and (2) providing free care to those that cannot afford to pay. For instance, the notion that “good service equals money” emerged as the status quo for accountability: those willing and able to pay (formally or informally) for care should expect to receive good maternity services. On the other hand, women and communities consistently describe health facility obligations to cover the delivery-associated costs of poorer patients (using NHIF cards, vouchers, or demanding free care). One woman describes facility accountability from the perspective of the poor.

“You better go to a public hospital because private hospitals can give you drugs that can adversely affect the baby- there you buy drugs at a high price. So even if you go to a public hospital and do not get drugs, it is better if you go there and see a doctor there who will give you a prescription...that is why people like me trust the public facilities.” (RDW in facility, FGD)

Recognizing that poor women are at a disadvantage in private and public facilities, numerous respondents imply that public facilities may be more accountable in certain areas (e.g. drug quality, general responsiveness) – a notion rooted in the social contract of the Kenyan government’s responsibility to provide and regulate public institutions.

At facility and community levels, examples of expectation-action alignment include reductions in discriminatory and corrupt practice or improvements in “good services”. A CHW reflects on his work with the Heshima project as an example of how he feels that actions build accountability and influence trust in maternity setting.

“Even though one has money or thinks that they are more important than others...I have been advising them to respect each other’s rights and ensuring that they don’t infringe on others. Every patient has a right to be served. It is therefore wrong to think that an individual is more important than the other and as such should be served first... Another problem is the issue of bribing to get good services. I have stressed to them that it is wrong to bribe to get a service. This is in a way infringing on the rights of others as they are denied services because they can’t be able to pay. We have really tried to tell them not to accept any form of corruption.” (CHW male, IDI)

Though the CHW’s narrative in this case refers predominantly to the community as a subject, similar lessons may be transferrable to providers who play an enabling role in informal exchanges. These

types of efforts to mitigate discrimination and corruption have implications for trust, extending to the consideration of ways to change some of the underlying norms around the health system.

At the health systems level, the expectation-action relationship is rooted in women's and community expectations of the MOH's role in effectively implementing reproductive health policies - most candidly observable through initial responses to Kenya's free maternity policy. Community perspectives suggest that policy rhetoric should be reflected in 'actual improvements' in administrative practice, management of service delivery, and positive care experience; otherwise, women seeking delivery care will be disappointed and question the government's accountability to its people. Irrespective of consensus around the altruistic principle set forth by the government to provide free maternity care, many women and men remain skeptical of its implementation as it relates to health facility, provider, and patient factors (*Figure 6*).

“(R2): Women can now go to the hospital, but they should not go there to be abused [laughter and nods] ...Even if it is free of charge, let them [government] do something about the number of doctors and nurses, because even if you don't pay . . . and you go and find only two nurses...At night I used to see only two nurses. Even if I was the one, how can I take care of all these people? You see, now that it is free of charge it can bring about a big problem because many women will now go to deliver at the hospital and providers are few.” (RDW in facility, FGD)

Skepticism about the implementation of free maternity stems from mismatched expectations and action in past social programs (e.g. free education) that fell short of the accompanying rhetoric and ended up not being “free” (e.g. parents pay administrators to enroll children, limited schools and teachers, etc.). In order to establish accountability within the free maternity context, necessary government actions include hiring sufficient facility staff to meet increased demand and enhancing oversight to mitigate corrupt practices at facilities. Women and communities thus articulate a need for promises made at the policy level to be followed up by actionable steps to promote impersonal trust in maternity care.

Free maternity – adapting to policy changes in a context

Facility and provider ability to adapt to shifting policy landscapes affect women's and community trust in the maternity setting in that moments of change enable these groups to reflect on

and evaluate how accountable their facilities are. For example, the free maternity policy aimed at benefitting the poor occurs not in a vacuum, but must be incorporated into a facility context with particular communication styles, history, norms, and shared understanding of service delivery and experience. For instance, an a priori understanding of facility-based maternity care experience in this peri-urban setting (below) considers what the policy change implies for underprivileged women who currently experience discrimination because of their inability to pay for their maternity care.

“I think that will help in a big way for woman who are underprivileged...But also, I feel like the services could deteriorate...Because you see down at the maternity, they will feel like they are doing charity work for you...I feel it will be worse...if someone could insult you now during delivery yet you pay for the service. So when they know you didn't pay, won't they insult you more? Maybe she [provider] will tell you that you are getting babies carelessly because of free maternity. I personally feel it will be worse; I am even scared of going there now.” (IDI, RDW, 27 years)

The anticipation of increased verbal abuse following the initiation of free maternity illustrates the idea of a facility's ability to adapt to the policy change (e.g. facility accountability with respect to provision of 'good services' and provider accountability to provide empathetic care) as a trust determinant (e.g. via content area of communication). Similar foreshadowing of increases in other types of disrespectful care weakens the accountability intended by the policy (promote access to the poor). For example, free maternity may exacerbate adverse effects observed in a pro-poor reproductive health initiative (vouchers for family planning and maternity care) concurrently operating in this study context.

“(R8): You just hear them say “people who are using the voucher, wait on that side”... [laughter]... (R9): They are told to step aside (R8) for those who have cash to pay first. Sometimes, even that one who is paying in cash found you on the queue...Now how will it be if it is free? Wouldn't they tell you to stay there with your pain' and then they go away? Now one can get scared. (RDW not in facility, FGD)

Given that discrimination on the basis of voucher use already figures into care experience as a norm encountered in this peri-urban locale, communities express a fear that facilities may further stigmatize those unable to pay 'extra cash' for efficient services in a scenario where increased patient flow overwhelms facility material and human resource capacity. This has direct implications for facility responsiveness and both interpersonal and impersonal trust in a maternity setting.

Contrastingly and simultaneously, the same policy shift may have accountability-enhancing effects as seen from the reductions in detentions (in public facilities) of women unable to pay for their delivery. Moreover, the policy's introduction alongside voucher program, respectful maternity care efforts, and media coverage of maternity care quality (and detentions, in particular) likely have joint implications for accountability, trust, and care-seeking in maternity settings.

Community voice

Despite a cultural deference to medical expertise (“when the nurse tells you anything, you should do it”) and fear of future access or care repercussions (“you do not want to be sent away”/ “she was shouting at me and didn’t want to hear me tell her anything”) that compel women and communities to stay silent in facility contexts, these groups value community voice as inherent to maintaining the accountability of providers and facilities. In particular, participants describe a collective sense that delivering mothers should be willing and able to ask questions, demand their rights, and report any complaints before, during, and after their maternity care experience.

“Even we the patients should not fear the doctors. They should even have a desire and love to know, how is my health? ...I think as patients, they should also have a right to be educated...that way you shall build confidence and trust with that person.” (CHW, female, IDI)

The CHW’s reflection captures the essence of a publicly accountable health system where providers respect and respond to patients’ queries. This dialogue is a precursor for promoting women’s and community trust in maternity care. Moreover, the need for public facilities to respond to community voice stems from the social contract embedded in government sector services and entitlements of tax payers as beneficiaries (“these hospital workers are paid with our taxes, right?” – Male partner). The inclusion of community voice emerges during discussions of citizens’ oversight roles in ensuring acceptable governance of social institutions (including hospitals) given their financial stakes, principles of a people-centered constitution ((FACT), 2013), and democratically elected government.

Recognizing the importance of addressing individual grievances in the context of ineffective mechanisms for reporting complaints, women’s and community perspectives concur that

incorporating collective voice in facility feedback and action is critical to enhancing accountability at provider and facility levels and determining trust in maternity settings.

“Even if they are the ones managing the place; they should get time and go the maternity and ask the patients how things are....the patients can give feedback. That way the directors would know whether the doctors are doing their work in the right way.” (Male partners, FGD)

Many participants describe individual grievance reporting mechanisms (e.g. suggestion boxes, individual queries) as often failing to elicit responses from the higher administration unless external checks or influences come into play (e.g. media, non-governmental actors). Rather, women and communities prefer sharing experiences within social networks to build and share collective voice (young RDW: *“trust when we work in groups together to improve our lives”*) through trusted community representatives.

“Like XX [CHW], he asked me what problems I had encountered when I went to deliver so that it could be changed...so that the service could have value...They [CHWs] have assisted us because they can reach us at the grassroots level. Like what I had gone through... another time, I wish that I will get changes when I reach the facility. I will not be harassed. Any other thing like that, I will be served. I will be served in the best way possible without being oppressed.” (RDW, 25 years, IDI)

The language of ‘oppression’ draws on a silenced individual perspective felt by this delivering woman; in contrast, community voice emerges as a potentially empowering force to determining accountability and trust.

Chapter Summary and Interpretation

This chapter shows that determinants of interpersonal and impersonal trust in the maternity setting from the women’s and community standpoint cluster around patient/individual, provider, health facility, community, and accountability factors, forming the initial stage of a contextualized determinants framework. The multi-faceted nature of the clusters emerges out of the combined appreciative inquiry (AI) and institutional ethnography (IE) guided qualitative methodology; particularly through AI’s emphasis on comparing ideal to actual experiences and IE’s use of hierarchical standpoints of ‘users of care’ to better understand how systemic and socio-political relationships and context affect trust. Moreover, the complexity in how these factors relate to one

another and influence trust in more than one way is profound and consistent with an emerging trust literature in the region (Østergaard, 2015; Gilson et al., 2005). For instance, a woman's trust may be influenced simultaneously and in different ways by her perceived risk, provider empathy, the navigability of processes in maternity wards, her social network, the implementation of free maternity, and whether her voice (individually or collectively) is heard and responded to through reciprocal interactions with facility management and providers.

Patient-factors of trust include prior experiences and perceived risks (particularly a fear of infection) associated with delivering in a facility, both of which are consistent with findings about maternity care in Thailand (Riewpaiboon et al., 2005), HIV-integrated maternity care in Tanzania (An et al., 2015), and use of personal injections in Uganda (Birungi, 1998). Country and regional understandings of perceived risks may vary; for instance, perceived risk at the individual level in peri-urban Kenya cover both social and biomedical aspects of facility interaction (i.e. chance of abuse, infection), while in urban, peri-urban, and rural maternity settings in Mali, risk perception reflects a disconnect between traditional and 'modern' medicine (Arborio, 2008). Socio-political contexts are embedded in community and accountability factors which together cover reputation, information sharing, expectation-action relationships, health facility resilience to policy shocks (e.g. free maternity), and voice. In peri-urban Kenya, intra-community confidence and readily shared positive and negative maternity experiences have implications for individual and collective trust. The notion of speaking up and engaging a collective voice to determine trust is salient in Kenya in that it bridges uneven power relations between health experts and laypersons (Nasong'o & Ayot, 2007). This echoes current literature in sub-Saharan Africa, which suggests that relational complexities due to uneven power dynamics are reduced in high trust environments (Østergaard, 2015).

Overlap with perceived quality

Many of the provider and health facility factors parallel notions of perceived quality of care in the health trust literature (Østergaard, 2015; Ng et al., 2014). Provider factors – empathy, respect, and personalized care – positively determine trust in maternity settings through the trust content areas

(Chapter IV) of reciprocal dialogue (communication) and mutual respect. When providers appear insensitive to and uncaring about women's needs, trust is reduced as these provider attitudes may foster fear and suspicion. These interpersonal factors, from the user perspective, are increasingly emergent as key determinants of quality of care (Attree, 2001; Jenkins et al., 2015; Karkee et al., 2014; Mead & Bower, 2000) and trust in health systems (Østergaard, 2015; Gilson, et al., 2005). Facility factors – “good services” and responsiveness that women and communities see through manifestations of EmONC-provision capacity, physical environment, navigability of processes during facility stay, absence of discrimination, intra-provider coordination, and functional oversight – span both technical and standard-driven definitions of perceived quality notions in maternity care and determine trust (Østergaard, 2015; Pittrof et al., 2002; Tabrizi et al., 2014). Given this study's focus on perceptions, it did not differentiate on objective quality (e.g. observational checklists); one can only infer the overlap of these provider and health facility features in comprising broader trust determinants.

Determinants in context: salience and challenges

The current national political and policy discourses ('increasing accountability' and 'free maternity', respectively) in Kenya render corruption and discrimination contextually salient. These determinants not only begin to unveil the role of money-exchange as relates to trust in health facilities, but also provide insight into structural factors that underlie trust relations. Despite the fact that both concepts undermine trust across multiple factor clusters, the ease and normalcy of discussing corruption is notably opposite to that of discrimination. For instance, skepticism around the free maternity policy readily emerges from group discussion around bribery norms (corruption) built into the informal health system 'marketplace' that operates to benefit the financially able compared to the disadvantaged poor in East Africa (Tibandebage & Mackintosh, 2005). Discrimination, on the other hand, is often masked by structural power dynamics and cultural deference to authority; women who experience of discrimination at provider and facility levels do not always recognize it as problematic, but rather regard it as normal practice. For instance, the collective

sentiment (“*Why will you go there if you don’t have money? You will just stay at home*”) reflects a passive acceptance of the status quo that those without sufficient financial resources refrain from going to certain facilities because they are unlikely to receive “good services.” In some cases, women’s deference reaches extremes of incurring self-blame in which they depreciate their own perspectives, questions and needs (“*when you keep disturb the providers, they have no choice but to leave you alone*”), thereby perpetuating system-induced norms of provider-client interactions. The normalization of provider behaviors and facility practice in maternity settings (McMahon et al., 2014; Freedman et al., 2014) poses challenges to understanding discrimination in the health context.

Gendered understanding

AI and IE approaches allow for better understanding the silence, self-blame, and fear of ‘speaking up’ described by women that manifest as a result of the asymmetrical health provider-patient relationship, the uncertainties surrounding pregnancy, and a gendered experience echoed across the multi-faceted trust determinants. Gender plays out as a socialization process of maternal altruism and women’s domestic roles as well as through the gendered structure of the health facility (Nasong’o & Ayot, 2007). Prevailing norms amongst women tend to value newborn outcomes over the quality of their own experience when it comes to trust in the maternity setting. A degree of concurrence across men and women in the sample aligns with women’s general responsibilities and decision-making power within the household. For instance, a juxtaposition occurred in two group discussions (RDW, male partners) of how reproductive choices and maternal care-seeking are dominated by male partners, while childbirth experience and its repercussions fall under women’s purview. This is in line with the broader socialization of gender processes in Kenya (Nasong'o & Ayot, 2007). As such, a male partner’s (or other relative’s) trust in a maternity setting may have implications for women’s trust in the context of an intimate social and familial network.

In the facility context, gender interacts more structurally through provider-patient relations. Women’s and communities’ mixed understandings of male compared to female providers are often expressed as frustration at the normalized harsh treatment of nurses (who were mostly women in the

sample maternity setting). This may relate to their role as female frontline health workers and intermediaries in a hierarchical workplace setting, as seen in South Africa (Jewkes, 1998). Women patients' fear of 'speaking up' to avoid harsh treatment by a provider as a person in power embodies Kenya's prior institutional 'culture of violence', which silenced anyone who opposed authority (Nasong'o & Ayot, 2007). Finally, women and communities frequently describe their study participation in both IDIs and FGDs as a unique experience, affirm their view that trust is 'very important' in health and social systems, and admit (for many) that it gave them their first opportunity to share their thoughts in a collective way. These sentiments, which are not unique to the Kenyan context, reflect the merit of combining appreciative and critical approaches to encourage debate, bring to bear underrepresented voices, and empower women (Duncan & Ridley-Duff, 2014; Grant & Humphries, 2006).

In summary, the theoretically guided approach reveals a multi-faceted clustering of determinants that shapes health systems trust in maternity settings from the perspective of women and communities living in peri-urban Kenya. The overlapping, reinforcing, and potentially opposing determinants render trust a complex but critical piece in understanding the 'social fabric' (Gilson, 2003) within which a health system is situated, as well as women's maternity care-seeking intentions. Building on the 'health system user' standpoint, the next chapter ascends the facility hierarchy to explore determinants of trust in a maternity setting from the perspective of those who, by profession, shape and embody the dominant discourse in the maternity care setting. These provider and management perspectives will elucidate the 'impersonality' (Giddens, 1990) of trust in maternity settings by exploring interactions and structural influences that affect the system of maternity care delivery in this peri-urban context.

VI. Determinants of a trusting environment for the maternity care: provider and management perspectives

Standpoint and Method

This chapter presents the viewpoints of health providers, managers, and supervisors on what determines trust in the maternity setting. Under the IE lens of eliciting multiple hierarchical standpoints (bottom-up) to ascertain a broader systems perspective, this chapter builds upon the thematic areas emerging from women's and community perspectives; it explores the providers' agreement with those determinants as well as salient factors surrounding the active provision of facility-based maternity care. Specifically, chapter findings stem from responses to the following questions.

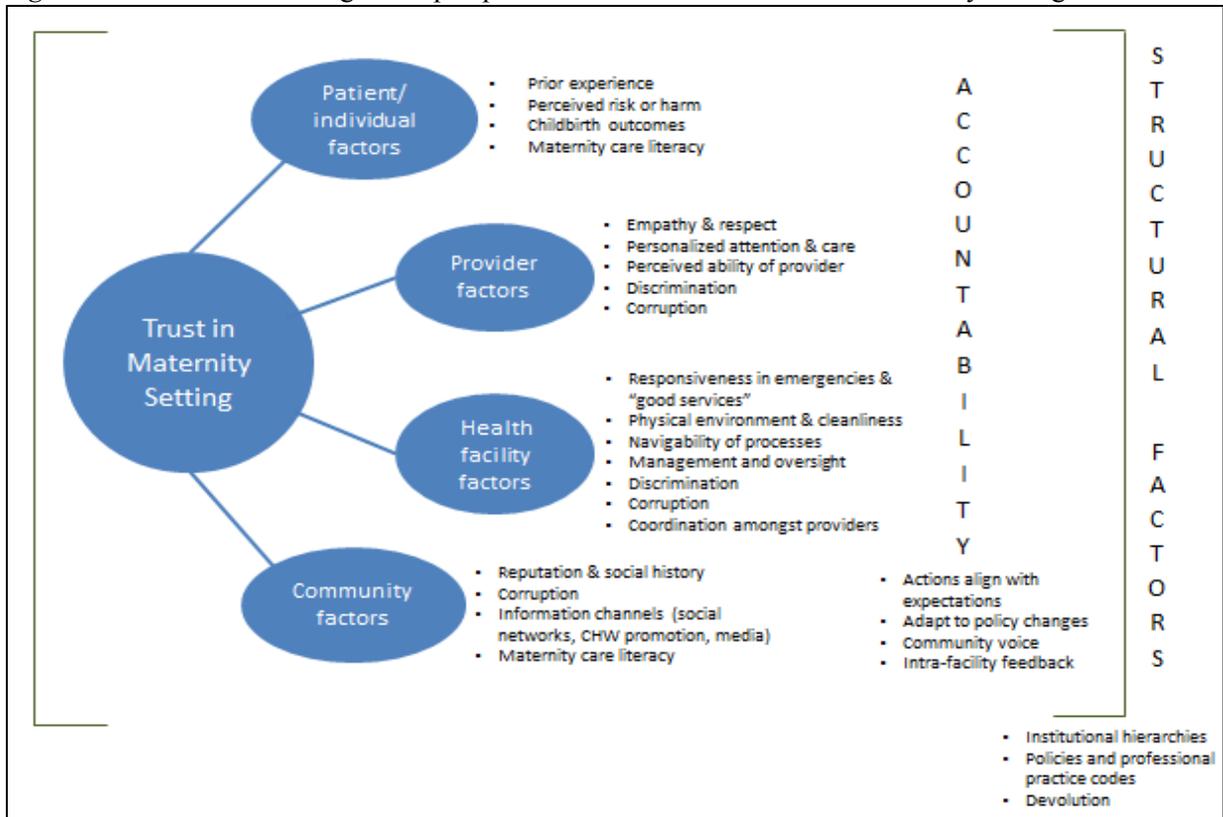
- What do you think makes patients trust the facility?
- We've heard that community mistrust in health facilities may be deterring care-seeking (from women, communities, and providers and providers). What do you think about this?
- Why do you think some women may trust providers and health facilities in this area more than others?
- Tell me about your role in assisting deliveries?
- Tell us about your relationships with other workers in the facility?
- How do you feel supervisors shape the work environment at the facility?
- Describe any ethical or professional codes that health workers like yourself follow? Consequences if codes are broken?
- What do you think about the free maternity mandate?

The chapter draws upon IDIs with health facility providers (n=11) and key management informants, which includes the matron of the facility and a district public health official (DPHO) (see Chapter IV for detailed characteristics). Health facility providers (referred to as 'providers' in this chapter) include doctors (n=4) – either medical or clinical officers – and nurse-midwives (n=7). One of the nurse-midwives – the supervisor of the maternity unit – provides reflections as both a provider and manager/supervisor. Underestimating the reported preference of ~85% of local women (Chapter V), only about half of the provider and management respondents believed that women preferred to deliver in a public facility; management noted that poorer women likely prefer public facilities given affordability barriers at private hospitals. In concurrence with women's and community perspectives, providers and management agree that facility delivery (compared to home) is the preferential norm in this peri-urban setting.

Results

Provider and management perspectives predominately agree with women and communities with respect to the multi-faceted clustering of determinants as patient/individual, provider, health facility, community, and accountability factors, adding maternity care literacy and intra-facility feedback (Figure 6). In describing the nature of interactions with patients and colleagues, providers elucidate how their challenges indirectly affect trust provider and health facility factors as determinants (not shown in figure). Provider challenges include working conditions and mental fatigue; motivation and support; supervision; and teamwork dynamics. Descriptions of these challenges unveil structural factors such as institutional hierarchies, policy and professional practice codes, and devolution, that are often less visible from the user perspective but affect all clusters as a contextual determinant underlying trust in the maternity setting. Structural factors reflect the diffusion of power through health facility interactions (Grimen, 2009). This diffusion captures the impersonal health system relations that influence features of maternity care experience and determine trust.

Figure 6. Provider and management perspectives on trust determinants in maternity setting



Concurrence on multi-faceted determinants framework

Patient and community factors

Providers and management agree that prior experience, perceived harms, and childbirth outcomes all determine trust in the maternity setting at patient and, through social network-based sharing, at community levels (*Figure 6*). Providers' understanding of these determinants emerges from their witnessing care-seeking as a consequence of trust (see Appendix 6 for patient flow). A nurse-midwife describes how childbirth outcomes and prior experience influence trust and care-seeking by describing women's bypassing proximate facilities for ones farther away.

"Their [mothers'] worry is the baby; they want even to see the baby is crying, the baby is ok...the baby and sometimes even their own health because they know about the complication that can arise. But I think they trust us because they keep coming. I deliver a lot of mothers in my ward so I think they trust the hospital. They trust the midwives because if they don't trust the midwives they can't come always - there are very many facilities but they keep flowing here a lot. You see, we even have mothers who come from Nairobi, they're neighbors to a tertiary hospital but they don't want to go there. They say we give better services so they come." (Nurse-midwife, 6 years at job)

The newborn outcomes are as important (if not more important) than mothers' experiences as a factor in affecting community trust (via social networks) in maternity care. Negative experiences, in particular, have implications for breaking a facility's reputation at the community level.

"They [community] are a bit biased to the nurses. On the past experience... maybe a woman came to deliver and had a very bad experience. She carries forward that bad experience to the next delivery. And also the information they get in the villages from other women given about nurses... it discourages them from coming to the healthy facility." (Medical officer, 1 year at facility)

Social network-based 'rumors' or information sharing is a powerful mechanism affecting reputation and women's intent to return to care. A few providers mention past negative radio publicity as undermining trust and subsequent care-seeking. Some describe reputation as particularly important in the free maternity context, where 'despite the cost going to zero' some women still deliver at home.

Providers consider reputation's influence on trust and facility delivery as further mediated by education level and maternity care literacy (*Figure 6*). Many providers, for instance, describe their challenge as counselors and educators in light of a less formally educated patient clientele.

"Cause most of them [women] are not even learned. They've barely gone to school. If they go [to school], they go up to form four [some high school]. In government hospitals, you mainly see people

from the villages. Cause the ones who are learned, who are working, they have good jobs they won't come to government hospitals..." (Medical officer, 1 year)

The implication here is that women with higher general education are likely to be better employed, have higher incomes, and so have the wherewithal to seek care at private facilities. Consequently, women left delivering at the public sub-county facility are potentially of lower education or income backgrounds. Beyond general education, providers spoke of 'maternal health literacy' as critical. Maternal health literacy reflects women's and community knowledge about the overall pregnancy-maternity process (i.e. antenatal care, demystified understanding of facility delivery, specific labor and delivery procedures, rights and obligations of patients and providers in maternity setting, postnatal care, and family planning counseling). Providers generally attribute negative perceptions of care to limited maternal health literacy. For instance, many describe how a lack of birth preparedness (e.g. a result of missed ANC visits) and not knowing what to expect during labor leads to misunderstandings and negative perceptions, which have implications for trust. Lack of awareness about the roles of distinct provider cadres, in particular, may undermine both interpersonal and impersonal trust in maternity.

"Some mothers come without knowing the role of a nurse or the role of a doctor; so they don't know the difference. So sometimes they accuse the nurses for things that nurses, things which are beyond our capability... So if the community is mobilized and they know how the hospital works, they will be able to know who is to be accused and who is not to be accused.... Sometimes a mother will come, you have examined the mother, maybe she is waiting for the doctor's review - the doctor is in theater, but she will think that you are the one who is keeping her...So, especially nurses, we face a lot of problems with the community because it's like the community is against us....because they don't understand our role in the hospital." (Nurse-midwife, 10 years at facility)

Providers and management concurred on the importance of maternal health literacy as a determinant of trust for all women, and first time mothers in particular, given that for this group facility reputation is salient for building trust and motivating delivery care-seeking intentions.

Provider Factors

Providers and management see interpersonal relations with patients as an integral determinant of trust in the maternity setting (*Figure 6*). They elaborate on the need to show empathy by

approaching women with kindness, being friendly, showing ‘leniency’ in their interactions with laboring mothers to assure women that they are not alone in the maternity process.

“You just talk to that person, as in it’s another human being, you don’t see them as a piece of work. Just have that humane spirit as you treating them ... even maybe sometimes it’s unfortunate some of them lose their babies. Just comfort them and tell them sorry. Then if there is a complication you explain to them so that they anticipate maybe if something is going to happen... So that you don’t just leave them - they’re anxious not knowing what is to happen, it’s wrong.” (Medical officer, 2 years at facility)

Providers agree that the nurse-patient relationship is particularly influential in determining trust since nurse-midwives in this context are the first to interact with and examine women, monitor labor, conduct normal deliveries, and provide continuous care.

“We are the people who can make these people to trust us... The patients trust you because if you show her how confident you are, you know she has a problem, you help her at the right time - she must trust you.” (Nurse-midwife, 8 years at facility)

Nurses reiterate that positive provider attitudes demonstrated through first impressions, verbal and facial gestures, and non-irritability signal a ‘willingness to help’ and establish confidence.

Personalized attention and open communication around maternity procedures (what is expected from a professional point of view) comprise a provider’s notion of demonstrating a caring attitude.

“You have to tell them what is expected of them, plus you have to talk to them lively... They are human beings and all patients are not the same...they are different. So you have to take patients as individuals not like huyo mwingine (“that other one”)... It’s good to try. People come with different problems, personal problem from home - she will come ready to this place...and you have to let them trust you... treat them as individual patients.” (Nurse-midwife/in-charge, 11 years at facility)

This quotation captures the duality of the provider role as a guide for a diverse range of women as well as a steward of a health profession discourse that normalizes expectations of how women ought to act in the therapeutic-dyad (i.e. comply with providers’ expertise and decisions).

Health facility factors

Provider and management perspectives concur on the health facility determinants (*Figure 6*) affecting trust in a maternity setting directly through the physical environment, but also indirectly through workplace conditions and management structures that affect provider ability to treat in an ideal way (see *provider challenges* section). The following quotations illustrate physical environment,

cleanliness, and infrastructural challenges that have implications for responsiveness in emergencies and for “good services”.

“...even the cleanliness of environment can mean a lot...it can turn them [women] off.... If they meet friendly staff and the environment is clean, it will help a lot with the trust...The availability of equipment and good working conditions...another problem with this hospital is patients sharing beds. We have shortage of beds here and it's very disturbing.... I think if we get maybe the county government to buy us some more beds... It's very disturbing for you to tell them to share... it's a bit on their privacy, they don't feel comfortable. But sometimes we are forced to tell them to share because we don't want to chase away a patient.” (Nurse-midwife, 10 years at facility)

“We need a maternity theater badly because our theater is busy – it's for every case. So we can have a mother who is really in distress but the theater is occupied. Now you see, you will try to explain to that mother, “We are taking you to theater...” She sees an hour pass, she has not been taken. So now she will be seeing as if there is a distrust.” (Nurse-midwife, 10 years at facility)

In addition to cleanliness and lack of a maternity-specific operating theater for cesarean sections, bed shortages and congestion limit providers' ability to maintain confidentiality, which they consider a highly salient component of trust (Chapter IV). Given the spatial layout of the labor and delivery ward (Appendix 4), providers reflect on confidentiality concerns at various stages of maternity care (e.g. open/ small admission area, doctors' rounds, open/shared wards).

“Imagine, this maternity is so small and I am expected to maintain confidentiality - how? When you are seeing a patient, there is another one who is sleeping there too - so when you are interviewing this patient, there is another one listening.” (Nurse-midwife, 10 years at facility)

Space shortage is cited particularly in doctors' rounds, where routine efforts to maintain the confidentiality of a patient's medical history (e.g. HIV status) are undermined by discussions between doctors, students, and nurses about treatment (e.g. PMTCT). Facility environment therefore affects trust in the maternity setting; perhaps more so for certain sub-groups of women (e.g. HIV-positives, younger women considering abortion, separated/single women) whose cases may require sensitivity and private consultation.

Beyond space, providers and management describe deficiencies and dependencies in supply chains for a range of material resources (drugs, gloves, boots for the delivery room, obstetric equipment, cotton wool, etc.) needed to provide quality maternity care acceptable to women.

“Sometimes you have to tell patients, ‘you have this diagnosis and you need this medication, but unfortunately we don't have it in the hospital. So we will prescribe for you then you go and buy.’ If

the patients come several times to the facility and find the same issues - in future they might say that 'I don't trust that place; why should I go there? They don't have medication...' So even the issue of supplies, it's a big problem - especially when it comes to patients' trusting that you actually have the capacity to help. 'Why should I come if you don't have medicine? Why should I come if you don't have gloves? ...But I think it's not only here, I believe it's the government- the public system. We don't have adequate allocation of funds... like every quarter of year there are supplies to the hospital. But you'll find that maybe the first month of the quarter, things are available. Maybe by the second month, some of them are already out of stock.' (Medical officer, 2 years at facility)

This medical officer's reflection on how shortages affect her ability to care for delivering women in the way she'd ideally like to reveals also the problem of delays in the public system. The maternity in-charge and facility matron concur on the complex process of asking for and delivering on quarterly installments, which result in delayed procurement and affect perceptions of 'responsiveness'.

"Some of our supplies have to come from KEMSA [Kenya Medical Supplies Authority].... it is not under our control. Also, our purchasing system is the tendering system- it takes time... It is set and the recommended by government because you are buying in bulk to save money. If you are not using the tender system, there is a provision to buy those other small things here and there, but it is not always that we have the money... [In the tendering system] Many merchants are invited -it is only the one who wins the bid who gets to supply us. And even if they have won, we are not so sure whether they will supply the right things at the right time. Some, they delay, some bring and we reject cause they are not the quality we prescribed. Like that and so, you end up getting some delays." (Matron)

The matron elaborates the facility's preference to give women in maternity individualized supplies; however, given that the hospital is not a profit-driven enterprise, discretionary funds are often unavailable. In the absence of independent facility financing for supplies, procurement delays may occur, so that women's and community perceptions of responsive "good services" fall short and have implications for trust. This notion is acutely noted in the post-free maternity period, where providers describe an influx of women delivering in the facility and demanding free care. The ability of facility management to hire more nurses or secure more supplies is limited because professional contracts and the decision-making power on procurement fall under the authority of the national or county governments. Moreover, as seen in Appendix 6, total admissions did not immediately change after the policy was instated; but rather the demographic profile of women seeking hospital care likely shifted from Nairobi's urban poor to those living in nearby peri-urban localities (e.g. the poor who had previously delivered at home or sought help at non-hospital clinics).

Though providers and management agree that discrimination and corruption affect women's and community trust in the maternity setting (*Figure 6*), they deny treating women differently based on appearance of wealth, social connections or voucher status. Similarly, though none admit to personally accepting informal payments, many providers concur on the existence of 'shortcuts' or the practice of 'giving something small' as part of the facility culture, particularly in outpatient areas.

"I attend to patients without using any shortcut... it is good to be genuine to the patient. When they come, if there is something to be paid, let them use the right channel, let them pay thorough the cash office. Let them be given the receipt, so that there is nobody who is pocketing their money... patients are very innocent. Sometimes they come and whoever is attending to them might ask for some money, so nobody will know because they are alone in the room.... So patients should also know their rights and they should know that if they pay for anything they should be given a receipt." (Nurse-midwife, 10 years at facility)

This quotation implies that not only should providers refrain from 'pocketing' bribes, but also patients ought to know where the legitimate payment channels are, and demand receipts for exchanged cash to prevent corrupt practices that render the care system unfair. As such, the underlying notion is that occurrences of corrupt practices require the action of two parties (women/ their families and providers) – and so, any efforts to curb corruption likewise demand action on both sides.

Management reflects on this duality and the challenge of addressing corruption in this peri-urban county where bribes are culturally commonplace, suggesting that these practices stem from a lack of reporting incentives; bribe acceptors benefit financially, while payers experience more efficient care.

"When you get a case of corruption, many of them (patients/community) end up pleading for the staff because according to them, the staff was helping them – 'now you want to punish them and they were helping me?! Next time I come, hata nisaidia (he won't help me). 'And they believe in being helped. They also believe out of some unknown notion that if I give this little money here I won't pay the big money there, unaona (you see). So is like there is suspicion. I would rather give you two hundred shillings rather than come and pay one hundred shillings at the registry cause I think it won't be one hundred shillings at the registry so I sort myself out with somebody there." (Matron)

This typical scenario in which bribery occurs at the facility shows how each party protects its own interest and is looking to gain from the situation; i.e. a patient/her family exchange informal payments with frontline workers to 'jump the queue', feel that they are getting a bargain by paying providers

side cash to avoid paying an extra fees at the registry (skepticism associated with formal payment system), and receive prompt attention. Women and their families end up defending providers that accepted bribes if they anticipate returning for future care. In comparing her work in different counties, the matron reflects on how, in places where the culture of bribes is more prominent in the community, corruption at the patient-provider or patient-facility interface is also greater. Irrespective of where corruption begins and ends, providers and management acknowledge that it is likely to affect trust in maternity settings.

Accountability factors

Provider and management perspectives concur on accountability factors that determine trust in maternity settings (*Figure 6*). For these groups, alignment of action with expectations additionally covers active management response to nurse and doctor expectations, government provision of adequate supplies and human resources, and engaging voices of frontline providers within facilities. Providers, for instance, have mixed opinions on how able the facility is to respond to the demands of free maternity (e.g. whether it lacks sufficient supplies and human resources). Overall, however, they collectively exhibit a greater sense of optimism than that shared by women and community members about the policy's enabling rhetoric for facility accountability in determining trust.

Providers and management describe 'intra-facility feedback' with respect to provider performance and patient satisfaction as integral to establishing accountability amongst providers and to women they serve. First, timely intra-facility response of management to providers may help address infrastructure-related issues in maternity settings (e.g. need for curtains). Second, providers describe a lack of performance feedback from the facility board (i.e. group of decision-makers for a particular facility that includes the facility matron, medical superintendent, and district/county level officials) and quality-improvement efforts conducted by in-house hospital staff with respect to women's perceptions of care and complaints.

"There is somebody who is allocated quality assurance at the hospital...she was doing research twice a year. And then if you don't get feedback, you don't know where you are going wrong, where you need to improve. I've only been given feedback once...on the waiting time, which could be an issue

even today. The waiting time of the patient could be an issue even today because we have one examination room.... When the doctor starts reviewing patients in the ward, patients in the waiting bay are forced to wait a bit longer... So, feedback on everything that is [relevant] - from what they research to what they get from the suggestion box... If you get a patients complaint, it's good to let the people on the ground know.... Like if a patient comes and complains to me, I always let the other nurses know what is happening.” (Nurse-midwife/in-charge, 11 years at facility)

The facility management collects feedback from patients through routine (e.g. sign near the ward entrance promoting a customer care desk, a suggestion box) and research-driven (e.g. bi-annual quality assurance research) mechanisms; delays in sharing findings with providers reduce accountability to health workers. These delays limit providers' ability to respond to patient complaints, which consequently affects women and community's sense of facility accountability and trust in the maternity setting.

Provider challenges

Mental fatigue and working conditions

Despite the intent to provide empathetic care and address women's unique needs, working conditions and overall 'mental fatigue' limited providers' ability to achieve these goals in practice.

“It is complicated ...the midwife works under pressure. You [the midwife] are alone and you have to handle all those cases and out of that tension, you want the mother to behave right the way so you kind of end up shouting at the mother. So they have undergone this pressure for long and there is no end to the solution of staffing - it's like they want to do their work fast - after all it's so tiring and they have to do it. And the mother - because she has come through this midwife - she will now go home with a negative attitude. She never found a calm midwife, she never found someone who would actually handle her the right way. So she will go back there [to the community] and say those nurses are very bad.” (Matron)

“By reducing the workload one will be able to at least have enough time to talk to this patient to get the problems and let the patient know you better... But with big workload, you are not able to handle that patient on a one to one basis. You are in a hurry to finish with that one so that you go to this other one so you don't get a good relationship.” (Nurse-midwife, 22 years at facility)

Providers and management concur that the high pressure of the maternity settings coupled with large numbers of patients and insufficient staff create working conditions that leave nurses (and providers in general) little time to spend to counsel and develop mutually respectful relationships with laboring mothers. In some cases, this pressure builds to the extent of 'mental fatigue', which results in

displaced frustration-driven action onto the patients (e.g. “being harsh”). Burnout and mental fatigue is typified in how the scope of nursing work affects professional functioning as well as personal life.

“You are educating, you are examining, you are delivering... all those things! You can’t perform in the afternoon - I would love to but I can’t. In the morning, I am full of strength and can do it, but when it reaches a certain hour... We also have our families. At the end of it all, you go to your family - your kid needs your support, she has some homework, she wants your help. Because here [in maternity] we are dealing with two lives and you must save both lives, so you put a lot of effort. So at the end of the day, you are burned out.” (Nurse-midwife, 8 years at facility)

A medical officer describes mental fatigue and burnout in recounting her 24-hour maternity shift.

“When you are on call, everybody else goes home and you are the one running show in maternity A [obstetric ward], maternity B [postnatal wards], ward six [gynecology ward] and [operating] theater. It’s like you are everywhere at all times- you have to be there. One minute you get a bleeding in ward six, another time you’ll get a bleeding here, and then all those delays... I can’t explain that feeling but it’s like at the end of the day you feel like you have achieved - but then it’s just tiring.” (Medical officer, 1 year at facility)

Though mental fatigue echoes across all health providers, it appears a greater concern for hierarchically lower worker cadres - those actively involved with providing continuous care (e.g. nurses, interns vs. consultants). As a nurse with 30 years’ experience at the facility describes, “They [supervisors] don’t do night duties for example - it is the juniors”. From provider perspectives, actions carried out when providers are suffering states of mental fatigue (e.g. “harsh treatment”) undermine trust.

Mental fatigue and overburdening of providers at particular times of day (e.g. night) may lead to varied perceptions in quality of care and undermine trust as described by nurse-midwives, doctors, and managers. For instance, night shifts generally consist of only two nurse-midwives working in the maternity ward and one medical officer rotating across the three physically separate obstetrics and gynecology wards; consultants are only called in during emergencies. The matron describes management challenges associated with increasing nighttime staff – both through redistribution and student support to nurses, given the status of the sub-county hospital as a teaching facility.

“I have tried my best to squeeze from other wards that are not urgent as maternity. So I have tried to put more staff in maternity to try and relieve them, but our numbers... the mothers who come to our facility overstretch us..... We have been trying –we made an MOU with [medical and nursing] schools to allow their students to come and do any shift in the hospital. Some are compliant and some are not because of transport issues. They argue about transport - when they have to take students on

shifts, I don't know if it's expensive to them.... But, a student has come with their own objectives and they are only temporary."

A number of political and institutional level challenges surround the redistribution and securing sufficient numbers of staff at night, with likely downstream consequences for trust in the maternity setting.

Broader facility environments challenge the maintenance of trust. A clinical officer describes one such instance, where a positive interpersonal connection dissolves after a woman experiences delays, long wait times, and confusing messages in another department (e.g. the 'lab').

"When they come back, you will find some of the patients are annoyed because of the time they spent there...At that point, that good relationship has some problems again. When the patient left you were discussing things very well. Maybe when the patient went there -they sometimes even become confused. They go, they don't know whether to pay first or queue for inquiries. Somebody may queue then is told to go and pay. When you pay, you queue again...So now there will be some displacement of aggression when the patient comes to you [in maternity], 'you people! You are not working well, how is this place?!' The patient who before was smiling and you were talking well - she will come frowning...annoyed and is not ready to talk to you as she was doing earlier." (Clinical officer, 7 months at facility)

The fragility of a relational construct like trust is seen in this example, where even after the establishment of empathetic, congenial communication, a plethora of environmental and procedural conditions affect the overall patient experience, and consequently, interpersonal and impersonal trust.

Provider motivation and support

In addition to workload-driven mental fatigue, providers broadly describe general motivation and support as challenges affecting their work in the maternity setting. Maternity nurses agree that working in maternity requires immense commitment and dual responsibility for the mother and newborn – they see this as directly related to outcomes, which determine trust. Given job demands and challenging clientele, providers draw on both intrinsic and extrinsic motivators to perform at their full capacity. Some providers describe the necessity of intrinsic motivation (e.g. a 'calling' to nursing) to maintain morale and function in a resource constrained sub-county facility. Nurses further elaborate on the recent growth of intrinsically motivated nurses following an increased professionalization of the field. Irrespective of the intrinsic motivation they 'once had', providers

consistently describe a lack of extrinsic motivation - resulting in demoralized staff and lowered ability to cultivate trusting relationships with their patients.

Providers describe feeling “underpaid”, “underappreciated” and having inadequate financial, material, psychosocial, and supervisory job support. We heard consistently about how providers felt they were not fairly compensated for their hard work (9 out of 11 questionnaire respondents).

“I might be having like eight deliveries - but it is like delivering thirty mothers because one mother probably cost me two hours or so, another one two hours, or one and thirty minutes. So if I combine these hours....they are a lot! So what I know, come to people on the ground, ask them the challenges they are having - they will tell you. Then they should listen to us, our in-charges - they should listen to us because we cannot always be right, but we can be having a point.”(Nurse-midwife, 8 years at facility)

Beyond unfair compensation that is incommensurate with workload, some nurses describe a lack of material appreciation in other forms – namely, ancillary resources to keep them motivated (e.g. replacing a broken flask for tea). Clinical officers complain of lacking a nominal salary (as paid to medical officers) during their internship year as particularly demoralizing.

“When we have some meeting and try to raise the issue, then they will tell you now, “you must be here for the internship” ... [but] we also need to survive - somewhere you can go work ...where you get some low income I think it the way the duties are performed - they could be better if the clinical officer interns were paid. Because you will be dedicated and so much devoted because you know it’s just like any other job...but now, the free service....there comes a time when somebody feels like giving up.” (Clinical officer, 7 months at facility)

Critical discussion around provider salaries in general (and clinical officer (CO) interns, in particular) with the facility matron reveals that the majority of salaries are determined and paid directly by the government. Moreover, there appears a clear divergence in perspective around CO compensation. According to the matron’s description, historically, medical superintendents locally arranged payment streams for COs; however, currently, this cadre is on formal payroll. Facility management and provider perspectives suggest a complexity in financial motivators to enable provider performance at full capacity due to the influence of higher level professional associations (Clinical Council) and government on salaries.

Providers describe psychosocial support as necessary to improve their functioning and interactions with patients – only 3 out of 11 respondents report such support from the facility. Family,

friends, and social media (e.g. a young CO describes a CO-Facebook group) comprise outlets for some nurses and doctors to debrief on job-stresses; however, others reveal that not all staff have supportive networks. One nurse explains the importance of this type of support and the existence of informal modes within departments or sub-groups (i.e. cadres of workers).

“It’s very important... right now I can say, at the departmental level -not the whole hospital...we [postnatal nurses] take care of the welfare of the staff....Like if one is sick, we even contribute something for them ...Contribute in even money, prayers...” (Nurse-midwife, 10 years at facility)

When asked specifically about psychological counseling, providers and supervisors agreed that though it was important, there was no formal avenue available beyond daily case debrief meetings (“we share the problems encountered every shift”) and infrequent individual conversations with the maternity in-charge.

“If you have anything personal, you can’t bring it to this [morning] meeting...If it’s something so personal, there are those things don’t feel like you want to share with everybody, those ones you can’t [bring] ... if you feel you are comfortable telling me, well and good...(I: Do they share that with you?)...Not so often, but once in a while.” (Nurse-midwife/in-charge, 11 years at facility)

Providers and management jointly consider a supportive environment to be an underlying factor that affects provider behavior, workplace trust, women’s and community trust in the maternity setting.

The next section looks specifically at supervision as one particularly salient type of support.

Supervision

Frontline facility providers (i.e. nurse-midwives, COs and MOs) express convergent views on how positive dialogue and response (verbal or action-oriented) from supervisors enable them to function at higher capacity. Many report feeling the sentiment that “somebody somewhere should listen to me,” which suggests that supervisors ought to readily respond to providers’ resource, staff, or senior consult requests.

“You can assess how helpful they [senior consultant doctors] are. Like are they available when you need to consult them?...cause some of them, maybe they don’t pick up the call... or some of them will always not be there - they keep telling you to call the HOD despite their names being on the roster.... so that way, as in with time, you get to know which consultant you can call any time and which consultant you don’t bother.” (Medical officer, 2 years at facility)

Though all providers report the general accessibility and responsiveness of supervisors (in-charges, department heads, consultants, facility matron), they also describe times at which they felt alone, unsupported, and overburdened (e.g. nights and weekends). Moreover, some providers mention that frequent audits or supervisor time spent in maternity areas (as opposed to administrative offices) would benefit supervisor-employee relations, enhance overall management of the ward, and consequently support women's trust. An experienced nurse (of 22 years) describes how timing and duration of supervisors' visits may affect their ability and willingness to respond to nurses' requests (e.g. supervisors may be absent when the nurses are busiest and need support, and present when nurses have a low workload).

Providers (experienced nurse-midwives, in particular) felt that a supervisor's expectations of nurses should be grounded in experience providing nursing care or time spent in the maternity wards.

"If you tell me, 'when I was on night duty, I did it all and I completed....' I know you are telling me from experience, so I will try so hard to finish. But if you tell me 'It is a must! You finish your shift and document everything,' but you've not done it...So I will know that you are really pressuring me ... you are forcing me to do things which are not really possible and you don't want me to say it is not possible." (Nurse-midwife, 30 years at facility)

In response to provider claims of absent supervisors, the maternity in-charge and facility matron describe their challenge of balancing multiple priorities in their roles as coordinators – including duty allocations, adequate supply of resources, conducting meetings and troubleshooting concerns, training/orienting nursing student interns every few weeks, and liaising with higher-level management (e.g. in-charge relays requests to matron, who advocates up to the superintendent who brings it to the facility board.)

Teamwork benefits and challenges

The range of skills and worker cadres required in labor and delivery renders teamwork integral to creating trust in a maternity setting (i.e. workplace trust, in providers, in facilities).

"We have to work as a team. You can't manage a patient alone... you have to communicate with the others so that you can offer good services to the patient. So it is a team work; we have to work together and have a good relationship...When you need help, all the team - for example, your patient has a complication like postpartum hemorrhage, you have to call for help and everyone stops whatever they are doing and comes to your rescue. You have to assist - you do everything for the

mother...In maternity, we have to differentiate what is emergency and other care –when we have an emergency, we really have to run to rescue that patient.” (Nurse-midwife, 3 years at facility)

Providers and managers agree that given the roles and responsibilities of nurse-midwives, COs, MOs, and consultants, collaboration is inevitable (“a doctor cannot work without a nurse, a nurse cannot work without a doctor – so we work hand in hand”).

“As long as there is a clear cut definition of who is doing what, you rarely have conflicts. The problem is when everybody seems to be doing the same thing at the same time. (Medical officer, 2 years at facility)

As the medical officer describes, conflicts may occur in scenarios with blurred roles, and uncoordinated actions undermine the team effort. Disagreements (e.g. providers start blaming each other) tend to occur when dealing with complications and poor outcomes. In such scenarios, the use of continuous medical education (CMEs) facilitates assurance that no single health worker assumes complete blame.

The other teamwork challenge faced by providers is with respect to complex inter-cadre dynamics. For instance, though nurses, COs, and MOs describe their ability to challenge one another while providing maternity care within their cadre, they are less confident to do so in situations where there exists a clear professional hierarchy (e.g. consultant vs. any other group).

“They [nurses] don’t argue at all with consultants....mainly it’s interns and medical officer - that level...There are some [consultants] who will just tell the nurses off in front of patients and all of us - which is not right in a way. But there are some doctors [MOs or COs] who actually do that - it is not age –related, it’s just that doctor-nurse relationship... ‘I am more superior cause am a doctor’ ...I think every individual deserves respect. (Medical office, 1 year at facility)

In maternity, number of years of nurse-midwifery experience plays a significant role in who decides the course of the patient’s care – therefore younger COs and MOs often defer to experienced nursing staff. The nurse in-charge reflects on her experience as a seasoned nurse-midwife negotiating with these cadres.

“Sometimes you get a doctor who is rude to you... as in he is more educated... that I have been told, ‘I have been to school for so many years, and we are supposed to be making decisions here.’ You know, you cannot stand back and wait for a patient to be mismanaged just because somebody is a doctor...you have to correct them...It’s difficult, you know, it’s a man (says emphatically) bringing you down...It’s tough, but you have to stand firm... I have not seen those extremes [often] ... [when] you tell the doctor to do this, the majority will listen. In maternity, most of the time it’s about

experience - he is intern, he has not been in maternity for longsome are good and they understand. But that is just one isolated case.” (Nurse-midwife/in-charge, 11 years at facility)

In this description, the nurse-midwife is at the receiving end of a double gendered interaction by a male doctor – who sits higher than herself in the formal professional hierarchy, but has less experience. Despite the fact that providers report such extreme scenarios as rare, any instances of inter-cadre disagreement in the maternity setting witnessed by laboring women may affect their trust.

Structural factors

Institutional hierarchies

Professional hierarchies and the hierarches between providers (experts) and patients comprise broad contextual determinants underlying trust in a maternity setting (*Figure 6*). Inter-provider power dynamics manifest particularly in the form of deference to authority and through facility norms that often blame those at hierarchically lower levels (e.g. nurses or delivering women). For example, the berating of nurses (or interns) by senior consultants may leave them feeling disempowered.

“Doctors should listen to the nurse because the nurse is the person who is always, always with the patient. The doctor comes to see the patient - ten minutes or so - and then he or she is gone. But you are the person who... [monitors] ... this patient is changing condition, this patient is restless, this baby...So the nurse can make...ok, she can't make the doctor's decisions, but at least they should listen to us.” (Nurse-midwife, 8 years at facility)

“It's always like they [nurses] are always looked down at...our consultants [senior doctors] will do that.” (Medical officer, 1 year at facility)

Doctors not ‘listening’ combined with a feeling of being ‘looked down at’ and normative expectation of nurse deference to higher medical expertise (‘she can’t make the doctor’s decisions’) may foster a deeper sense of inadequacy and powerlessness. This powerlessness toward superiors may have repercussions for the care of delivering women, which gives rise to skepticism around providers’ integrity and communication with their patients (Chapter IV), thereby negatively affecting trust.

Structural norms within facilities upheld and induced by supervisors and professional codes (Appendix 7; described further in next sub-section) facilitate a gendered provider-patient structure, where providers internalize their role as ‘superior’ (e.g. experts) and use language of ‘cooperation’ (the primary obligation of delivering mothers). ‘Cooperation’ is used across different cadres of

providers and generally refers to how well patients obeyed providers' instructions during labor and delivery. When this cooperation disappears or is made 'complicated' (i.e. when a patient does not follow instructions), a few providers describe a tendency to blame (to a small degree) patients for negative outcomes. In the first quotation, the 'uncooperativeness' refers to the provider's perception of the patient's unwillingness to obey the providers' orders, while in the second it relates to non-disclosure of relevant information for providing optimal care.

"We just explained to her, when you do this you are going to kill your baby... She was so cooperative. And when she heard that she has twins, she was shocked, but everything went on well and she didn't complicate in any way. There are others who are very uncooperative. You tell them 'if you do this you are going to kill the baby,' and then they just continue. And then, you know, there isn't much you can do when the head has not crowned here cause that is the only time you can tell the patient to push. But when the head is just up there a bit, there is her part and time. But if she is uncooperative, she will just push and push until the whole place is just been swollen and may be the head has been mangled or the baby will just die there because she is not cooperative..." (Nurse-midwife, 30 years)

"The way you [patient] come and present yourself, that is what will guide me on how I treat you. But if you keeps things to yourself I will be like leaving out some things [of the detailed history]so if I make I mistake, I made it cause you [patient] led me to that." (Clinical officer, 7 months in facility)

As evident from the tone of these excerpts, the subtle ways in which hierarchies and power relationships get formalized through language (e.g. charter obligations) and norms of practice in the maternity ward may affect indirectly women and community trust.

Policies, professional codes, and obligations

Structural factors (*Figure 6*) rooted in providers' fiduciary obligations to serving their patients are often guided by official documents that politically contextualize professional practice. Providers and management elaborate on their fiduciary roles through reference to policies (e.g. free maternity care, new constitution), professional codes of ethics, national guidelines, and service charters as guiding documents for decision-making about patient care, and for behavioral norms in the maternity ward.

"I have professional ethics which bind me - there are unethical things that I can't doLike now, for example, even if a patient comes and insults me, I can't refuse to attend to that mother. Whether she has annoyed me or not because am bound by the ethics." (Nurse-midwife, 10 years at facility)

For managers, policy and professional practice codes include guidelines for money management, dispute resolution, and disciplinary action.

“There are rules and guidelines that guide all those monies that come into hospital... [also] The guidelines are helpful because when it comes to push and shove or when it comes to legal cases - that is what we depend on. Without them, we would not have anything to depend on...It talks about: if you do this, what would happen, what should I do – that kind of thing. Guiding the number of days you go on leave, guiding your conduct basically...so you see we are guided as a block. So you can't go outside that block....Also guiding how would I discipline a staff; what cases would demand what kind of discipline - so that I don't depend on my own whims.” (Matron)

Some of these documents – including the Nursing and Citizen's Service Charters – are physically posted on the walls surrounding the waiting area in the maternity ward (Appendix 7). The utility of these documents in patient interactions and counseling is mixed.

“It's useful because it reminds us of what is expected of us and what is expected of the patients also - you see, it has two columns... Most of them [patients] don't even read it ...Most of them are pre-occupied with their problems - they don't see it....It can be useful because they can also see there is something expected of them. You know, they are also supposed to cooperate.” (Nurse-midwife, 10 years at facility)

“If we had time [for counseling] we would use it [nursing and citizen's charter], but here rarely do we use it.” (Nurse-midwife, 3 years at facility)

Most providers agreed that the charters ought to be used, particularly in educating patients, as the nurse denotes that women are ‘also supposed to cooperate’ (i.e. listen to and follow providers’ instructions) during maternity care. The sub-text of hierarchy embedded in seemingly neutral language (e.g. ‘cooperation’) is important to note in many provider interviews. Acceptability of charter translation into Kiswahili (despite the area's majority is Kikuyu) appears reasonable given women patients' literacy and comprehension in the county. Providers consistently responded that maternity patients spoke Kiswahili given their age (mostly under 40 years), general education levels (mostly have completed 8th grade level) and current socio-political norm in the peri-urban context (enforcing Kiswahili as the national language).

Discussion of service charters prompted critical debate about the obligations of both patients and providers. Providers seem aware of the concept of patient rights as outlined in the new constitution and the RMC charter (WRA 2011); however, they express frustration about a lack of

clearly documented provider rights or protections. A nurse who had worked at the facility for 10 years describes scenarios that render providers powerless and without adequate formal support.

“Also it’s good for the patients to know that the health workers also have their own rights ... because the way the community believes is that health workers have no rights...They come and demand so much from a health worker –a health worker is left there helpless with no one to support her or him.”

She goes on to explain that in some cases of poor maternal outcomes (e.g. a maternal death) that individual health providers suffer the blame of communities – despite the hard work they put into saving a woman. If providers lack formal rights protections, it compromises their sense of accountability in the health system broadly and workplace trust in particular.

Devolution

Devolution forms the final structural factor affecting both community and facility health management, which has repercussions for trust in maternity care. Managers (of facilities and community health strategy) note how the national devolution process to county governments has structural implications for roles and responsibilities of facility boards and community health units, which form a pivotal role in accountability and determine trust in maternity settings (e.g. feedback).

“The county health services are still in that [gesturing low] infant stage...But of course, the team has been formed, because county officers were posted. What we don’t know is how the structures will be in future....they are likely to change a bit. But much as they change, there will still be some management at the sub-county levels....It doesn’t really matter if it’ll be one county or two or three counties put together with some sub county management on top...I think it is a bit impossible for the county administration to go directly to the facilities....They are still at that stage of trying to negotiate to see who will be where, how will it be done. There are coming up with the structures - it is important to have some structure between the county and the health facility levels.” (District Public Health Official)

The ambiguity of accountability-maintaining structures suggests that the relationship between facility management and new county government will affect health system responsiveness to the demands of women seeking maternity care and providers requesting more human and material resources. This social-political force (i.e. structural factor) plays a significant role in the notion of accountability at the facility level and contextually affects women’s and community trust in the maternity setting.

Chapter Summary and Interpretation

There is relatively high degree of convergence of perspective (‘providers and management’ with ‘women and communities’) with respect to the multi-faceted determinants framework influencing trust in the maternity setting. Though divergence exists in terms of perceptions of discrimination at the facility, providers and management confirm that corruption at the facility level influences women’s trust. In addition to the complexity of the multi-faceted trust determinants operating simultaneously, providers suggest that information sharing (via social networks) may be mitigated by maternity care literacy levels in the community. Workplace interactions as experienced by providers and management reveal challenges surrounding working conditions, mental fatigue, motivation, supervision, and collaboration; all of which affect workplace trust and, indirectly, women’s and community trust in maternity settings. Inter-personal dynamics of different health worker cadres and facility-based maternity practice norms unveil institutional hierarchies, policies and professional codes, and devolution that comprise structural factors as underlying and cross-cutting contextual determinants of trust in peri-urban Kenya.

Trust and care-seeking in the community

Providers and management explicitly connect trust and care-seeking (i.e. care-seeking is often described as a consequence of trust). Though trust has a long standing association with care-seeking, it only recently entered the literature as a potential determinant to maternity care-seeking (Ganle, 2014; Ng et al., 2014; Riewpaiboon et al., 2005; Yidana & Issahaku, 2014). While positive patient-facility interactions have been associated with increased utilization, reduced levels of trust amongst historically marginalized groups act as deterrents to care access (Gilson, 2007; Goepf, 2006). In the current study, providers and management often see care-seeking, particularly bypassing of other facilities, as a result of greater trust in the facility. Bypassing based on expected EmONC and quality has been shown to occur in under-resourced care settings (Kruk et al., 2009), though so far it has not been attributed to trust. As such, providers’ primary understanding of community-level determinants revolves around the influence of reputation; they perceive that information sharing about past

maternity experiences and outcomes within women's social networks (or potentially via media) perpetuate higher or lower trust in maternity settings. Some anticipate that the importance of trust (as relates to maternity care-seeking) will increase in the current policy context where affordability is a lesser concern, while all agreed on trust's intrinsic value in promoting effective engagement in the therapeutic dyad.

Provider morale

Provider mental fatigue resulting from working conditions, facility environments, and insufficient motivation and support resonate with growing concerns in sub-Saharan African maternity settings. A mixed methods study in Kenya attests to the health worker concerns about general motivation, burnout, job satisfaction, intrinsic job satisfaction, and organizational commitment – all of which emerge from working environments (Mbindyo et al., 2009). Beyond workload, mental fatigue relates to broader household and family-centric responsibilities of female providers, reflecting both cultural values and social pressures as have been shown to affect health provider morale and functional capacity (Arnold et al., 2015). Contrastingly, workplace happiness, reflective of provider-well-being, has been shown to intrinsically motivate and affect productivity of health workers (Sharif & Majid, 2014). Moreover, small appreciative gestures and recognition as seen in Kenya (e.g. tea flask) may serve as both extrinsic motivation and reinforce management's respect toward its provider employees (Aberese-Ako et al., 2014). As seen in other maternity settings, social and psychological support structures for nurses may be particularly important where there is inherently more active social and familial decision-making and emotionally heightened interaction with providers are involved (Hurley et al.; Samir et al., 2012). Mid-level management and supervisors (e.g. maternity in-charge) represent a key group in supporting provider morale through various avenues. In Kenya, this health worker cadre's role is relatively undefined, unsupported and expansive; ranging from interpersonal skills, to mentorship, to strategic negotiation with superiors, to goal setting and planning (Nzinga et al., 2013). Structurally-induced stresses of devolution and free maternity, in light of

Kenya's nursing shortage (Burrows, 2013; Muraya, 2013; Wakaba et al., 2014), further influence provider morale, which, in turn, affects patient-provider interaction in maternity wards.

Collaboration in the context of hierarchy

Study findings support the claim that reciprocal relationships and mutual respect gained from workplace congeniality between different cadres are particularly important in determining trust in maternity settings (Østergaard, 2015; D. C. Smith, 2015). According to Denise Colter Smith, effective collaborative processes in maternity involve organizational (e.g. commitment/interest/goal), procedural (e.g. role clarity, decision-making), relational (e.g. communication), and contextual (e.g. shared power) confluence across workers. In the peri-urban Kenyan setting, providers and management concur on the idealized understanding of these notions; however, at times, existing hierarchies between nurse-midwives and providers may negatively affect collaboration in practice. For instance, non-response of supervisors in times of need or verbalizing position-based 'superiority' (e.g. consultants to nurses) affect the collaborative spirit. Similar 'injustices' towards lower-tier workers have been studied in Ghana (Aberese-Ako et al., 2014). Verbal abuse by supervisors and co-workers combined with instances of less shared power in the maternity setting affect workplace dynamics; similar findings are seen in Tanzania and Egypt, where normalization of abuse at different levels undermines the reciprocal relationships needed to build women's trust in facilities (McMahon et al., 2014; Lilian Mselle et al., 2013; Samir et al., 2012).

Structural context, power and trust

Underlying structural factors demonstrate how normative, policy, and political contexts affect trust through its multi-faceted determinants and through structured power relations that affect the governance, provision, and use of maternity care (Brinkerhoff, 2004; Gilbert, 2005; Gilson, 2003). First, unequal trust associated with maternity care appears to stem from the role of corruption and discrimination as determinants, reducing the levels of trust felt by poorer women. This point resonates with broader literature that suggests discriminatory provider attitudes reflect discriminatory societal

norms and often result in poorer populations' having lesser trust in formal health systems (Gilson, 2007).

Next, hierarchical norms and professional codes affect how mutually respectful and trusting providers are of one another (between cadres). The study identifies the nurse-midwife as an intermediary in the gendered facility structure (i.e. lower than consultant physicians, but higher than patients); as such, her role offers a compelling window into how 'obligatory rules' of the facility and professional ethics (i.e. national standards) are transferred to her relationships with women in the maternity setting. Harsh treatment of women as an 'occasional' result of this intermediary role— contextualized by mental fatigue and structured gender norms in nurse-midwives' personal lives — corroborates with the 'continuous struggle' facing this predominantly female health worker group in South Africa (Jewkes et al., 1998).

Finally, policy shifts - free maternity and devolution – and programmatic influence (as in Heshima RMC interventions) introduce complexity into the valuation of providers' and management's economic and resource environments as well as their professional roles and responsibilities. Though the policies lead to ambiguity in roles and uncertainty in resources, concurrent local Heshima engagement likely heightens awareness around practice norms, patient and provider rights, and accountability. As such, structural factors show how power diffuses through health facility interactions (Grimen, 2009) and determines trust in maternity settings – often through provider, facility, and accountability factors.

In summary, provider and management perspectives enable adaptation of the multi-faceted determinants framework to include structural factors as a set of contextual trust determinants in the maternity setting. Moreover, this standpoint collectively considers maternity care-seeking as a consequence of trust – which at individual and community levels is seen as determined by social networks and rooted in perceived experience. The exploratory nature of this work gives rise to a number of questions for future research. To what degree and magnitude do each of these factors influence trust? How are determinants in the maternity setting different from those in other health

areas? How do different determinants, particularly structural factors, vary across facility type, across the county, and in areas with ethnic and religious heterogeneity? How do structural factors affect different health worker cadres (including CHWs) in relation to trust? Given the social-political changes occurring in the peri-urban county and Kenya under the new constitution, the qualitative researcher chose to focus on the appreciative nature of this inquiry and explore plausible trust building mechanisms that may begin to address the multi-faceted determinants.

VII. Building trust

Method and standpoint

Building a trusting environment for the delivery and receipt of respectful maternity services is a complex challenge involving a range of individual, community, and institutional actors. As seen in Chapters V and VI, trust in a maternity setting is determined by multi-faceted factors. Building on these findings, this chapter qualitatively explores trust-enhancing mechanisms by factor cluster as proposed by women, communities, health providers, managers and officials. Guiding questions draw particularly from the AI lens, but also from IE-inspired critical probes that focus on changing the dominant discourse (e.g. status quo facility norms).

- How do you think we can build trust between patients and providers?
- How do you think we can build trust between patients and facilities?
- How do you think we can build trust between communities and the health system overall?
- How do you think we can build trust between cadres of providers?
- How do you feel ethical or professional codes could be changed?
- Tell me about the work you currently do around improving quality of maternity care in Kenya?

The chapter standpoint covers all study participants and data collection methods (FGDs and IDIs) as described in the sample and method section of Chapter IV.

Results

Summary trust building mechanisms in the maternity setting that address the multi-faceted determinant clusters from Chapter VI include: education and empowerment of women and communities through appropriate channels; provider training and supportive work environments; improvements in health facility structure, management and transparency; and accountability-enhancing mechanisms that help address aspects of structural imbalance, including sustained community-facility linkage and provider protections (*Table 8*). The emergence and discussion of multi-level and cross-cutting trust-building mechanisms further lead to a discussion of key stakeholders required to formally incorporate, implement, and sustain the proposed interventions.

*Table 8. Mechanisms for building trust in maternity settings**

Intervention/ factor cluster	Determinants	Trust building mechanisms
Patient/ individual and community	<ul style="list-style-type: none"> • Prior experience • Perceived risk or harm • Childbirth outcomes • Reputation & social history • Corruption • Maternity care literacy • Information channels (social networks, CHW promotion, media) 	<ul style="list-style-type: none"> • Increase awareness of patient rights to RMC and empower communities to realize (via questions and demanding) these rights • Promote maternity care and reproductive health literacy by educating women & communities prior to their labor & delivery • Use appropriate information relay channels (i.e. involve key community stakeholders)
Provider	<ul style="list-style-type: none"> • Empathy & respect • Personalized attention & care • Perceived ability of provider • Discrimination • Corruption 	<ul style="list-style-type: none"> • Enhance interpersonal skills (training) • Educate and deploy more nurse-midwives to public maternity wards • Routine meetings • Financial and non-financial incentives to motivate frontline workers • Counseling
Health Facility	<ul style="list-style-type: none"> • Responsiveness in emergencies & “good services” • Physical environment & cleanliness • Navigability of processes • Management and oversight • Discrimination • Corruption • Coordination amongst providers 	<ul style="list-style-type: none"> • Increase and rotate human resources • Support supervision and disciplinary actions • Promote social and work-related interactions to improve inter-cadre dialogue • Improve infrastructure (private spaces) and material resources (e.g. beds, drugs) • Enhancing transparency of management decisions, processes, and fee schedules
Accountability and structure	<ul style="list-style-type: none"> • Actions align with expectations • Adapt to policy changes • Community voice • Intra-facility feedback • Institutional hierarchies • Guiding documents and obligations • Devolution 	<ul style="list-style-type: none"> • Monitoring and feedback of experience, complaints, and rights at all levels (patients and providers) • Strengthen community-facility linkage • Continuity/sustainability

*Selection of activities/mechanism by consensus across standpoints from Chapters V and VI

Patient/individual and community-related mechanisms

At the patient and community levels, education and empowerment emerge across all respondents as essential to building trust in maternity care (*Table 9*); providers repeatedly describe the main trust-building mechanism as, “It’s just education to the community.” The essence of educating and promoting maternity care literacy among women and communities is to prime women for facility delivery and encourage psychosocial and financial birth preparedness beyond that

available through ANC⁵. For example, as outlined in *Table 9*, education in a community setting ought to explain how the labor and delivery process works (what procedures will be done and why) and any items patients and their families should bring in anticipation of childbirth (e.g. cash for extra medication, cotton wool). Moreover, it ought to address the lack of spouse awareness around childbirth and family planning as described by male partners and some RDW groups; similar claims were also made for families and the larger community. Nurse-midwives particularly emphasize the need for educational sessions to clarify the roles and obligations of different provider cadres (what each can and cannot do) to avoid confusion and unwarranted health worker blame (for instance, blaming the nurse for something over which she has no power may lead to poor communication and hinder interpersonal trust development).

Table 9. Trust building at women and community levels

Trust building mechanisms	Supporting quotations	Key stakeholders to involve
<ul style="list-style-type: none"> • Promote maternity care and reproductive health literacy by educating women & communities: <ol style="list-style-type: none"> (1) labor and delivery procedures (2) roles of different provider cadres (3) financial and logistical processes (4) family planning • Increase awareness of patient rights to RMC and empower communities to realize these rights using: <ol style="list-style-type: none"> (1) service charters (2) human rights tools (e.g. RMC charter) (3) community meetings 	<p><i>“Sometimes we can reach out to them instead of waiting for the patients to come to the hospital. Maybe we can have like campaign where actually the community health workers can organize something...then they can be accompanied by a few doctors.... You know some of them have myths and you need to demystify... that would help.”</i> (Medical officer)</p> <p><i>“Women need to be called for a meeting somewhere and are taught about these things...[and] family planning.”</i> (RDW, IDI)</p> <p><i>“She does not know what exactly they did to her. Therefore it is important for her to ask. She should stop fearing. She should know everything that is done to her and why.”</i> (RDW, IDI)</p> <p><i>“I have been informing them of the need to participate in these activities [community meetings]especially those in our area so as to ensure we get most of the services offered at other public health institutions...It is their right to know which services are being and should be offered. This is because the community members don’t know that it is their right to get these services and to be served appropriately. When the doctor is serving you, it is not a favor they are giving you, it is the patients right to get high quality service at the health facility. I have been informing them of such issues.”</i> (CHW, IDI)</p> <p><i>“I trust you very much...because for all the time I have lived in this county I have never attended a workshop such as this one and I never thought I would. What you are discussing seems good and I trust it.”</i> (Pregnant women, FGD)</p>	<ul style="list-style-type: none"> • Community liaisons (CHWs, elders, chiefs) • NGOs involved in RMC activities (e.g. PC) • Advocates familiar with rights frameworks (e.g. FIDA) • Nursing association (e.g. NNAK or NCK) • County governments and their community health units

⁵ Antenatal care in Kenya covers iron supplementation, treatment for intestinal parasites, height/weight/blood pressure measurements, urine & blood samples, information on pregnancy complications and breastfeeding.

Participants describe empowerment as integral to promote alongside maternity care education, emphasizing the importance of teaching women and their families to claim patients' rights (e.g. use of RMC and service charters) and encouraging patients to communicate openly with providers about individual concerns and health status.

Group settings and participatory discussions may be particularly important for a community's trust building, as seen, for example, from a pregnant woman's description of how the intimate FGD environment facilitates trust by enabling women to voice their perspectives (*Table 9*). As evident from prior chapters, social networks and informal sharing of experiences represent key determinants of trust in the maternity setting. Accordingly, trust-building activities should focus on similar modalities. Particular venues (i.e. community settings) for reaching women in the peri-urban Kenyan context include "*chamas*" or "merry-go-rounds" (existing community groups that provide social and small financial support), presence at celebrations and rites of passages (e.g. weddings), churches and church events (e.g. medical camp), social gatherings, chief's *barazas* (local chief's meetings), and action days (e.g. where health facility providers, management, CHWs, and communities convene to discuss challenges in health service provision). In both formal and informal venues, CHWs are often described as the primary culturally acceptable agents through which education and information is relayed. Additional stakeholders that ought to be involved are listed in *Table 9* and elaborated on in the 'stakeholders' sub-section.

Provider-related mechanisms

Provider level mechanisms reflect the need to enhance provider empathy and personalized care in the particularly intimate and vulnerable maternity care setting; they include training and sufficient capacity (numbers), financial and non-financial incentives, redress mechanisms, and counseling to help with mental fatigue (*Table 10*). Women and communities and CHWs consistently describe the importance of changing provider attitudes and behaviors (verbal, facial or physical) that prevent a reciprocally trusting interaction, namely citing the need for changes in provider education

(pre-career and refresher courses) to emphasize caring and interpersonal skills. Though the terminology varies somewhat by specific individual and collective perspective, a CHW illustratively captures the need to incorporate better “public relations” in provider training (*Table 10*). Given the continued medical education (CME) sessions and other routine meetings described by providers and management at the facility, it appears that these venues would be appropriate for trainings that may help to cultivate patient-provider trust and inter-provider cohesion (*Table 10*).

Table 10. Provider-level trust building mechanisms

Trust building mechanism	Supporting quotations	Key stakeholders to involve
<ul style="list-style-type: none"> • Enhance interpersonal skills (training) • Educate and deploy more nurse-midwives to public maternity wards • Routine meetings • Financial and non-financial incentives to motivate frontline workers • Counseling 	<p><i>“There is no connection...What I can say is the way now this person (provider) who is not taking this other person (the patient) as a human being like her/him (provider)...the training which they undergo should also include the public relation.....and so much so, the public relation should be accommodated the highest percentage [be taught more], so that when they come to the ground, they will be connected so much to their people.”</i> (CHW, male, IDI)</p> <p><i>“Employment of more health providers ...to be able to cope when there are many people in the labor ward”</i> (RDW in facility, FGD)</p> <p><i>“The employees themselves should have a number of seminars often so that they can build trust and cohesion in the administration.”</i> (CHW, male, IDI)</p> <p><i>“It’s just that you appreciate if someone does something good because you have nothing to offer...at least you tell them ‘today you tried’... not always [only] seeing the mistakes - appreciating work well done.”</i> (Nurse-midwife/in-charge)</p> <p><i>“They can even appreciate [financially or recognize] the people who work extra hard...Like some of us even work overtime; your time is over but you find yourself still working.”</i> (Nurse-midwife)</p>	<ul style="list-style-type: none"> • Professional associations and councils (nursing, medical officer, clinical officer) • External training body (e.g. NGO) • Health facility management teams (HFMTs) • Community health Units (CHUs) • National & county governments (e.g. MOPHS, MOMS)

The other set of provider mechanisms cross over partially into facility and structural factors, but affect behavior at the patient-provider interface. For instance, providers generally agree that a small gesture on behalf of facility management or an immediate supervisor to show appreciation (whether financial or non-financial) improves morale. Despite the difficulties expressed by the nursing in-charge, as a mid-level manager (low-to-moderate positional power), of balancing maternity ward-leadership responsibility with facility management demands, she recognizes the salience of praising her staff for their effort (*Table 10*). Financial incentives operate in perverse ways. Salaries are described as lower in the public sector compared to the private sector and may be a source of

corruption at the provider-level. Increasing salaries overall and ensuring nominal pay for clinical officer interns (i.e. a government and professional association responsibility) may help mitigate some of this activity. Finally, many providers describe psychosocial support as helpful (questionnaire, see Appendix 3) given the intensity of work for nurse-midwives and junior doctors (medical officers and clinical officers); counseling (in some form) presents an appreciable mechanism to ease the emotional burden of providing maternity care.

Health facility-related mechanisms

Health facility-related trust-building mechanisms (*Table 11*) relate to improving working conditions, rotating and supporting providers, improving infrastructure and material resources, and enhancing transparency of facility processes (e.g. payment) for users. Increasing the number of nurses and doctors responsible for maternity services, particularly at night, may address the lower capacity concern and would likely increase trust. Working in maternity is emotionally and physically demanding given the hours and range of tasks involved. Providers suggest that rotating nurses throughout other departments in the hospital may help organize and maintain an energized staff in this setting. Most providers agree that working with a team for ~6 months is necessary to develop a collaborative peer sense; however, if staff remain for years at a stretch in maternity, their tendency to burn out and engage in trust-undermining behaviors toward their patients increases. Shortening shifts, promoting breaks, or rotating nurses may alleviate some of this burden. Furthermore, given the facility's teaching hospital status, streamlining student nurse assistance in way that is supportive and not detractive for nurse-midwives is important. Additionally, given the range of managerial tasks awaiting supervisors, there may be a benefit to rotating supervisory roles (particularly amongst experienced nurse-midwives) to maintain a perspective that is simultaneously grounded in maternity practice and broader departmental oversight (*Table 11*).

Women and communities felt that providers engaging in problematic practices (harsh or neglectful behaviors, discriminatory treatment, bribery) ought to receive disciplinary action. Providers

and management, on the other hand, felt it necessary to adopt ‘support supervision’ to improve facility and county health management practice.

Table 11. Health facility-related trust building mechanisms

Trust building mechanism	Supporting quotations	Key stakeholders to involve
<ul style="list-style-type: none"> • Increase and rotate human resources • Support supervision and disciplinary action • Promote social and work-related interactions to improve inter-cadre dialogue • Improve infrastructure (private spaces) and material resources (e.g. beds, drugs) • Enhance transparency of processes and fee schedules 	<p><i>“If we would rotate, we would get the same experience. So today I am overworked, tomorrow she [supervisor] is overworked, then the third day, she will know how to handle somebody else’s problem.” (Nurse-midwife)</i></p> <p><i>“Support supervision is you sit there, tell me how you are doing things and I tell you how I feel these things could be done. So that if there is an area that you are doing it in a better way, I also commend you because of the good job that you have been doing. You may find that in some facilities, some very innovative in-charges - in-charge of that facility, be it a nurse or a clinical officer.” (DPHO)</i></p> <p><i>“Occasionally we reward the whole maternity team with some airtime or we identify individual staff who excel above others... like there is one in maternity - we took a photograph and displayed him so that others can try to copy his way of working as role model. That one would motivate him and motivate others to copy him. At the end of the year we appreciate all staff for what they do with a party. We eat together and mingle together.” (Matron, IDI)</i></p> <p><i>“Beds are usually very few. When you deliver, you are taken to maternity B....So when you go there, you get so many other people who had delivered the previous day still there ...there is only one bed, you are close to four or five people and you are allocated one bed....unless they [government] provide drugs, gloves and other things needed in the hospital. When they provide the medical things needed, that is when free maternity will be a reality....” (RDW, IDI)</i></p> <p><i>“There are payments which are made there at the hospital. Sometimes - like the card, there is money that is paid....When you go to the laboratory, there is money that is paid. So others look at it as if this money is not supposed to be paid. So they think it is those doctors, who are eating that money or ‘I don’t know where it goes’. They fail to have that trust. So they say, “ I am not going to give my money!” (CHW, female, IDI)</i></p>	<ul style="list-style-type: none"> • Health facility management teams (HFMTs) • Managers and supervisors (mid-level and higher) • Providers • Community health Units (CHUs) • National & county governments (e.g. MOPHS, MOMS)

A support supervision style that encourages dialogue between supervisors and the supervised in a way that allows for a deliberative process was described by a district public health officer (*Table 11*). The notion of co-learning that emerges from a support supervision conversation may help address unique time-specific needs of different types of providers and in-charges to foster an amenable atmosphere for providing maternity services, increasing (downstream) women’s and communities’ trust. Given women’s and communities’ understanding that providers are overwhelmed at times and overworked,

both support supervision and disciplinary processes ought to be promoted at the health facility level. Though these supervisory and oversight mechanisms exist in public Kenyan facilities (e.g. disciplinary chain up from frontline worker to medical superintendent and back down), county governments would benefit from strengthening their functioning for facilities under their jurisdiction (via financial or technical support).

Increasing the collaborative spirit of providers is also a key part of building workplace trust in the facility, which, if the positivity of attitude translates into bedside interactions with women, will increase trust in providers and the facility. Though some nurses and doctors described within-cadre solidarity beyond their professional work, they felt less socially connected to other types of workers. Encouraging inter-cadre interactions may be one way to bridge this gap. The matron of the facility described attempts to reward high performers through different modes of encouragement and appreciation for all staff through a ‘party’ (*Table 11*). Nurses and clinical officers spoke of staff retreats as another potential team-building mechanism through which facility management could enhance cross-cadre communication and rapport. These types of informal gatherings, beyond the within-cadre communities that appear already to exist (e.g. postnatal ward nurses have a ‘*chama*’; clinical officers have a Facebook group), may help to address structural divisions that sometimes challenge collaboration in maternity settings. One way of institutionalizing inter-cadre rapport is through establishing annual (or bi-annual) social gatherings outside of the facility premises as well as encouraging cross-cadre *chamas*.

Health facility-related trust-building mechanisms also include addressing physical and material resource constraints (*Table 11*). Keeping providers informed about the stages of infrastructure improvement (e.g. new maternity wing built, not yet functional) may help to build providers’ and women’s trust in facility management’s making active changes to address congestion issues and increase privacy (as through changes in physical environment). In the interim, curtains were mentioned as an option that may facilitate some privacy, although from women’s and community perspectives curtains might have unintended consequences of worsening communication

(a content area of trust), for instance, if they exacerbate non-response to calls for help.

Communicating any changes to women and the community (via CHWs or radio media) is critical given the importance of past experience and the effect of information channels on their trust in a maternity setting.

Finally, enhancing transparency of facility processes is a key part of addressing the financial and logistical concerns and corruption norms. For example, as seen in prior chapters, though public fee schedules exist, they may or may not be visible to patients and their families. Furthermore, the individuals operating at registers may not adhere firmly to these fixed schedules, as experienced in the past by women and communities. This gives rise to women's and communities' skepticism about facility payment mechanisms. Publicly communicating fee schedules and requiring receipts to be given to patients at the registry may bolster trust at the facility level (Table 11). Given the recent context of free maternity – which, in theory, should eliminate some financial issues – the oversight of financial transparency to avoid corruption may need to be strengthened. In particular, unintended consequences of the free maternity policy include a potential increase in corruption due to high influx of women to the facility (for instance, increasing pressure to pay/accept bribes for more efficient service), thereby affecting financial trust in maternity settings. On the other hand, strengthening county and HFMT oversight mechanisms through audits and supportive supervision may curb informal payments at least to some extent. In order for such oversight to occur, it is imperative to draw on feedback mechanisms that begin to address accountability and structural determinants of trust.

Accountability and structural factor -related mechanisms

All participant perspectives describe sustained community-facility feedback as integral to reciprocally building trust and accountability in the maternity setting. Empirically derived mechanisms that enable effective feedback and continued community participation include: monitoring women's maternity experiences, complaints, and rights-violations; strengthening community-facility linkage to actively build and sustain a trusting environment for maternity care;

and ensuring continuity and sustainability through programmatic, financial, legal, and policy commitments (Table 12).

Table 12. Trust building through accountable feedback and structural considerations

Trust building mechanism	Supporting quotations	Key stakeholders to involve
<ul style="list-style-type: none"> • Monitoring (reporting) and feedback of maternity experience, complaints, and rights • Strengthen community-facility linkage through <ul style="list-style-type: none"> (1) Dialogue days between providers and communities (2) CHW mediated feedback channels • Continuity and sustainability <ul style="list-style-type: none"> (1) Maintain programmatic commitment (2) Increase financial commitment (3) Enhance legal and policy commitment (e.g. health worker protections) 	<p><i>“Then the doctors should be aware of the complaints the patients have against them...for example, when this report [of collective voices] gets to the director, the doctors will be informed and they will act and reform accordingly.”</i> (RDW not in facility)</p> <p><i>“...if you don’t get feedback, you don’t know where you are going wrong, where you need to improve. Cause I have received feedback only once.”</i> (Nurse/midwife, in-charge)</p> <p><i>“I think maybe we can have a seminar where all the health workers are present. We can have a few women who have gone through the system and who really think they have valid complaints... and then, maybe they can air these things in front of the doctors and the nurses, then it can be like a discussion. I think it would really be a nice thing because you get to hear what the patients have gone through - cause they tell you their experience. And maybe the doctors and the nurses can feedback to the mothers. Then maybe all of them come up with a way in which they can improve in that.”</i> (Medical officer)</p> <p><i>“However much we put the suggestion boxes and encourage them to give the suggestions, I don’t think they do that....I would like to see a situation where all the health facilities have very active community health units in their catchment areas so that the dissemination of information will take place in a very good way. And then the feedback can also be got by the management in a very easy way.”</i> (DPHO)</p> <p><i>“Like now this program we have now of Heshima project, we have been going round... it should not only be done annually; it should be a continuous process so that our people who did not know their rights and their roles in the facility, we have educated them. Like me I have gone round to women I have explained to them. I took the section on their rights which are enshrined in the Constitution of Kenyan. I would prefer this process or this project to be a continuous process.”</i> (CHW, IDI)</p> <p><i>“When we’ve done community strategy...ok fine, the government embraces community strategy. But we have seen the trainings and funding for the community strategy mostly coming from the donors... Of course, I know the donors are in collaboration with the government...But what I say is that it should be in the Ministry national budget.”</i> (DPHO)</p> <p><i>“Also it’s good for the patients to know that the health workers also have their own rights ... because the way the community believes is that health workers have no rights. They come and they demand so much from a health worker and a health worker is left there helpless with no one to support her or him.....Maybe there can be a government policy to protect the health workers.”</i> (Nurse-midwife, IDI)</p>	<ul style="list-style-type: none"> • Women (RDW) and communities • Managers and supervisors (mid-level and higher) • Providers • Community liaisons (CHWs, elders, chiefs) • NGOs involved in RMC activities (e.g. PC) • Advocates familiar with rights frameworks and with history of community mediation (e.g. FIDA) • Nursing association (e.g. NNAK or NCK) • Health facility management teams (HFMTs) • National & county governments

Developing a culture of reporting on maternity experience, complaints, and rights of patients emerges at the forefront of health system accountability and is salient in the revived structural spirit of devolution as well as in the prevailing ethos of people-centered governance. As described by both women and providers (*Table 12*), timely monitoring and feedback of women's maternity experiences is necessary to build trust via provider and health facility determinants (e.g. identify problematic provider behaviors or facility-centric issues undermining trust). Reporting ought to be operationalized through acceptable communications channels to accommodate both individual complaints and collective grievances (e.g. CHW mediators) to enable participatory action to enhance trust in maternity settings.

Providers, women, and communities feel that enhanced community-facility linkage enables the mutual understanding and open communication needed to build trust in maternity care. A female medical officer elaborates on one plausible mode for community-facility linkage in which providers and women are brought together to have structured dialogue about positive and negative experiences (*Table 12*). The goal of such a dialogue revolves around understanding what went wrong in the care process from multiple perspectives, thereby legitimating both patient and provider standpoints. Such deliberative processes for finding solutions may require mediation by a third party such as a CHW, manager, or unrelated socio-legal broker. The matron and DPHO (representing facility and community health management perspectives) reiterate the importance of “Dialogue Days⁶” or “Action Days⁷” but mention that despite guidelines for these forums (e.g. Heshima interventions), implementation occurs infrequently in practice. The DPHO suggests that this challenge can be partially attributed to the weakness of community health units (CHUs) (comprised of CHEW, CHWs), to which each former district bequeathed a set of unique challenges (catchment population variation, geography, insufficient numbers of CHWs, etc.). In light of devolution, the DPHO

⁶ Days where health facility providers, management and CHWs come together to discuss and address challenges in health service provision and receipt.

⁷ Similar to dialogue days but include community voices

describes the promise of active CHUs and their ability to link functionally with hospital boards through the new county governments (*Table 12*). The majority of respondents agree that the presence of ‘suggestion boxes’ to lodge individual complaints was ineffective; rather, the involvement of community-facility liaisons in collective feedback of complaints and propositions is more likely to enhance health systems trust.

Finally, ensuring continuity and sustainability with respect to programs, financing, and a supportive legal and policy landscape is integral to trust-building in maternity care. Examples of necessary programmatic and financial commitment are described by a CHW involved in direct implementation of the Heshima community interventions and the DPHO with respect to dependencies (e.g. external funder) and challenges associated with the community strategy (*Table 12*). In terms of the legal and policy environment, health worker protections emerge as a structural consideration to mitigate frontline provider blame in the institutional hierarchy (*Table 12*). ‘People-centeredness’, under the new constitution, ought to encompass addressing the needs of lower cadre health providers who not only work in under-resourced conditions, but also have considerable influence in shaping a maternity environment that promotes trust. Though protections were explored only in the health facility setting, it is likely a concern for CHWs operating in the community with little support. Given that trust in maternity settings build on trust in both providers and CHWs (Chapter IV), supportive legal and structural mechanisms for both groups, in parallel to the on-going women’s and community rights efforts, are likely to promote a more trustworthy labor and delivery environment.

Stakeholders

The nature of building trust in maternity care renders it a norm-shifting systems effort; the multi-faceted mechanisms proposed require the involvement of a range of stakeholders. In addition to women, communities, providers, and management involved in maternity care, such an effort requires the involvement of community liaisons (CHWs, elders, chiefs), civil society organizations concerned with RMC or quality of care activities, legal advocates familiar with national rights frameworks, health professional associations, health facility-management teams (HFMTs), community health units

(CHUs), and national and county governments. Different mechanisms require buy-in from various stakeholders in both planning and implementation. For instance, health facility trust-building mechanisms (broadly) may require the government to provide sufficient supplies and may require HFMTs to institutionalize inter-cadre team-building activities. A dialogue day may require the involvement of HFMT-CHUs (as implementers), mid-level managers and supervisors, women and community participants, and an NGO mediator. Amongst all the stakeholders, study participants unanimously concur that CHWs play a pivotal role in building trust in maternity settings.

As ‘patient, community and facility advocates’, respected ‘health experts’, ‘social support persons’ and ‘mobilizers’ in the community, CHWs are uniquely positioned to build trust; however, they face a number of challenges. CHWs express frustration with the current community-facility feedback loop given the lack of responsiveness to concerns raised from those managing the community strategy and the facility board. In addition to the lack of recognition they sometimes experience at facilities (Chapter V), CHWs also describe difficulties they face in covering their allotted area; moreover, despite their love and commitment for the work they do, its voluntary nature poses challenge for their ability to sustain high levels of performance over time, given that many CHWs have families to support. Providing CHWs with stipends or supporting them with income-generating activities (e.g. dairy farming, assisting at health facility) are described by the DPHO and CHWs as ways to address CHW financial concerns. CHW recognition (e.g. certificates) would help boost morale and show appreciation for their work. Irrespective of these challenges, the value of CHWs as a bridging group that can monitor women’s experiences and promote real dialogue between facility providers and communities has implications for trust-building.

Chapter Summary and Interpretation

Building trust in maternity care requires a multi-pronged effort by a range of stakeholders, from users of care (women and communities) to providers and management and governance structures, which include government, civil society and donors. Maternal health education and rights-based empowerment are key trust-building mechanisms targeting users. These mechanisms not only

affect women's perceptions of risk and demystify facility-based processes, but they also demonstrate that other actors value communities' collective voice as a part of demanding health facility responsiveness. Provider-related mechanisms revolve around training, incentives, and modifying work environments to enable more empathetic relationships with women delivering. A range of health facility improvements affect impersonal trust in the maternity setting; some are tied to structural decisions at county and national levels (e.g. hiring, procurement) while others may be accommodated at the facility level (e.g. staff rotation, recognition, supervision, inter-cadre bonding opportunities, transparency in fee schedules,). Community-facility linkage, the roles of intermediaries (e.g. CHWs), and the development of a culture of reporting are particularly important for trust building in maternity care. Structural considerations at county, national, and international (donor) levels related to supportive programmatic, financial, legal, and policy commitments are critical to realizing the potential for building and maintaining trust in maternity settings in Kenya.

Education and empowerment

Maternal health education and women's empowerment in this chapter are key trust-building mechanisms; these strategies have been associated to varied degrees and in differential ways with increased birth preparedness and utilization of facility-based maternity care in a number of African settings (Fotso et al., 2009b; Ganle, 2014; Jennings et al., 2010). In Nairobi's slums, for instance, though education appeared to influence care-seeking, intra-household autonomy had a more nuanced relationship with facility delivery in that its effect varied by economic status (less of a positive effect in poorest women) (Fotso et al., 2009b). In Ghana, education and community mobilization strategies to increase rights awareness, and efforts to demand that facilities be 'culturally responsive', parallel mechanisms proposed in peri-urban Kenya (Ganle; 2014). Additionally, discussions around outreach mechanisms (use of RMC and service charters) in Kenya suggest that these ought to be integrated into training materials in preparing mothers for facility delivery. The use of charters that incorporate community participation and voice (rather than static messages of obligations) are important for cultivating the kind citizen-user dynamic that is required to promote trust in hierarchy-laden public

health service delivery systems (Gaster & Deakin, 1998). In Benin, pictorial counseling aides serve as empowering and educational tools for birth preparedness (Jennings et al., 2010). The utility of these job aides may be limited to addressing perceptions of risk at the individual level; at the community level, birth preparedness beyond minimal ANC-based education can be modeled on group ‘centering pregnancy’ sessions piloted in sub-Saharan Africa (Patil et al., 2013). In the Kenyan context, sessions ought to cover labor and delivery procedures, roles of different provider cadres, financial and logistical processes, and family planning.

Increasing rights-awareness and overall empowerment (i.e. to speak up in maternity contexts or report complaints) of women and communities in this peri-urban context is linked to a discursive process. FGDs in peri-urban Kenya show that users prefer to engage actively in group discussions that foster a sense of learning and shared understanding of maternity experiences. Action researchers have noted that FGDs may have multiple functions; mechanistically, FGDs are at the intersection of pedagogy, activism, and interpretive inquiry (Dimitriadis, 2011). This method is considered particularly apposite when engaging gendered groups in current social and political debates. Given population demographics and political timing of this dissertation research, the current Kenyan peri-urban context fit these characteristics with respect to prevailing rhetoric of trust, rights, and accountability of government (in general) and free maternity care (in particular). Accordingly, group discussions may have encouraged to some extent, through the promotion of dialogue, critical questioning amongst women and may have instilled increased readiness to ask for one’s needs in the maternity setting. Practices of discussion-based education and empowerment through community are supported by theoretical literature on ‘communicative action’ and trust (Kemmis, 2006; Thiede, 2005) and practice-based research showing positive effects of women’s groups on maternity care-seeking (Manandhar et al., 2004).

A ‘comfortable’ and just health provision environment

Creating a comfortable and ‘trustworthy’ space (physical, psychosocial, navigable and responsive) for maternity care delivery and receipt is critical to building trust amongst facility

providers and management, as well as for women and their families. The emphasis of provider interpersonal skills training on qualities like empathy, reciprocal dialogue, and responsive bedside manner echoes findings from RMC, trust, and communication literatures (Bohren et al., 2014; Karkee et al., 2014; Østergaard, 2015; Roter, 2000; Roter & Larson, 2002). Moreover, though women and community's interpersonal trust building at the facility hinges on provider interaction, impersonal trust draws on facility infrastructure changes, technical capacity, the maintenance of a clean and resource-equipped environment, and the cultivation of positive socio-political conditions (supervisory, collegial) in the workplace (Gilson et al., 2005). Similar considerations and recommendations around working conditions have been made across quality of care studies in East Africa (LT Mselle et al., 2011; Lilian Mselle et al., 2013; Pearson & Shoo, 2005). Promotion of facility environment changes and provider recognition to improve staff morale and interpersonal patient-provider dynamics echoes a need for health worker justice in health facilities (Aberese-Ako et al., 2014; Gilson, 2007). For example, in Ghana, insufficient resource allocation and inadequate implementation of a free maternity policy led to a sense of 'unfairness' at the level of the health system amongst frontline workers (Aberese-Ako, et al., 2014). Critical to trust building in the Kenyan peri-urban health systems context is the reduction of corruption – which at the facility level requires better supervision (e.g. in health facility), increased oversight (e.g. county governments, CHUs), and enhanced transparency in payment mechanisms.

Community participation and “cultural security”

Trust building, as it relates to accountability, should embrace the notion of “cultural security” as a result of community participation. Michael Thiede defines this principle as the acceptability of health delivery systems (which includes maternity care) that extends beyond technical quality, and is grounded in the expectations and needs of the local people (i.e. is ‘culturally secure’) (Thiede, 2005). He further describes that incorporation of people's expectations as a dialogic process integral to trust. Community-facility linkage was noted by all groups of respondents as a critical way of monitoring facility improvements in realizing women's rights to a dignified childbirth and a way to build and

maintain trust. This trust-building mechanism draws on Brinkerhoff's notion of political or democratic accountability, Gilson's idea of social fabric and Thiede's conception of cultural security (Brinkerhoff, 2004; Gilson, 2003; Thiede, 2005). Once this cultural security has been established, trust grows out of the communicative action process that elicits 'accountable' responses from those in power (e.g. facility managers, county governments). Feedback loops represent a mode of communicative way to achieve 'cultural security', by situating perceptions of patient-provider and patient-health system interactions within the broader 'social fabric'. In peri-urban Kenya, community-facility linkage - either through formal dialogue days that encourage participation or individual feedback streams through CHWs - promotes communicative action and builds trust.

Structural context and stakeholders

Building trust in maternity care requires a health systems approach that necessitates oversight, financing, and a supportive policies environment. Stakeholders' commitments need to align in order to encourage non-corrupt and fair behaviors in management-health provider, health provider-patient, health provider/facility-CHW, and health facility-community relationships. First, the responsibility of oversight ought to be placed on both the public and county governance structures to assure a real 'people-centered' accountable system as prescribed by the new constitution. Second, in order to operationalize an accountable oversight, there is also a need for public comprehension of the system, which can be achieved through media advocacy and other awareness generating avenues (Gesami, 2013; Ghai & Ghai, 2011). Given the institutional hierarchies in which stakeholders sit (i.e. power they hold) and the prevalence of corruption as a complex trust determinant, addressing this issue requires both bottom-up and top-down approaches to encourage reporting, allow for disciplinary action, and address provider incentives. Maintaining active and functional CHUs by assuring financial support to those carrying out a range of monitoring and feedback activities around RMC is critical to achieve better feedback within the devolved government and free maternity context. Strengthening CHUs requires further understanding social support networks and inter-worker

collaboration between CHWs; these networks may have direct implication for interaction-based (interpersonal) trust as seen in Ethiopia (Dynes et al., 2014).

Intra-facility processes and policies that guide professional rhetoric (e.g. rights and obligations) may need to change in order to motivate and sustain health workers facing a range of barriers to functioning (Aberese-Ako et al., 2014). Moreover, given the gendered structure of health facilities and vulnerabilities of the lower cadres of health workers (Grimen, 2009; Jewkes, 1998; Mselle et al., 2013) (Lilian Mselle et al., 2013), provider protections at the policy level ought to be considered. Protections and rights should further extend to CHWs, who may have even less support from formalized professional networks compared to facility-based workers, and who may experience more pointedly the gendered reaction of the community in which they work (Hurley et al., 2014). Establishing provider protections and engaging actively with rights-driven mechanisms have the potential to tackle problematic institutional hierarchies and practice norms. These mechanisms promote culturally secure maternity care and consequently enhance trust in the maternity setting.

VIII. Discussions and Conclusions

Discussion

The research objective of this dissertation was to contextually explore, across hierarchical perspectives, features of trust in a facility-based maternity setting and propose potential avenues for building trust in a peri-urban county in Kenya. The theoretical lenses of appreciative inquiry (AI) and institutional ethnography (IE) enabled the qualitative researcher to gain in-depth contextual understanding of the manifestation and determinants of trust in the maternity setting, and to propose mechanisms for its enhancement. Findings from Chapters IV-VII build steadily on both combined perspectives (Chapters IV and VII) and unique standpoints (Chapters V and VI) to develop a multi-faceted determinants framework for trust in the maternity setting. The structure of the discussion and conclusions chapter first highlights significant chapter-specific findings in the ‘summary of results’. It next reflects on broad cross-cutting themes related to trust in the maternity setting, including complexity and dynamism, perspective, social-political context, and trust equity. This is followed by discussion of theoretically informed research process, data quality, and transferability. This chapter elaborates on strengths and limitations, offers recommendations for future research, discusses implications for policy and programming, and presents a general conclusion.

Summary of results

The findings reported in Chapter IV suggest that trust in maternity care is complex, multidimensional, and an intrinsically and instrumentally valued construct in the peri-urban Kenyan context. Trust in the maternity setting can be categorized into four generalized types: trust in the provider; trust in the facility; trust in CHWS (representative of community health system); and workplace trust. Understandings of trust are nested in broader conceptualizations of ‘trust in social institutions’ and ‘general societal trust’ (*Figure 4*). Considerable overlap of trust content areas across relationship types and perspectives suggests that despite the seemingly elusive nature of trust, there is a generally shared sense of the concept’s features across hierarchical perspectives. Moreover, hierarchical perspectives agree that women’s and community trust is of integral importance in

maternity settings, not only in light of the generic urgency and unpredictability associated with childbirth, but also in light of the specific current socio-political Kenyan context. Local notions of confidence, communication, integrity, mutual respect, competence, fairness, confidentiality, and systems trust resonate largely with the Health Systems Trust: Content Area Framework definitions; this resonance suggests that, despite unique manifestations and terms used in this particular sub-Saharan context, health systems trust may be a globally transferrable concept.

Chapters V and VI present the determinants of interpersonal and impersonal trust in a maternity setting from generalized ‘user’ (Chapter V) and ‘provider’ (Chapter VI) standpoints. These chapters focus primarily on ‘trust in provider’ and ‘trust in facility’ relationships; and more peripherally on workplace trust as relates to health worker collaboration. The AI and IE theoretical lenses allowed for triangulation across perspectives with respect to what determines trust in the maternity setting. The women and community standpoint provided baseline insight into maternity experiences, which allowed for understanding the health systems and socio-political relationships that affect trust. Corroborating these perspectives with those of providers and management through critical probing and exploration of challenges associated with maternity care provision (e.g. working conditions, mental fatigue, motivation, supervision, teamwork), resulted in the emergence of a multi-faceted determinants framework. Trust determinants in the maternity setting cluster around patient/individual, provider, health facility, community, accountability, and structural factors. Patient/individual determinants include prior experience, perceived risk or harm, childbirth outcomes, and maternity care literacy. Provider factors include empathy and respect, personalized attention and care, perceived ability, discrimination and corruption. At the health facility interface, determinants include responsiveness in emergencies and “good services”, physical environment and cleanliness, navigability of processes, management and oversight, discrimination, corruption, and coordination amongst providers. Community factors revolve around reputation and social history, corruption norms, information transmission channels, and maternity care literacy. Accountability cuts across the four prior factors (patient/individual, provider, health facility and community; see *Figure 6*) and

manifests in expectation-action dynamics, adaptability to policy change, and the incorporation of community and intra-facility feedback. Structural factors cut across the five prior factors (see *Figure 6*) and reflect power dynamics affect working and therapeutic relationships in the maternity setting. These power dynamics include institutional hierarchies, written policies and professional codes and the transitional devolution process. The complexity of the framework lies in how determinants at various levels relate to one another in influencing trust, at times simultaneously and in both positive and negative ways.

Chapter VII shows that building trust in maternity care requires a multi-pronged health systems approach that involves various actors, from users (women and communities) to providers, to facility management, to government, to civil society and donors. Proposed trust-building mechanisms targeting patient/individual and community determinants include maternal health education and rights-based empowerment, while provider-centric mechanisms cover interpersonal skills training, incentives and work support conditions. Trust-building mechanisms clustered around the health facility comprise staff rotation, support supervision, inter-cadre bonding opportunities, infrastructure improvements, and enhanced transparency in processes and fee schedules. Hiring additional providers and improving material resource procurement address health facility determinants; however, in the public sector, these are tied to structural decisions at county and national levels. Accountability-centric trust-building mechanisms include enhanced community-facility linkage, the roles of intermediaries (e.g. CHWs), and a developing a culture of reporting. Structural considerations at county, national, and international (donor) levels related to supportive programmatic, financial, legal and policy commitments are critical to building and sustaining trust in maternity settings in Kenya.

Cross-cutting theme: Complexity and dynamism

Complexity and dynamism emerge as key concepts that integrate features of trust in the maternity setting across chapters. The typology of relationships in maternity care and multidimensional nature of trust described in Chapter IV illustrates concept's complexity and nuance. For example, complexity in studying both interpersonal and impersonal relationships shows that these

may reinforce or undermine one another (e.g. a woman's trust in provider may or may not be tied to her trust in the facility). Multidimensionality of trust further adds a layer of complexity to understanding how this concept manifests in different relationships (e.g. content area coverage by perspective). This complexity often challenges researchers' ability to isolate trust as a construct and points toward the value of contextualized understanding. Chapters V and VI reveal a complexity in the multi-faceted determinants framework: namely, that each individual determinant as well as each collective set of factors may affect trust in the maternity setting in concurrent, but different ways. Multiple determinants may affect different content areas of trust and trust relationships simultaneously – for instance, a woman's perception of low infection risk (patient/individual factor) may enhance her trust in the facility (content areas: competence, systems trust) while prior harsh treatment or unempathetic providers may undermine her trust in the provider (content areas: confidence, communication). Complexities around what influences trust manifest across determinants are particularly challenging when considering accountability and structural factors. Chapter VII's multi-pronged set of potential trust-building mechanisms exhibit a complexity in the range of stakeholders (with unique interests) as well as the need for institutional commitment – accordingly, the devolution transition in the Kenyan political context poses a challenge as well as a window of opportunity. Despite its complexity, the intrinsic and instrumental relevance of trust resonates across the dissertation chapters.

The dynamics of trust – that is, how the construct changes over time – threads through the chapters and provides insight into what undermines and enhances trust in the maternity setting. Trust is socially embodied phenomenon, which in a particular setting like maternity, may exhibit fragility. Chapter IV suggests that impersonal trust tends to be more stable than interpersonal trust in the maternity setting that was studied (e.g. trust in facility vs. trust in provider). It further suggests that if confidence, communication, and systems trust are broken in maternity settings – which, according to user and provider perspectives (Chapters V and VI), often occurs – trust may be difficult to reestablish. For example, the reputation or socio-political history of a facility (e.g. detention) may

affect the trust that a woman and her community place in that facility (whether for maternity or general health care). Breakdown of women's trust, compounded by their gendered role in the household, may have ramifications for trust's instrumental role in motivating their intentions to seek care for themselves or their family members. In the case of the patient-provider relationship, trust's dynamic nature is propelled by the intensity of the labor and delivery period, as described in Chapter IV. Trust in providers, as determined by prior experience, may exhibit slower development over time (through single or multiple pregnancies), as echoed across Chapters IV, V, and VI. The stability and dynamism of impersonal trust in the facility is tied to the rapidity and nature of information flow within the community, sustained community-facility feedback, and resiliency to policy shocks (Chapters V, VI, and VII).

Cross-cutting theme: Perspective

The notion of perspective reflects the social constructivist paradigm and links the findings in this dissertation in multiple ways: first, through explicit focus on hierarchical and multiple types of perspectives; and second, through a gendered perspective that captures the intersectionality of health system embedded power structures as experienced by frontline female providers.

Hierarchical and multiple types of perspectives

Drawing on hierarchical perspectives allows for a more contextualized exploration of trust and explicitly incorporates embedded positions of power into the analysis (Grimen, 2009). Bringing to bear multiple standpoints (users, CHWs, providers and management) in a purposeful way enables a comprehensive description of trust at the facility-based care interface. If provider and management perspectives alone had been solicited, the content area of fairness (Chapter IV), the influence of discrimination and corruption as determinants (Chapter V), and trust-building mechanism of community-facility linkage (VI) may not have readily emerged. Contrastingly, if the study captured solely women and community perspectives, the importance of confidentiality (Chapter IV), maternity care literacy, and structural determinants (Chapter V) would have emerged less clearly. In eliciting perspectives rooted in the positional power of health worker cadres both in the facility (nurses,

doctors, management) and community (CHWs, management), the study unveils nuanced understandings of the multi-faceted trust determinants as well as the heterogeneity of the dominant discourse (medical experts) in maternity care (Chapters V and VI).

Hierarchical perspectives suggest reveal a shared trust understanding. In Chapter IV, the confluence of trust relationship type and perspective (e.g. *Table 7*) suggests consensus around the underlying concept with slight variation in how certain content areas (e.g. confidentiality, fairness) manifest across type and perspective. In Chapters V and VI, perspective plays a clear role in the emergence of findings as they typify a particular standpoint on the institutional hierarchy. Despite divergence in respondent groups' descriptions of certain determinants (e.g. maternity care literacy, discrimination), provider perspectives on what determines trust in a maternity setting align to a large degree with descriptions by women and communities. For example, both user and provider standpoints articulate that not only an individual's prior experience and outcome influence trust, but also that one's trust can be influenced her social networks. Trust-building mechanisms (Chapter VII) are rooted in a consensus among the viewpoints of varying hierarchical perspectives on potential changes to each multi-faceted determinant cluster.

In addition to hierarchical perspectives, the use of both individual and group-normative perspectives enables a richer contextual exploration of trust. Across chapters, it is noted that collective perspectives (FGDs) resemble individual perceptions (IDIs) of trust. This suggests that there is an influence of community norms on both psychosocial attitudes (e.g. trust) and behavioral intentions (e.g. care-seeking). Corroboration of individual and collective perspectives, for instance, allows for confirmation of the finding that an individual's trust in maternity care may be affected by the information she learns from her social network.

Gendered perspective

Sensitivity to gender as a both a social norm and a structural process weaves together the perspective in which trust in maternity care manifests throughout the research reported in this dissertation. First, given the notion of childbirth as traditionally a women's issue in Kenya (Nasong'o

& Ayot, 2007) and women's experience of disrespect and abuse in this peri-urban maternity context (Abuya et al., 2015), this study actively engages and incorporates views of women and female providers in defining trust, exploring its determinants in maternity care (Chapter IV, V, VI). It further elevates women's perspectives through communicative action (Thiede, 2005) by appreciatively asking these groups how to build trust in the maternity setting (Chapter VII). Enabling voice for communities in general and women in particular has long been advocated by feminist scholars motivated by concerns of social justice.

“Group interviews are particularly suited for uncovering women's daily lived experiences filled with cultural symbols, words, signs and ideological representations that reflect different dimensions and of power and domination that frame women's quotidian experiences.....help both individual women and groups of women find or produce their own unique and powerful ‘voices’.” (Madriz, 2000)

Given that women's perspectives are paramount in studying maternity care in Kenya, the study draws both on group and individual perspectives; which in this context complement one another.

The structural perspective of gender is most apparent in the chapters that elaborate specifically on distinct user and provider voices (Chapters V and VI). Dialoguing between the different hierarchical perspectives further allows for understanding the structured (gendered) relations through which power operates in the maternity settings. Frontline female providers best illustrate the gendered perspective in this peri-urban context, which reflects the intersectionality of professional and social power-laden structures. Intersectionality refers to when and how an individual occupies multiple categories (Delgado & Stefancic, 2012). For instance, the nurse-midwife embodies the dominant professional discourse as trained health provider, which positions her as having high power compared to delivering women in the therapeutic dyad; however, she also falls victim to an under-resourced setting where she holds low power compared to mid-level and top facility management (Aberese-Ako et al., 2014; Gilson, 2007). As seen through the role of the midwife in Chapter VI, intersectionality represents a structural factor in process (institutional hierarchy). When exacerbated by a lack of protections and facility determinants (e.g. limited support structures, congested physical environment, inadequate material resources), this structural factor may lead to transference of mental

fatigue onto laboring and delivering women (via disrespectful or abuse practice), which has subsequent implications for trust.

Cross-cutting theme: Inequity

The consideration of perspective relates to the emergence of another linking theme: inequity. Inequity factors into the selection of an underserved peri-urban area where poorer women experience higher incidence of disrespect and abuse in maternity settings (CRR/FIDA 2007) as well as through its implications for cross-chapter findings related to fairness, systems trust, discrimination and corruption.

First, this study focuses on perspectives within a peri-urban area, which complements regional maternity care work in urban and rural settings in Africa (Bazant & Koenig, 2009; Ng et al., 2014; Ni Bhuinneain & McCarthy, 2015). Peri-urban populations are particularly vulnerable; while they live closer to urban centers with higher costs of living, their socioeconomic capacity is closer to that of their rural counterparts, rendering these groups vulnerable to high levels of inequality in terms of access to health services. The majority of our community perspectives represent this underserved group residing in slum-village environments. The dissertation focuses on perspectives of those who suffer from inequitable burden of trust and acceptability barriers as described below by Lucy Gilson

“Acceptability and trust barriers are clearly disproportionately faced by socially disadvantaged groups in all societies, and influence both the distributional and procedural justice of health care. As structural and power relations influence patient and provider behavior, and the interactions between them, an examination of acceptability barriers demonstrates, moreover, how social inequality is embedded within health care.” (Gilson, 2007).

The focus on a geographically understudied locale and on socially disadvantaged perspectives (both women and frontline providers) renders this study’s findings interpretable through an inequity lens.

Inequity – particularly as relates to discriminatory maternity experience and financial trust – resonates across chapters. In Chapter IV, consensus around the importance of ‘fairness’ and ‘systems trust’ manifests as in the ‘need’ to provide equitable care to all women irrespective of perceived wealth status or any other arbitrary factor. Chapters V and VI further describe discrimination (present

and past) in maternity care (e.g. longer wait times and detentions for inability to pay) as undermining trust in providers and facilities. Not only is corruption a cross-cutting and a particularly challenging trust determinant to address, it inequitably burdens the poor in terms of undermining trust and limiting access to quality care. Prevailing anxiety around payment mechanisms at facilities and anticipation of increased informal payments in light of the new free maternity policy across chapters suggest that wealth status (ability to pay) and the social norm of corruption may jointly influence trust or mistrust of facilities.

Cross-cutting theme: Socio-political context

Trust is intrinsically tied to social-political context beyond the facility – it hinges on how these structures influence maternity practice norms and the social history of a health facility. This is captured in the nested trust types (Chapter IV), multi-faceted determinants framework (Chapters V and VI) and the proposition of trust-building mechanisms (Chapter VII). In particular, the socio-political context of Kenya’s new constitution, transitioning governance structures, and the free maternity policy are critical to interpreting trust in this peri-urban maternity setting. The confluence of these policy factors as well as a generalized RMC rhetoric likely affect participants’ articulation of trust as a valued construct as well as their willingness to engage critical discussion around trust in maternity care and health facilities at large.

New constitution and devolution

The 2010 Kenyan Constitution and spirit of devolution grew out of over a decade of active national and international politics, committed policy champions, civil society lobbying, and the impetus for change amongst citizens expressing frustration at unchecked authoritarian regimes. The new constitution embraced the rhetoric of ‘accountability’ and ‘people-centeredness’, direct implications for trust in public facilities. In particular, these widely publicized discourses appear to have linked to trust determinants and proposed trust-building mechanisms in the maternity setting (Chapters V, VI, and VII). For instance, the rhetoric of ‘people-centeredness’ can be linked to both facility determinants (e.g. personalized care) and accountability factors (e.g. incorporation of

community voice). Community-facility linkage as a trust-building mechanism is likely also influenced by principles of ‘accountability’ and ‘people-centeredness’ (Chapter VII). Moreover, the notion of health rights and equity embedded in the Constitution (Ghai & Ghai, 2011) likely affects participant descriptions of fairness as a content area of trust in maternity settings (Chapter IV).

Devolution transfers a range of national powers to county level, which in the case of maternity care, translates into political restructuring of health facility management and community health leadership. The devolution transition process has implications for accountability and health facility determinants of trust (Chapters V, VI, VII). For example, communities, CHWs, managers and officials felt that devolution offered a promising structural change that could lend itself to better oversight through formal audits and enhanced community-facility feedback (e.g. accountability trust-building mechanism) to ensure overall facility responsiveness to maternity care (e.g. facility determinant of trust). Providers see devolved governance structures as another type of institutional hierarchy that could positively or negatively affect their interactions with patients depending on how much flexibility is granted to facility management around procurement of supplies (health facility factor) or the timeliness of performance feedback (accountability). The efficiency and effectiveness of the transition is a shared concern, particularly amongst people who occupy management perspectives (Chapter VI).

Free maternity

The free maternity policy emerged readily as a cross-cutting social-political factor characterizing the trust environment in the peri-urban maternity setting. Though free maternity addresses a subset of past facility-based maternity care concerns (e.g. detention, formal user fees), users and providers remain skeptical – to varying degrees – of its implementation (Chapters V and VI). Skepticism about the policy stems predominantly from the fear of its unintended consequences for the quality of women’s experiences (potential increases in D&A) and increased corruption due to elevated service demand. Women’s and communities’ concerns regarding depreciated quality draw upon their (mis)trust of other ‘free’ institutions (e.g. education) as well as shared experiences with

voucher-based maternity care (e.g. voucher users experience discrimination). These groups also fear the increase in corruption at the facility interface – namely, those who can afford it are likely to pay bribes and receive more responsive care (Chapter V). Given the expectation that free maternity will increase facility deliveries, women, communities and providers describe the need for government expansion and better remuneration of its public health workforce to accommodate this policy-induced burden (Chapters V and VI). Care users and providers concur that facility resilience to the free maternity policy shock (e.g. maintaining “good services”) is a key accountability determinant of trust (*Tables 9 and 10*).

Data quality and transferability

The credibility and dependability of the data comes from the qualitative researcher’s immersion in the context, the intimate nature of environments in which data were collected, and quality checks performed in the data management process. The qualitative researcher’s involvement in Population Council’s routine project implementation activities in facility and community settings allowed for familiarity with gatekeepers working in the peri-urban county. FGDs and IDIs were conducted in living rooms of homes, farmhouses, convenient community settings such as schools or churches, a small back room at the health facility, or offices of key informants. The intimate nature of these data collection venues allowed participants to feel comfortable and open up to interviewers and moderators. Participants often told data collectors, during their explication of the ‘trust ‘concept, that they trusted the study team. This participant-researcher trust grew out of shared conversations; participants describe the researcher’s willingness to listen to and care about their perspectives as a rare, authentic, and positive experience. Sometimes background noises of children playing, animals milling about, construction, or outside chatter or interruptions rendered audio-recordings more difficult to discern, posing challenges for transcription and translation. The data management team supported each other by validating audio segments and clarifying concepts and terms with the qualitative researcher, the interviewer/moderator, and a registered nurse midwife at the Population Council’s Nairobi office. Fieldnotes and iterative discussions concurrent with data collection allowed

for research assistants and the qualitative researcher to engage in the reflexive process required for rigorous qualitative work.

Transferability of findings

Study findings are likely transferrable to peri-urban environments in Kenya or sub-Saharan Africa that experience similar resource constraints and human capacity challenges in facility-based maternity care. The consistency of locally-derived trust manifestations of trust with the global perspective of the Health Systems Trust: Content Area Framework suggests conceptual transferability of trust to different care settings and LMIC contexts. The multi-faceted trust determinant framework is likely transferable other Kenyan provinces, although specific manifestations may vary based on socio-demographics and ethno-religious composition of the population. It can further be adapted to understand contextual factors in other sub-Saharan African settings. Finally, the meaning, determinants, and mechanisms of trust in maternity care may be transferrable to trust in the health system broadly as well as in other disciplinary areas including women's health and urgent care.

Strengths and Limitations

This study has a number of strengths and limitations that ought to be considered while interpreting its findings and conclusions.

Strengths

This study is the first to apply the unique lens of trust to better understand and address the increasingly visible problem of disrespect and abuse in maternity settings in peri-urban Kenya. It is the first to apply the Health Systems Trust: Content Area Framework in sub-Saharan Africa and to maternity care. Also, as far as the qualitative researcher is aware, it is the only one thus far to look specifically at how Kenyan socio-political contexts relate to trust in this peri-urban setting. A core strength of this study is its application of rigorous qualitative methodology that draws upon theoretical orientations of appreciative inquiry and institutional ethnography to elicit an in-depth contextual understanding of meaning, determinants, and potential trust-building mechanisms. The

combined AI and IE lenses facilitates a critical approach that incorporates power and perspective as central to understanding trust.

Study strengths further include the researcher's familiarity with applying qualitative methods in under-resourced settings and the week-long intensive training of data collectors. The data collection team worked jointly in a way to maximize each other's strengths (local experience, methodological expertise, language fluency) as well as draw upon the support of PC colleagues involved in the Heshima Project. Additional strengths are the researcher's post-fieldwork debriefs with research assistants and PC colleagues and her extensive fieldnotes that allowed for her to connect deeply with the data. The researcher's ability to quickly build rapport in the Kenyan context, as well as her involvement with the global RMC movement in which the study was nested, allowed for a more nuanced understanding how trust emerges in the context of maternity care in Kenya. The reflexive and iterative process was further strengthened by the application of AI and IE lenses to the data at the data collection and final analysis phases. Triangulation of multiple data sources including IDIs and FGDs, hierarchical perspectives, textual documents (e.g. service charters, monthly returns, etc.), observations made at the facility and community, peer-reviewed and grey literature, media clippings related to free maternity and current political debates in Kenya, and informal conversations with other researchers and program persons related to the field site strengthened framing of this study. The qualitative researcher presented an earlier version of this dissertation's findings at the Third Global Symposium on Health Systems Research in Cape Town, South Africa and considered the constructive feedback offered by attendees.

Limitations

One of the limitations of this study is that it is cross-sectional; a longitudinal design would have enabled for more time to follow up with women, communities, CHWs, providers and managers. It would have allowed for expanding the scope through additional probing for nuances of trust, its determinants, trust-building mechanisms, and a better understanding of how trust changes over time (across pregnancy stages including ANC and postnatal care and pregnancies). Follow-up interviews

would have allowed more time for rapport building, an important concern in qualitative interviews on sensitive topics. Though childbirth is a common topic of discussion for most women in the area, critical questioning around past experiences (e.g. disrespectful and abusive) and trust in power-laden systems with a history of ‘silencing’ (and given the sample’s coverage of poorer Kikuyu populations in the Central Province) required sensitivity. The qualitative researcher’s affiliation with a known NGO and her experience with qualitative methods in other urban-slum settings prepared her and her experienced local research team to encourage open communication in both FGDs and IDIs.

Conducting this research under the PC’s Heshima Project may have resulted in social desirability bias, in which participants make judgements (based on social norms) about what the researcher wants to hear and answer accordingly. ‘Heshima’ in Kiswahili means respect; and therefore as seen in chapter IV, mutual respect as an integral component of trust in the maternity setting may have emerged in part given indirect exposure to concurrent dignified care interventions. At times, these concurrent interventions rendered it difficult to disentangle trust’s meaning from its contextual determinants. The involvement of some of the CHWs, providers and management in RMC intervention activities in addition to their participation as subjects in this study may have affected their responses via social desirability. Engaging in a reflexive process and asking questions in different forms enabled the researcher to acknowledge this bias. It was likely that these contextual factors that allowed her to ascertain the ‘dominant discourse’ earlier on in each interview, which then could be followed up through critical questioning.

The fact that this study is rooted in perceptions and did not observe interactions limits its ability to distinguish between objective and perceived quality of maternity care, the latter of which (as seen in this study) is often linked to a subset of trust determinants. Given that all the data are self-reported in response to questions asked about respondents’ most recent maternity experience, the qualitative researcher attempted to minimize recall bias amongst RDW by selecting those who had delivered in the last year (for IDIs, in the last 6 months). RDW who had particularly negative

experiences may exhibit lesser recall bias than those with ‘normal’ and ‘generally positive’ experiences.

Another limitation is related to the study scope in one sub-county facility and its catchment area. Conducting similar qualitative exploration in rural settings; in predominantly low or high income settings; in ethnic, religious, or linguistically heterogeneous populations, and in different provinces would have provided information on the variability in contextual understandings (i.e. socio-political and cultural context). The study lacked capacity to fully understand trust in CHWs and the role of intermediaries in building trust, in part due to its facility-centeredness and the limited number of CHWs interviewed. Finally, the study’s scope may limit transferability of the Health Systems Trust: Content Area Framework to the conceptual level; a mixed methods approach may have allowed for the development of trust scales, conducting factor analysis on content areas or quantifying the influence (magnitude and direction) of determinants on trust.

Recommendations for future research

The findings from this study raise a range of questions around the conceptualization, measurement, politics, and consequences of trust in maternity care and in health systems broadly.

First, given study findings support the Health Systems Trust: Content Area Framework, a series of questions around the quantification of trust through scale development, adaptation and validation emerge. Development of a quantitative measure would enable trust monitoring for routine use or research purposes. Such a measure ought to capture the content areas identified in this study: confidence, communication, integrity, mutual respect, competence, fairness, confidentiality, and systems trust. Adapting existing Likert scales to the Kenyan context requires that these content areas linguistically reflect the spirit of local sentiments of the content areas (e.g. “I am confident that the nurse will come when I call out in pain.”)

Second, qualitative exploration of trust in the maternity setting often raises questions around the nature and dynamics of trust in other types of health areas – in both emergency and non-emergency settings. Do peri-urban Kenyan residents understand trust in maternity care in the same

way that they trust a facility for other reproductive health, child health, infectious or chronic disease needs? Are the trust content areas of confidence, communication and systems trust that appeared central in the maternity context similarly dominant in generalized emergency care settings? How fragile is trust in maternity care – is impersonal trust of a facility more stable than interpersonal relationships? Conceptually, the study suggests that trust may be mediator in the psychosocial pathway relating experience to care-seeking. What is the nature and direction of this relationship? To what extent does trust mediate other contextual (social, political, economic, cultural) factors relationship with care-seeking?

The next series of questions raised by this body of work relate to the multi-faceted determinants framework. How does the patterning of trust determinants in a peri-urban setting compare to that in rural area or urban areas? How does it compare to other counties with different demographic characteristics or social histories (e.g. ‘equally poor’ counties, predominantly a non-Kikuyu ethnic group, Coastal province)? Are certain factor clusters (e.g. structural, provider) or unique determinants (e.g. corruption) more influential with respect to determining (positively or negatively) trust in maternity care? How does the framework resonate with other highly unequal peri-urban settings globally (e.g. under-resourced areas with mixed public-private composition of options for care)?

The role of communities, CHWs and community-facility linkage emerge as particularly important in understanding both trust determinants and trust-building mechanisms. How a community’s trust in CHWs relates to their trust in formal health delivery systems emerges as a key area to explore for better policy and programming. The role of information channels – particularly social networks – in building, maintaining, or undermining trust in maternity care requires further exploration. The use of social network analysis may help to determine how effective informal networks are in influencing women’s trusting attitudes and care-seeking intentions. Given that community-facility linkage as a trust-building mechanism emerges in a specific socio-political climate, how would such a participatory process work in a transformative setting? Longitudinal study

designs would enable exploration of whether community-facility linkage or other proposed mechanisms actually build trust.

Finally, this study proposes the need to further explore how structural factors relate to trust in different settings (e.g. health settings, geographic settings, and ethnic/religiously heterogeneous settings). Central to such future explorations is the importance of studying power as an undercurrent to trust. This dissertation utilized appreciative and critical lenses that incorporated hierarchy as a way of accounting for power into the study design. It further elaborated on how a particular policy context (e.g. free maternity, devolution) affected trust in the relational interface between users, providers and managers of facility-based maternity care. There is a need for expansion of theory-driven qualitative and mixed methods approaches that seek to understand how socio-political factors influence trust in the health system.

Implications for policy and programming

The following policy and programming recommendations are presented in light of the dissertation chapters, the Heshima Project setting in which study is situated, and the ‘discontinuity’ (Giddens, 1990) characterized by political and policy climates of the new constitution, devolution and free maternity. They revolve primarily around the importance of creating communicative action around maternity care as a starting point, but maintain the perspective that such an agenda will likely accrue benefits to health systems accountability in women’s health and general care-seeking in peri-urban LMIC settings.

Strengthen community-facility linkage

The importance of community-facility dialogue – through direct (e.g. dialogue days between providers and communities) and indirect (via CHWs or other community leadership) mechanisms are critical to building and maintaining trust in maternity settings over time. At the policy level, these mechanisms involves oversight bodies (e.g. new county government) to hold facilities health management teams (HFMTs) and community health units (CHUs) accountable to conducting routine

feedback sessions. At the implementation level, sustained community-facility dialogue requires understanding and supporting the needs of intermediaries (e.g. CHWs). Moreover, this demands that facility boards and CHUs increase routine communication around facility practice norms and women's experience of care. In the case of direct mechanisms, the benefit of active listening and deliberation provides a positive opportunity for understanding challenges of both users and providers. In the case of indirect mechanisms (e.g. particularly negative experience that need redress), there is a need to involve the legal system to assist CHWs in mediating with health facility boards. This notion of multi-sectoral action is in line with current Heshima interventions, in which an NGO, the Kenyan Government, a professional nursing association and a female lawyer's association are engaging in the pilot of a socio-legal mechanism to enhance RMC in Kenya (Warren, et al., 2013).

Strengthen facility capacity and supportive work environments

In order to promote empathetic provider-patient relationships at the peri-urban maternity interface, there is a need to strengthen facility capacity and cultivate supportive work environments that enable frontline providers to 'be heard' by management. At the policy level, this requires (a) the creation of provider protections with respect to their time and person and (b) increasing human resources to meet projected increases in facility deliveries. This requires national regulatory agencies (e.g. MOMS, MOPHS) and county level structures management structures to rethink and encourage flexibility in procurement schedules and securing a budget to hire more nurse-midwives. At the programmatic (facility) level, proposed mechanisms include staff rotation (e.g. biannual for nurses), attention to provider incentives, recognition of staff effort, and promotion inter-cadre social and work-related interactions. Additionally, establishing a supportive supervision structure and identifying counseling opportunities to mitigate burnout is critical to enhancing provider moral – these two items could fall under the active oversight of county health management teams. Facilitating a culture of communication between providers and their immediate supervisors would help break down structural barriers to being heard.

Support community level activities: education and empowerment

In light of the ‘people-centered’ nature of the new constitution and devolution as well as the salience of community voice as a determinant of trust in maternity care, it is recommended that policy and programs ought to support ongoing community education and empowerment efforts such as community dialogues and RMC rights education (e.g. Heshima community interventions). At the policy level, this requires sustained funding from the government to CHUs and multi-sectoral collaborations (civil society, government, university, and nursing association) that work at the intersections of health and human rights. Civil society and CHWs (or similar liaisons) are preferred agents of education and empowerment to the community. Since CHWs may feel a gendered effect of the overall health system on their capacity to carry out a range of functions without fair compensation, this study recommends the development of CHW protection and stipend policies by MOPHS, legal bodies, and county-CHUs. At the programmatic level, education and empowerment through group-based sessions are recommended to promote maternity care literacy as well as increase awareness of patient rights to RMC. Education and empowerment sessions should cover (1) labor and delivery procedures, (2) roles of different provider cadres, (3) financial and logistical processes at facilities, and (4) family planning. Sessions ought to use service charters, the RMC charter and human rights tools available. Sessions conducted in a familiar community environment with women and men of similar life stages allows for open discussion and learning. These types of group sessions may facilitate a community’s readiness to engage in direct community- feedback mechanisms (e.g. dialogue days).

Global implications

Trust offers a valuable lens for understanding health systems relationships and ought to be adopted widely to improve users’ experiences of care and motivate utilization of necessary health services. As evident from the Kenyan context, understanding how trust can be built in maternity care requires a multi-pronged effort by various actors and groups spanning from users of care, to those providing it, to those managing and overseeing the process of service delivery. Inherent in this

process is the notion of communicative action as a way of developing ‘culturally secure’ care. Many of these policy and programmatic recommendations are made at a nascent phase in health systems trust development and require further research to fully understand whether or not this trust-building mechanism work. However, given the trust barrier concentration in socially disadvantaged groups, trust in maternity care and in the broader health system ought to be considered in peri-urban settings that are undergoing structural changes. The application of this lens in such moments allow for reflection on the politics of health service provision.

Conclusion

Trust is an important lens through which to examine maternity care and health systems. Despite its nuance and complexity, trust serves as an integral link between experiences of D&A during childbirth and intentions to seek care. Determinants of trust draw not only on women’s past experience, but a range of social-political, cultural, community and institutional factors that can be unveiled through the use of critical and appreciative approaches. The politics of health care settings render building trust a challenging, yet feasible task. This body of work serves as a start to considering a set of trust-building mechanisms that draw on hierarchical perspectives and efforts to promote dignity.

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Appendices

Appendix 1. Focus Group Discussion Guides

Focus Group Guide (Recently delivered women in facility)

1. **Tell us how do you all generally feel about doctors and nurses that provide maternity care in facilities?**
 - a. How do you know your provider is being *honest* with you? (probe: communication? Open?)
 - b. How do you know your provider is being *fair* to you? (probe: do they treat you differently because of your age, parity, ethnic group, poverty status)
 - c. What makes you *confident* that the provider has your best interest at heart? (probe: compassion? Respect? Competence?)
 - d. How are facility doctors and nurses different from traditional birth attendants?

Je, kwa ujumla mnaona aje Madaktari na wahudumu(nurses) ambao hutoa huduma kwa kina mama wajawazito katika vituo vya afya vya uma?

- a. *Utajuaje kuwa mhudumu wako hakufichi chochote/anakwambia ukweli? (Probe: Mawasiliano? Uwazi?)*
- b. *Utajuaje kwamba mhudumu anakuhudumia kwa njia sawa na wengine? (Probe: Je, huduma ni tofauti kwa ajili ya umri, kulingana na nambari ya watoto ulionao, kabila lako, hali ya umaskini au utajiri?)*
- c. *Ni nini kinakuhakikishia kuwa mhudumu wako anakuwazia na kuhakikisha kuwa unapata huduma iliyo bora zaidi? (Probe: Roho ya kutaka kusaidia? Heshima? Uwezo wa kutenda kazi yake vizuri, na wala sio tu kwa sababu ya pesa?)*
- d. *Kuna tofauti gani kati ya wahuduma kwenye vituo vya afya na wakunga wa kienyeji?*

2. **How do you feel about the health system as a whole to provide maternity care?**

- a. What makes you *confident* enough to deliver in a facility? (probe: Respect? Competence? Outcomes? Coordination? Reputation?)
- b. How do you know the health system is being *fair* to you? (probe: do they treat you differently because of your age, parity, ethnic group, poverty status)

Je, maoni yanu ni yapi kuhusu huduma zinapewa kina mama wanapoenda kujifungua kwenye vituo vya afya vya uma?

- a. *Je ni nini inakupatia imani ya kutosha kwenda kujifungulia kwenye kituo cha afya? (Probe: Heshima, vifaa vinavyohitajika, matokeo ya kiafya ya watoto na kina mama kwenye kituo hicho, jinsi wahudumu wote wanafanya kazi pamoja kukupa usaidizi)*
- b. *Utajuaje kwamba kituo cha afya kinakuhudumia kwa njia sawa na wengine? (Probe: Je, huduma ni tofauti kwa ajili ya umri, kulingana na nambari ya watoto ulionao, kabila lako, hali ya umaskini au utajiri?)*

3. **We have heard from women that often there is a fear to ask doctors any questions about their care or to speak up when there they have been disrespected. Can you explain why this is?**

Tumesikia kutoka kwa wanawake kuwa mara nyingi wao huogopa kuwauliza wahudumu maswali kuhusu utunzi wao au kuongea kama wamekosewa heshima. Je, ni kweli? Unafikiri ni kwa sababu gani?

4. **What do you think of when you hear the word trust?**

- a. Describe people do you usually trust and why?
- b. Describe social institutions (schools, government, police) you trust and why?
- c. How do you know you can trust someone or an institution?
- d. How do you know you can trust a health provider or the health system?

Unaposikia neno 'kuamini' unafikiri nini?

- a. *Elezea watu ambao wewe kwa kawaida huwaamini na ni kwa nini?*
- b. *Eleza vituo vya uma kama Shule, vituo vya Polisi, Serikali unavyoviamini na ni kwa sababu gani?*
- c. *Je, utajuaje unaweza kumwamini mtu au kituo cha uma?*
- d. *Je, unawezaje kujua kama unaamini mhudumu au kituo cha afya?*

5. **How did trust influence your decision to seek care in the facility in which you delivered?**

Mara ya mwisho ulipojifungua imani yako katika kituo kilichochea vipi uamuzi wako?

6. Tell me about a maternity experience (your own or someone you know) where there was a lot of trust in the facility or the health system? Probe: in the provider? (explore differences by cadre of worker, private/public, age and sex of provider)

Je, unaweza kutuelezea kisa ambapo wewe ama mtu mwingine unayemjua ulikuwa na imani katika kituo cha afya wakati wa kujifungua? Probe: imani kwa mhudumu

7. Tell me about a maternity experience (your own or someone you know) where there was very little or no trust in the health system? Probe: In the provider?

Je, unaweza kutuelezea kisa ambapo wewe ama mtu mwingine unayemjua hamukuwa na imani katika kituo cha afya wakati wa kujifungua? Probe: bila imani kwa mhudumu

8. Please describe how your last maternity experience met (or did not meet) your expectations?

- How was trust related to your maternity (ANC and delivery) experiences?
- Does trust influence your choices on where to seek care for your next delivery?

Je, tuelezee jinsi uliridhishwa au haukuridhishwa na huduma ambayo ulipokea wakati ulipojifungua mara ya mwisho?

- Ni nini kilikufanya uamini kituo hicho ili uende kupata huduma za kina mama wajawazito? Na kujifungua?
- Jinsi ulivyohudumiwa, itachangia vipi uchaguzi wako unapotaka kujifungua wakati mwingine?

9. With whom do you discuss your maternity experiences and health care seeking decisions?

- How much do you value these discussions?

Nyinyi huzungumzia yale mliyopitia wakati wa kujifungua na uamuzi wa kutafuta huduma za afya na kina nani?

- Mazungumzo haya yana umuhimu gani kwako?

10. Do you think people in your community generally trust or mistrust the health system?

- What are ways in which you think trust could be built?

Je, unafikiri watu wa jamii yenu wanawaamini au hawaamini vituo vya afya?

- Ni njia zipi unafikiri uaminifu unaweza kuboreshwa?

Probe: Free maternity care....what do you think of it? Do you trust it?

Focus Group Guide (Recently delivered women not in facility)

1. Tell us how do you all generally feel about doctors and nurses that provide maternity care in facilities?

- How do you know your provider is being *honest* with you? (probe: communication? Open?)
- How do you know your provider is being *fair* to you? (probe: do they treat you differently because of your age, parity, ethnic group, poverty status used a voucher)
- What makes you *confident* that the provider has your best interest at heart? (probe: compassion? Respect? Competence?/skills)
- How are facility doctors and nurses different from traditional birth attendants?

Je, kwa ujumla mnaona aje Madaktari na wahudumu(nurses) ambao hutoa huduma kwa kina mama wajawazito katika vituo vya afya vya uma?

- Utajuaje kuwa mhudumu wako hakufichi chochote/anakwambia ukweli? (Probe: Mawasiliano? Uwazi?)
- Utajuaje kwamba mhudumu anakuhudumia kwa njia sawa na wengine? (Probe: Je, huduma ni tofauti kwa ajili ya umri, kulingana na nambari ya watoto ulionao, kabila lako, hali ya umaskini au utajiri?)
- Ni nini kinakuhakikishia kuwa mhudumu wako anakuwazia na kuhakikisha kuwa unapata huduma iliyo bora zaidi? (Probe: Roho ya kutaka kusaidia? Heshima? Uwezo wa kutenda kazi yake vizuri, na wala sio tu kwa sababu ya pesa?)
- Kuna tofauti gani kati ya wahuduma kwenye vituo vya afya na wakunga wa kienyeji?

2. How do you feel about the health system as a whole to provide maternity care?

- How do you know the health system is treating you *fairly*? (probe: are you being treated differently because of your age, parity, ethnic group, poverty status, used a voucher)

- b. What makes you *confident* enough to deliver in a facility? (probe: Respect? Competence? Outcomes? Coordination? Reputation?)

Je, maoni yanu ni yapi kuhusu huduma zinapewa kina mama wanapoenda kujifungua kwenye vituo vya afya vya uma?

- c. *Je ni nini inakupatia imani ya kutosha kwenda kujifungulia kwenye kituo cha afya? (Probe: Heshima, vifaa vinavyohitajika, matokeo ya kiafya ya watoto na kina mama kwenye kituo hicho, jinsi wahudumu wote wanafanya kazi pamoja kukupa usaidizi)*
- d. *Utajuaje kwamba kituo cha afya kinakuhudumia kwa njia sawa na wengine? (Probe: Je, huduma ni tofauti kwa ajili ya umri, kulingana na nambari ya watoto ulionao, kabila lako, hali ya umaskini au utajiri?)*

3. What do you think of when you hear the word trust?

- a. Describe people do you usually trust and why?
- b. Describe social institutions (schools, government, police) you trust and why?
- c. How do you know you can trust someone or an institution?
- d. How do you know you can trust a health provider or the health system?

Unaposikia neno 'kuamini' unafikiri nini?

- e. *Elezea watu ambao wewe kwa kawaida huwaamini na ni kwa nini?*
- f. *Eleza vituo vya uma kama Shule, vituo vya Polisi, Serikali unavyoviamini na ni kwa sababu gani?*
- g. *Je, utajuaje unaweza kumwamini mtu au kituo cha uma?*
- h. *Je, unawezaje kujua kama unaamini mhuduma au kituo cha afya?*

4. Tell me about a maternity experience (your own or someone you know) where there was a lot of trust in the facility or the health system? Probe: in the provider? (explore differences by cadre of worker, private/public, age and sex of provider)

Je, unaweza kutuelezea kisa ambapo wewe ama mtu mwingine unayemjua ulikuwa na imani katika kituo cha afya wakati wa kujifungua? Probe: imani kwa mhudumu

5. Tell me about a maternity experience (your own or someone you know) where there was very little or no trust in the health system? Probe: In the provider?

Je, unaweza kutuelezea kisa ambapo wewe ama mtu mwingine unayemjua hamukuwa na imani katika kituo cha afya wakati wa kujifungua? Probe: bila imani kwa mhudumu

6. Please tell us why you did not deliver in a facility for your last birth? (probe: did this have to do with what others told you about the quality of facilities? Your trust in facilities?)

Tafadhali tuelezee sababu iliyokufanya ukakosa kujifungulia kwenye kituo cha afya mara ya mwisho? (Probe: Je, ni kwasababu ya yale ulikuwa umeskia kutoka kwa watu au haukuamini kituo cha afya?)

7. How do you think trust in providers influence your choice on where to deliver next? (probe: trust in facility?)

Una fikiria imani yako kwa wahudumu wa afya itachochea vipi uamuzi wako wa pahali utakapojifungulia wakati ujao?

8. With whom do you discuss your maternity experiences and health care seeking decisions?

- a. How much do you value these discussions?

Nyinyi huzungumzia yale mliyopitia wakati wa kujifungua na uamuzi wa kutafuta huduma za afya na kina nani?

- b. *Mazungumzo haya yana umuhimu gani kwako?*

9. Do you think people in your community generally trust or mistrust the health system?

- a. What are ways in which you think trust could be built?

Je, unafikiri watu wa jamii yenu wanawaamini au hawaamini vituo vya afya?

- b. *Ni njia zipi unafikiri uaminifu unaweza kuboreshwa?*

Probe: Free maternity care...what do you think of it? Do you trust this?

Focus Group Guide (First time pregnant women)

1. Describe what you think happens during labor and delivery for women in this community?

- What have you heard about this process from women who have delivered in facilities?
- What have you heard about this process from those who did not deliver in a facility?
- With whom have you discussed care-seeking decisions during this pregnancy?
 - How much do you value these discussions?

Tuelezee unafikiri ni nini hufanyika wakati mama anaposikia uchungu wa kuzaa na anapojifungua katika jamii hii?

- Nini umesikia kuhusu kujifungua kutoka kwa wamama walio jifungulia kwenye kituo cha afya?
- Nini umesikia kuhusu kujifungua kutoka kwa wamama mbao hawakujifungulia kwenye kituo cha afya?
- Ukiwa na mimba hii mme jadili kuhusu uamuzi wa kutafuta huduma za afya na kina nani?*
 - Mazungumzo haya yana umuhimu gani kwako*

2. Tell us how do you all generally feel about doctors and nurses that provide antenatal care in facilities?

- How do you know your provider is being *honest* with you? (probe: communication? Open?)
- How do you know your provider is being *fair* to you? (probe: are you being treated differently because of your age, parity, ethnic group, poverty status, used a voucher)
- What makes you *confident* that the provider has your best interest at heart? (probe: compassion? Respect? Competence/skills?)
- How are facility doctors and nurses different from traditional birth attendants? (probe: differences between private and public? Old and young? Male or female?)
- How did (or did not) your antenatal care experience meet your expectations?**

Je, kwa ujumla mnaona aje Madaktari na wahudumu(nurses) ambao hutoa huduma za clinic kwa kina mama wajawazito katika vituo vya afya vya serikali?

- Utajuaje kuwa mhudumu wako hakufichi chochote/anakwambia ukweli? (Probe: Mawasiliano? Uwazi?)*
- Utajuaje kwamba mhudumu anakuhudumia kwa njia sawa na wengine? (Probe: Je, huduma ni tofauti kwa ajili ya umri, kulingana na nambari ya watoto ulionao, kabila lako, hali ya umaskini au utajiri?)*
- Ni nini kinakuhakikishia kuwa mhudumu wako anakuwazia na kuhakikisha kuwa unapata huduma iliyo bora zaidi? (Probe: Roho ya kutaka kusaidia? Heshima? Uwezo wa kutenda kazi yake vizuri, na wala sio tu kwa sababu ya pesa?)*
- Kuna tofauti gani kati ya wahuduma kwenye vituo vya afya na wakunga wa kienyeji?*
- Je, tuelezee jinsi unaridhishwa au hauridhishwi na huduma ambazo unapokea unapoenda clinic ya kina mama wajawazito ?**

3. How do you feel about the health system as a whole to provide maternity care?

- What makes you *confident* enough to deliver in a facility? (probe: Respect? Competence? Outcomes? Coordination? Reputation?)
- How do you know the health system is being *fair* to you? (probe: do they treat you differently because of your age, parity, ethnic group, poverty status)

Je, maoni yanu ni yapi kuhusu huduma zinapewa kina mama wanapoenda kujifungua kwenye vituo vya afya vya uma?

- Je ni nini inakupatia imani ya kutosha kwenda kujifungulia kwenye kituo cha afya? (Probe: Heshima, vifaa vinavyohitajika, matokeo ya kiafya ya watoto na kina mama kwenye kituo hicho, jinsi wahudumu wote wanafanya kazi pamoja kukupa usaidizi)*
- Utajuaje kwamba kituo cha afya kinakuhudumia kwa njia sawa na wengine? (Probe: Je, huduma ni tofauti kwa ajili ya umri, kulingana na nambari ya watoto ulionao, kabila lako, hali ya umaskini au utajiri?)*

4. What do you think of when you hear the word trust?

- Describe people do you usually trust and why?
- Describe social institutions (schools, government, police) you trust and why?
- How do you know you can trust someone or an institution?
- How do you know you can trust a health provider or the health system?

Unaposikia neno 'kuamini' unafikiri nini?

- Elezea watu ambao wewe kwa kawaida huwaamini na ni kwa nini?*
- Eleza vituo vya uma kama Shule, vituo vya Polisi, Serikali unavyoviamini na ni kwa sababu gani?*

- k. Je, utajuaje unaweza kumwamini mtu au kituo cha uma?
- l. Je, unawezaje kujua kama unaamini mhuduma au kituo cha afya?

5. **Tell me about a maternity experience (someone you know) where there was a lot of trust in the facility or the health system? Probe: in the provider?** (explore differences by cadre of worker, private/public, age and sex of provider)

Je, unaweza kutuelezea kisa ambapo mtu mwingine unayemjua alikuwa na imani katika kituo cha afya wakati wa kujifungua? Probe: imani kwa mhudumu

6. **Tell me about a maternity experience (someone you know) where there was very little or no trust in the health system? Probe: In the provider?**

Je, unaweza kutuelezea kisa ambapo mtu mwingine unayemjua hakuwa na imani katika kituo cha afya wakati wa kujifungua? Probe: bila imani kwa mhudumu

7. **How do others delivery experiences influence your trust in the providers? In the facility?**

Yale ambayo wamama wengine wamepitia wakati wa kujifungua yanachochea vipi imani yako kwa wa hudumu? Kwa vituo vya afya?

8. **Do you think people in your community generally trust or mistrust the health system?**
b. **What are ways in which you think trust could be built?**

Je, unafikiri watu wa jamii yenu wanawaamini au hawaamini vituo vya afya?

- c. Ni njia zipi unafikiri uaminifu unaweza kuboreshwa?

FREE MATERNITY CARE...what do you think? Do you trust it?

Focus Group Guide (Male Partners of RDW)

ICE-BREAKER: Please describe how care-seeking decisions are made in your household?

Tafadhali tueleze jinsi mnavyofanya uamuzi wa kutafuta huduma za afya nyumbani kwako?

1. **Tell us how do you all generally feel about doctors and nurses that provide maternity care in facilities?**
- a. How do you know your provider is being honest with your partner and you? (probe: communication, open?)
 - b. How do you know your provider is being fair to your partner and you? (probe: do they treat you and your differently because of age, parity, ethnic group, poverty status, used a voucher)
 - c. What makes you confident that the provider has your partner's best interest at heart? (probe: compassion? Respect?)
 - d. How are facility doctors and nurses different from traditional birth attendants?

Je, kwa ujumla mnaona aje Madaktari na wahudumu(nurses) ambao hutoa huduma kwa kina mama wajawazito katika vituo vya afya vya uma?

- n. Utajuaje kuwa mhudumu wako hawafichi chochote/anaawambia ukweli wewe na bibi yako? (Probe: Mawasiliano? Uwazi?)
 - o. Utajuaje kwamba mhudumu anawahudumia wewe na bibi yako kwa njia sawa na wengine? (Probe: Je, huduma ni tofauti kwa ajili ya umri, kulingana na nambari ya watoto ulionao, kabila lako, hali ya umaskini au utajiri?)
 - p. Ni nini kinakuhakikishia kuwa mhudumu wako anamuwazia bibi yako na kuhakikisha kuwa anapata huduma iliyo bora zaidi? (Probe: Roho ya kutaka kusaidia? Heshima? Uwezo wa kutenda kazi yake vizuri, na wala sio tu kwa sababu ya pesa?)
 - q. Kuna tofauti gani kati ya wahuduma kwenye vituo vya afya na wakunga wa kienyeji?
2. **How do you feel about the health system as a whole to provide maternity care?**
- a. What would make you *confident* enough to encourage your wife to deliver in a facility? (probe: Respect? Competence? Coordination? Reputation?)
 - b. How do you know the health system is treating your partner and you fairly? (probe: are you or your partner being treated differently because of age, parity, ethnic group, poverty status, used a voucher)

Je, maoni yanu ni yapi kuhusu huduma zinapewa kina mama wanapoenda kujifungua kwenye vituo vya afya vya uma?

- g. *Je ni nini inakupatia imani ya kutosha kumuhimiza bibi yako kwenda kujifungulia kwenye kituo cha afya? (Probe: Heshima, vifaa vinavyohitajika, matokeo ya kiafya ya watoto na kina mama kwenye kituo hicho, jinsi wahudumu wote wanafanya kazi pamoja kukupa usaidizi)*
- h. *Utajuaje kwamba kituo cha afya kinamuhudumia bibi yako kwa njia sawa na wengine? (Probe: Je, huduma ni tofauti kwa ajili ya umri, kulingana na nambari ya watoto ulionao, kabila lako, hali ya umaskini au utajiri?)*

3. **We've heard from the community that there is a fear to ask doctors any questions about their care or to speak up when there is disrespect during treatment. Can you explain why this is?**

Tumesikia kutoka kwa jamii kuwa mara nyingi kuna uoga wa kuwauliza wahudumu maswali kuhusu utunzi wao au kuongea kama wamekosewa heshima. Je, ni kweli? Unafikiri ni kwa sababu gani?

4. **What do you think of when you hear the word trust?**
- a. **Describe people do you usually trust and why?**
 - b. **Describe social institutions (schools, government, police) you trust and why?**
 - c. **How do you know you can trust someone or an institution?**
 - d. **How do you know you can trust a health provider or the health system?**

Unaposikia neno 'kuamini' unafikiri nini?

- m. *Elezea watu ambao wewe kwa kawaida huwaamini na ni kwa nini?*
- n. *Eleza vituo vya uma kama Shule, vituo vya Polisi, Serikali unavyoviamini na ni kwa sababu gani?*
- o. *Je, utajuaje unaweza kumwamini mtu au kituo cha uma?*
- p. *Je, unawezaje kujua kama unaamini mhuduma au kituo cha afya?*

5. **How did trust influence the decision to seek care in the facility in which your wife delivered?**

Mara ya mwisho mke wako alipojifungua imani yako katika kituo alipojifungulia ilichochea vipi uamuzi wako/wenu?

6. **Tell us about a maternity experience (your partner's or someone else) where there was a lot of trust in the facility or the health system? Provider trust? (explore differences by cadre of worker, private/public, age and sex of provider)**

Je, unaweza kutuelezea kisa ambapo bibi yako ama mtu mwingine alikuwa na imani na kituo cha afya wakati wa kujifungua? Probe: imani kwa mhudumu

7. **Tell me about a maternity experience (your partner's or someone you know) where there was very little or no trust in the health system? In the provider?**

Je, unaweza kutuelezea kisa ambapo bibi yako ama mtu mwingine hawakuwa na imani na kituo cha afya wakati wa kujifungua? Probe: bila imani kwa mhudumu

8. **Please describe how partner's last maternity care experience met (or did not meet) your expectations?**

- a. **How do you think it relates your trust in the health system or the provider?**
- b. **How will it influence your decisions to seek care for your partner, yourself or the family?**

Je, tuelezee jinsi uliridhishwa au haukuridhishwa na huduma ambayo bibi yako alipokea wakati alipojifungua mara ya mwisho?

- c. *Ni nini kilikufanya uamini kituo hicho ili umuhimiza bibi yako iende kupata huduma za kina mama wajawazito? Na kujifungua?*
- d. *Jinsi bibi yako alivyohudumiwa, itachangia vipi uamuzi wako wa kutafuta huduma za bibi yako, zako, na, za familia yako?*

9. **How believable is the information you get from others about maternity experiences in your community? Your family? How much do you value these discussions?**

Yale ambayo huwa mnayasikia kotoka kwa wengine kuhusu wanayoyapitia wanawake wakati wakuajifungua niyakuaminika kiasi gani?

- c. *Mazungumzo haya yana umuhimu gani kwako?*

10. **Do you think people in your community generally trust or mistrust the health system?**

a. What are some ways you think trust could be built?

Je, unafikiri watu wa jamii yenu wanawaamini au hawaamini vituo vya afya?

d. *Ni njia zipi unafikiri uaminifu unaweza kuboreshwa?*

Probe: Free maternity care....what do you think of it?

Appendix 2. In-Depth Interview Guides

Interview Guide (Recently delivered women in a facility)

1. Please describe how you felt about your last experience delivering in a health facility?

- a. How did you feel about the doctors and nurses that provided the care?
 - i. How do you know your provider is being *honest* with you? (probe: communication?)
 - ii. How do you know your provider is being *fair* to you? (probe: do they treat you differently because of your age, parity, language, used a voucher, poverty status)
 - iii. What makes you *confident* that the provider has your best interest at heart? (probe: compassion? Respect? Competence?)
- b. How did you feel about the procedures done in the facility?
- c. How did you feel about the coordination of care?
- d. Did you feel confident about the overall service delivery before you went to the facility? Did that change after you left the facility?
- e. Who was involved with the decision to seek care at the facility? Who do you usually talk to about care seeking decisions?

Tafadhali eleza vile ulijihisi mara ya muisho ulipojifungua katika kituo cha afya?

- a. Je, kwa ujumla mnaona aje Madaktari na wahudumu(nurses) ambao hutoa huduma kwa kina mama wajawazito katika vituo vya afya vya uma?
 - i. Utajuaje kuwa mhudumu wako hakufichi chochote/anakwambia ukweli? (Probe: Mawasiliano? Uwazi?)
 - ii. Utajuaje kwamba muhudumu anakuhudumia kwa njia sawa na wengine? (Probe: Je, huduma ni tofauti kwa ajili ya umri, kulingana na nambari ya watoto ulionao, luga/kabila lako, voucher, hali ya umaskini au utajiri?)
 - iii. Ni nini kinakuhakikishia kuwa muhudumu wako anakuwazia na kuhakikisha kuwa unapata huduma iliyo bora zaidi? (Probe: Roho ya kutaka kusaidia? Heshima? Uwezo wa kutenda kazi yake vizuri, na wala sio tu kwa sababu ya pesa?)
- b. Je ulihisi vipi kuhusu mipangilio zinazo fanywa katika kituo cha afya?
- c. Je ulihisi aje kuhusu kufanya kazi wa utunzi pamoja kwa wahudumu na wafanyikazi wote?
- d. Je ulikuwa na imani katika huduma zote kwa ujumla kabla ya kwenda kwa kituo cha afya? Ili badilika baadaye?
- e. Ni nani alihusika katika kukata kauli ya kutafuta huduma katika kituo cha afya? Ni nani we humzungumzia kuhusu kukata kauli hizi za kutafuta huduma?

2. Now tell me what an ideal maternity care experience would be like for you?

Sasa uniambie vile ungependa huduma ile nzuri zaidi ya kujifungua iwe.

3. How are facility doctors and nurses different from traditional birth attendants?

Kuna tofauti gani kati ya wahuduma kwenye vituo vya afya na wakunga wa kienyeji?

4. Now tell me if you recall being treated unfairly in this instance or any other instance? What made you feel this way?

- a. Do you know of any others in your community who felt as if they were treated unfairly for any reason? (probe: age, parity, language, used a voucher, poverty status?)

Utajuaje kwamba kituo cha afya kinakuhudumia kwa njia sawa na wengine? (Probe: Je, huduma ni tofauti kwa ajili ya umri, kulingana na nambari ya watoto ulionao, luga/kabila lako, voucher, hali ya umaskini au utajiri?) Je, unaweza kueleza ni kwa nini?

5. We have heard from women that often there is a fear to ask doctors any questions about their care or to speak up when there they have been disrespected. Can you explain why this is?

Tumesikia kutoka kwa wanawake kuwa mara nyingi wao huogopa kuwauliza wahudumu maswali kuhusu utunzi wao au kungea kama wamekosewa heshima. Je, ni kweli? Unafikiri ni kwa sababu gani?

6. What do you think of when you hear the word trust?

- a. Describe people do you usually trust and why?
- b. Describe social institutions (schools, government, police, etc) you trust and why?
- c. How do you know you can trust someone or an institution?
- d. How do you know you can trust a health provider or the formal health system?

Unaposikia neno 'kuamini' unafikiri nini?

- q. Elezea watu ambao wewe kwa kawaida huwaamini na ni kwa nini?
- r. Eleza vituo vya uma kama Shule, vituo vya Polisi, Serikali unavyoviamini na ni kwa sababu gani?
- s. Je, utajuaje unaweza kumwamini mtu au kituo cha uma?
- t. Je, unawezaje kujua kama unaamini mhuduma au kituo cha afya?

7. Can you remember an instance where you trusted/mistrusted providers or the health system?

- a. Why did you feel you could trust (or mistrust) your doctor/nurse/CHEW/TBA? How might this trusting/mistrusting attitude change?
- b. Why did you feel you could trust (or mistrust) the health facility? How might this trusting/mistrusting attitude change?
- c. Describe to me an instance where you may trust the facility but not the provider? (probe: trust the provider but not the facility?)

Je, una weza kumbuka wakati uliamini/haukuamini muhudumu ama utaratibu wa afya?

- a. Kwa nini ulihisi ungemwamini/hungemwamini daktari wako/muuguzi/mkunga? Kuamini/kutoamini ita badilika aje?
- b. Nielezee wakati una weza amini kituo cha afya lakini sio muhudumu? (probe: amini muhudumu lakini sio kituo cha afya)

8. How did trust influence your decision to seek care in the facility in which you delivered?

- a. How do you feel about facility delivery compared to home delivery? (is trust relevant?)

Imani ilichangia vipi uamuzi wako wa kutafuta huduma katika kituo cha afya, ulipojifungulia?

- b. Ulijihisi namna gani kuhusu kujifungua katika kituo cha afya iki linganishua na kujifungulia nyumbani?

9. Thinking back to your recent delivery ...

- a. Why did or didn't your experience meet your expectations?
- b. How did your trust in the providers influence your experience?
- c. How did your delivery experience influence your trust of providers?
- d. How did your experience with ANC relate to your trust in the health system?
- e. Describe how your trust in the health system relates to your labor and delivery experience?

Ukifikiria namna ya kujifungua hivi majuzi ...

- a. Kwa nini namna ilikua kwako ilifika/haikufika kiwango ulichotarajia?
- b. Imani yako kwa wahudumu ilichangia vipi namna ilikuwa kwako?
- c. Namna ulijifungua ilichangia vipi imani yako kwa wahudumu?
- d. Namna ilikua katika kliniki cha mimba ulikuwa na uhusiano upi na imani yako kwa utaratibu wa afya?
- e. Eleza vile imani yako kwa utaratibu wa afya inahusiano na namna ya uchungu wa kuzaa na kujifungua?

10. Do you think people in your community generally trust or mistrust the health system?

- a. How does this influence (or does not influence) your trust?
- b. What are ways in which you think trust could be built?

Je, unafikiri watu wa jamii yenu wanawaamini au hawaamini utaratibu wa afya?

- a. Inachangia vipi imani yako?
- b. Ni njia zipi unafikiri uaminifu unaweza kujengwa?

*** FREE MATERNITY...what do you think?/unafikiria nini kuhusu huduma ya bure ya kujifungua?

Interview Guide (Community Health Worker)

1. **Please describe your interactions with women who are getting ready to deliver.** (probe: what your role is? How is your relationship with women in the community?)
2. **In prior interviews with health workers in Kenya, we've heard different ideas about what respect and dignified maternity care looks like.**
 - a. What does respectful maternity care to women look like to you? (probe: How do you know women and their families are treated with respect at facilities?)
 - b. How do providers at facilities generally approach patients? (probe: in the same way?/equally?)
 - c. We've heard from community members about long wait times, unfriendly facility providers and differential treatment based on using a voucher. Can you give us any examples of such instances?
3. **Tell us about your relationships with health workers at the facility?**
 - a. Describe about how you feel respected (or not) by doctors and nurses? (probe: Others in the facility?)
 - b. Describe how you feel supervisors and management shape the work environment at the facility.
4. Now, we've been talking to women about trust. **What do you think of when you hear the word trust?** (what does it mean to you?)
 - a. How do you know you can trust someone or an institution?
 - b. How does trust factor into your relationship with facility providers (explain how there is trust or mistrust between them and you?)
 - i. What do you think drives this trust or mistrust?
5. **How important is patient trust as an issue?**
 - a. What do you think a patient's understanding of trust is all about?
 - b. What do you think makes patients trust the providers?
 - c. What do you think makes patients trust the facility and health system overall?
6. **We've heard that community mistrust in formal health facilities may be deterring care-seeking. What do you think about this?**
 - a. **From your experience in the community, are there any alternative options that are more trusted?**
 - b. **How trusting are the public and women coming for maternity care are of other social institutions in the area?** (i.e. schools, government programs, police)
 - c. **How is trust in the health system different from trust in these other institutions?**
 - d. **Why do you think some women may trust the providers and health facilities in this area more than others?** (probe: are women being treated differently because of age, parity, ethnic group, poverty status, used a voucher)
7. **Could you describe any ethical or professional codes that CHEWs like yourself follow?** (if possible >> get copy of text)
 - a. How were these created?
 - b. Tell me about how they are helpful or not?
 - c. Tell me how you feel they could be changed?
8. **In your opinion, how can trust be built**
 - a. **between patients and providers?**
 - b. **between patients and the facilities and health system overall?**
 - c. **within the health system (between the different cadres of providers and supervisors)?**

(some things heard from FGDs: provider trainings, role of management and supervision, community outreach and education, encouraging bringing complaints/building community voice)
9. What do you think about the president's free maternity service mandate?

Interview Guide (Health workers in the facility)

1. Please tell me about your role in assisting deliveries?
 - a. Describe interactions with women coming to deliver.
 - b. What does respectful maternity care look like to you?
 - c. How do you generally approach all patients in the same way? (probe: in the same way?)
2. Tell us about your relationships with other workers in the facility?
 - a. Tell me about who you regularly interact and work with?
 - b. Describe to me if you feel respected (or not) by your supervisors? By other colleagues?
 - c. Describe to me how you are treated by your supervisors? By other colleagues? (probe: treated fairly?)
 - d. Describe interactions with co-workers that are helpful? Not helpful?
 - e. Describe how you feel supervisors and management shape the work environment at the facility.
3. What do you think of when you think of when you hear the word trust? What does it mean to you?
 - a. How do you know you can trust someone or an institution?
 - b. Describe how trust (or mistrust) factors into your relationships with your supervisor? Other colleagues?
4. Tell me about ways that you are able to face and work through challenges you face in your work?
5. Think about any deliveries that went particularly well or particularly poorly?
 - a. In any of these instances, do you think patient trust was an issue?
6. How important is patient trust as an issue?
 - a. What do you think a patient's understanding of trust is all about?
 - b. What do you think makes patients trust the facility and health system overall?
7. We've heard that community mistrust in health facilities may be deterring care-seeking. What do you think about this?
 - a. How trusting are the women coming for maternity care are of other social institutions in the area? (i.e. schools, government programs, police)
 - b. How is trust in the health system different from trust in these other institutions?
8. Why do you think some women may trust the providers and health facilities in this area more than others? (probe: age, parity, voucher, language, poverty status)
9. Could you describe any ethical or professional codes that health workers like yourself follow? (if possible >> get copy of text)
 - a. How were these created?
 - b. Tell me about how they are helpful or not?
 - c. Tell me how you feel they could be changed?
10. How do you think we can build trust
 - a. between patients and providers?
 - b. between patients and the facilities and health system overall?
 - c. within the health system (between the different cadres of providers and supervisors)

(some things heard from FGDs: provider trainings, role of management and supervision, community outreach and education, encouraging bringing complaints/building community voice)
11. What do you think about the president's free maternity service mandate?

Interview Guide (Key Informants – Managers/County Officials)

1. Tell me about the work you currently do around improving quality of maternity care in Kenya?
 - a. Describe any challenges you face? (Legal or policy challenges? Practical challenges?)
2. Tell me about your understanding of the disrespect and abuse problems in public and private health facilities? How concerned are you about this and why?
 - a. In prior interviews and focus groups in the community in Kenya, we've heard different ideas about what respect and dignified maternity care looks like. For instance, unfriendliness, general lack of empathy, make comments that are hurtful or ignorant, neglect and sometimes physically harm (pinching/beating) are all examples of disrespect. When providers are friendly, community openly patients, and show a human side along with professional competence, it is considered respectful. What do you think about this?
3. We've also heard the ideas of patient trust and mistrust come up in discussions with health providers as well as communities and want to understand what you think these concepts mean.
 - a. What do you think makes patients trust their providers?
 - b. What do you think makes patients trust the system of maternal health care provision?
4. Why do you think some women may trust the providers and health facilities in this area more than others? (probe: age, parity, used a voucher, language, poverty status)
5. We've heard that community mistrust in formal health facilities may be deterring care-seeking. What do you think about this?
 - a. How trusting are the public women coming for maternity care are of other social institutions in the area? (i.e. schools, government programs)
 - b. How is trust in the health system different from trust in these other institutions?
6. Could you describe any ethical or professional codes that health providers follow? (get copy of text)
 - a. How were these created? How are they operationalized? How are they monitored?
 - i. What there any consequences for if the codes are broken?
 - b. Tell me about ways that you feel guidelines (or implementation) could be improved?
7. Tell me about any other trainings, debriefing sessions or feedback mechanisms around challenges faced by health workers at facilities? For community health workers?
8. How do you think we can build trust
 - a. between patients and providers?
 - b. between patients and the facilities and health system overall?
 - c. within the health system (between the different cadres of providers and supervisors)(some things heard from FGDs: provider trainings, role of management and supervision, community outreach and education, encouraging bringing complaints/building community voice, government role)
9. We've heard a lot about fear of speaking out from the community (to providers) when there are instances of disrespect and abuse. Are there any avenues through which you think this can be changed or made safer?
10. We've also heard skepticism around the Free maternity services (i.e. care will be worse for those who can't pay and demand free services). What do you think about this?

Appendix 3. Questionnaires for supplemental information from all participants

Questionnaire version for recently delivered and pregnant women

Respondent ID: _____

1. IDI or FGD (circle one)

2. IDI/FGD Location: _____

3. Language of IDI/FGD: _____

4. How old are you?/ Uko na miaka mingapi? _____

5. What was the highest level of school you attended?/ Ulisoma hadi darasa la ngapi? (check one)

- Pre-Primary
- Primary
- Secondary
- University
- Other (specify).....

6. What is your marital status?/ Umeoa au kuolewa?

- Single/never married
- Married
- Divorced/Separated
- Other (specify)....

7. What religion are you?/Unashiriki dini gani?

- Catholic
- Protestant
- Muslim
- Other...

8. How long have you been living in this area ? / Je, umekuwa ukiishi hapa kwa muda gani? _____

9. What kind of work do you mainly do?/Unafanya kazi ya aina gani?

- Homemaker
- Farming
- Teaching
- Business
- Small sales
- Crafts or trades work
- Self Employed
- Health work
- Student
- Not employed
- Other (specify).....

10. How many children do you have?/ Je, una watoto wangapi? _____
(if zero, skip to 12)

11. Where did you deliver your children? / Je, ulijifungua watoto wako wapi? (Kituo cha afya/nyumbani?)

Child 1: _____

Child 2: _____

Child 3: _____

Child 4: _____

12. Where you think you will deliver your baby? / Unapanga kujifungulia wapi?

- Health facility/ Kituo cha afya
- Home/ Nyumbani

13. Who usually makes maternal health care seeking decisions in the household? / Je, ni nani ambaye hutoa uamuzi wa kutafuta huduma za afya ya uzazi?

- Myself
- My husband/partner
- Both
- Family Member (specify)

14. Where do you think your community prefers women to deliver? / Je, unafikiri jamii yako hupendelea wakina mama wajifungulie wapi?

- Health facility/ Kituo cha afya
- Home/ Nyumbani

15. What types of facilities does the community prefer women to deliver in? / Je, ni kituo cha aina gani cha afya ambacho jamii hupendelea wakina mama kwenda kujifungulia?

- Public
- Private
- Faith-based

16. Is there an opportunity for the community to provide feedback to maternal health clinics? / Je, jamii iko na njia ya kutoa maoni kuhusu huduma zinazopeanwa katika clinic za wa mama wajawazito?

- Yes/Ndiyo
- No/La

17. Would a collective feedback process be helpful to build trust in providers? / Je, ikiwa jamii itaungana kutoa maoni kwa pamoja hiyo itasaidia kuleta imani kwa wahudumu wa afya?

- Yes/Ndiyo
- No/La

18. Would a collective feedback process be helpful to build trust in the health system?/Je, ikiwa jamii itaungana kutoa maoni kwa pamoja hiyo itasaidia kuleta imani kwa vituo vya afya?

- Yes/Ndiyo
- No/La

19. Do you feel your vote makes a difference in shaping the social and political future for Kenya? / Je, unafikiri maoni yako yanaweza kuleta mabadiliko ya kijamii na kisiasa nchini Kenya?

- Yes/Ndiyo
- No/La

Questionnaire version for male partners

Respondent ID: _____

1. IDI or FGD (circle one)

2. IDI/FGD Location: _____

3. Language of IDI/FGD: _____

4a. How old are you? / Uko na miaka mingapi? _____

4b. How old is your partner? / Je, Mchumba wako ana miaka mingapi? _____

5. What was the highest level of school you attended? / Ulisoma hadi darasa la ngapi? (check one)

- Pre-Primary
- Primary
- Secondary
- University
- Other (specify).....

6. What is your marital status? / Umeoa au kuolewa?

- Single/never married
- Married
- Divorced/Separated
- Other (specify)....

7. What religion are you? / Unashiriki dini gani?

- Catholic
- Protestant
- Muslim
- Other...

8. How long have you been living in this area? /Je, umekuwa ukaa hapa kwa muda upi? _____

9. What kind of work do you mainly do? / Unafanya kazi ya aina gani?

- Homemaker
- Farming
- Teaching
- Business
- Small sales
- Crafts or trades work
- Self Employed
- Health work
- Student
- Not employed
- Other (specify).....

10a. How long have you and your partner been together?/ Je, wewe na mke wako mmeishi pamoja kwa mda gani? _____

10b. How many children do you and your partner have? / Je, wewe na mke wako mna watoto wangapi? _____

11. Where did your partner deliver your children?/ Je, mke wako alijifungulia watoto wapi? (Kituo cha afya/nyumbani?)

Child 1: _____

Child 2: _____

Child 3: _____

Child 4: _____

12. Who usually makes maternal health care seeking decisions in the household? / Je, kati yako na mke wako, nani ndiye anayefanya uwamuzi wa kutembelea idara ya afya ya huduma za kina mama?

- Myself
- My wife/partner
- Family Member (specify)

13. Do you think your presence in the room during delivery would improve the quality of care given to your wife? / Je, unafikiri kuwa kwako kwenye chumba cha huduma za kina mama kunaweza kuimarisha huduma ambazo mke wako anapata?

- Yes/Ndiyo
- No/La

14. Where do you think your community prefers women to deliver? / Je, wapi unafikiri Jamii hupendelea kina mama kutafuta huduma za kujifungua?

- Health facility/Kituo cha afya
- Home/Nyumbani

15. What types of facilities does the community prefer women to deliver in? / Je, ni aina ipi ya huduma za afya ambayo jamii ingependelea kina mama wajawazito kujifungulia?

- Public
- Private
- Faith-based

16. Is there an opportunity for the community to provide feedback to maternal health clinics? / Je, kuna njia ambayo Jamii inaweza kupeana maoni kwa idara ya afya ya huduma za kina mama?

- Yes/Ndiyo
- No/La

17. Would a collective feedback process be helpful to build trust in providers? / Je, muungano wa maoni unaweza kusaidia ujenzi wa uwaminifu wa wahudumu?

- Yes/Ndiyo
- No/La

18. Would a collective feedback process be helpful to build trust in the health system? / Je, muungano wa maoni unaweza kusaidia ujenzi wa uwaminifu kwenye uendelezaji wa afya?

- Yes/Ndiyo
- No/La

19. Do you feel your vote makes a difference in shaping the social and political future for Kenya? / Je, unafikiri maoni yako yanaweza kubadilisha ujenzi wa kisiasa siku za usoni za nchi ya Kenya

- Yes/Ndiyo
- No/La

Questionnaire version for health facility workers

Respondent ID: _____

1. IDI Location (including facility name): _____

2. Language of IDI: _____
3. What type of health worker are you?
 Physician Nurse/Midwife CHW TBA
4. What specific professional training did you have? _____

5. How long have you been working in maternal health? _____
6. How long have you worked at this facility? _____
7. What is your average caseload in a week?
8. Where do you think women living in the community your facility serves prefer to deliver?
 Home Public facility Private facility Faith-based facility
9. What type of facilities do you prefer to work in?
 Public Private Faith-based
10. Do you feel professional and ethical codes are widely known in your profession?
 Yes No
11. Do you feel you get fairly compensated for your work?
 Yes No
12. Do you feel you get sufficient guidance from supervisors in your work?
 Yes No
13. Do you feel you have enough psychosocial support in your job?
 Yes No
14. How much opportunity do you have feedback your concerns and queries to your supervisors and other colleagues in your work?
 No opportunity Some opportunity Many opportunities
15. Did you vote in the last election?
 Yes No
16. Do you feel your vote makes a difference shaping the social and political future for Kenya?
 Yes No

Questionnaire for Key Informants

Respondent ID: _____

1. IDI Location : _____

2. Language of IDI: _____
3. What is your job title? _____
4. How long have you worked at this particular job? _____
5. How long have you been working in maternal health? _____
6. What is your relationship to the work in Kenya on disrespect and abuse in maternity care facilities?

Appendix 4. Emergence of Themes

Chapter	Guiding questions	Focused and initial codes	Themes and linking themes
IV	<ul style="list-style-type: none"> - What do you think of when you hear the word trust? - Describe people you trust? - Describe social institutions you trust? - How is trust in the health system different from in other institutions? - How do you know your provider is being <i>honest</i> with you?[‡] - How do you know your provider is being <i>fair</i> to you?[‡] - How they treat you differently because of your age, parity, ethnic group, poverty status?^{‡†} - What makes you <i>confident</i> that the provider has your best interest at heart?[‡] - How are facility doctors and nurses different from traditional birth attendants? - What do you think a patient's trust is all about?[†] - How do you feel about the health system to provide maternity care? - How important is patient trust as an issue? 	<ul style="list-style-type: none"> 'who we trust' Trust/mistrust in providers (CHWs, facility) Trust and being left alone Vulnerability Feeling alone, neglected, powerless Urgency in maternity Procedural delay without effective communication Companions powerless Influences care-seeking Dependability, confidence Competence & qualifications Confidentiality & Privacy Fidelity Honesty (stems from closeness of a relationship, the nature of conversation, non-verbal cues, faith/social characteristics) Communication (what? how? active listening, open dialogue, fear to speak) "mutual respect" Fairness high risk groups systems trust TBAs v. Facility providers Trust/mistrust in facility and management does not always align with trust in providers nor with CHWs Trust may change over time 	<ul style="list-style-type: none"> Types and perspectives of trust (four types in maternity setting; a nested concept) Relevance of trust Health systems trust in context of maternity care Confidence Communication Integrity Mutual respect Competence Fairness Confidentiality & privacy Systems trust Content areas not evenly represented Trust (four types) dynamic and mutable
V	<ul style="list-style-type: none"> - How do you know you can trust someone or an institution?* - How do you know you can trust a health provider or the health system?* - Tell me about a maternity experience (your own or someone you know) where there was a lot of trust in 	<ul style="list-style-type: none"> "ideal maternity" Enables trust Reduces trust Consequence of negative or positive experience TBAs v. facility Outcomes Even if not me, my baby Showing caring nature/ empathy, 	<ul style="list-style-type: none"> Women and community perspectives (standpoint) of trust in maternity setting Patient/individual factors Prior experience Perceived risk or harm Childbirth outcomes Provider factors Empathy & respect,

	<p>the facility or the health system? Probe: in the provider?</p> <p>- Tell me about a maternity experience (your own or someone you know) where there was very little or no trust in the health system? In the provider?[†]</p> <p>- Describe how your last maternity experience met (or did not meet) your expectations?</p> <p>- Tell me what an ideal maternity experience would be like for you?*</p> <p>- With whom do you discuss your maternity experiences and health care seeking decisions? How much do you value these discussions?</p> <p>- What do you think about the free maternity mandate?</p>	<p>establishing a real connection Good hearts v. bad hearts Verbal, physical abuse continuity of care corruption (bribes, nepotism, favoritism)</p> <p>organization/coordination context and process continuity of care responsiveness to needs number/rotation of providers infrastructural issues, supply chains corruption (bribes, nepotism, favoritism)</p> <p>community attitudes about facility conversations and facility environment Consequence of negative or positive experience Recommending care Reporting complaints and feedback How believable is what you hear from others?</p> <p>Trust and accountability Expectations met/promises kept Rhetoric, concerns and benefits of free maternity Need to educate/empower communities and women Mechanism for feedback Increased transparency in facility decisions/spending Power dynamics: culture of deference and acceptance</p>	<p>Personalized attention & care Perceived ability of provider Discrimination Corruption</p> <p>Health facility factors Responsiveness in emergencies & "good services" Physical environment & cleanliness Navigability of processes Management & oversight Discrimination Corruption Coordination amongst providers</p> <p>Community factors Reputation & social history Corruption Informational channels (social networks, CHW promotion, media)</p> <p>Accountability Actions align with expectations Adapting to policy changes Community voice</p> <p>Strutural factors</p>
<p>VI</p>	<p>- What do you think a patient's trust is all about?</p> <p>- What do you think makes patients trust the facility?</p> <p>- We've heard that community mistrust in health facilities may be deterring care-seeking (from women, communities, and providers and providers). What do you think about this? [†]</p> <p>- Tell me about your role in assisting deliveries?</p>	<p>Enables trust Reduces trust</p> <p>Consequence of negative or positive experience TBAs v. facility Outcomes Even if not me, my baby Need to educate/empower women and communities</p> <p>Trust/mistrust in provider; facility Showing caring nature/ empathy Communication Quality of counseling trust/distrust in providers: male/female; younger/older;</p>	<p>Pateint/individual factors (agree with women & community perspective, care seeking evidence of trust)) Prior experience Perceived risk or harm Childbirth outcomes Maternity care literacy</p> <p>Provider factors (agree with women & community perspectives – expand in challenges) Empathy & respect, Personalized attention & care</p>

	<p>- Tell us about your relationships with other workers in the facility?</p> <p>- How do you feel supervisors shape the work environment at the facility?</p> <p>- Describe any ethical or professional codes that health workers like yourself follow? Consequences if codes are broken? †</p> <p>- Why do you think some women may trust providers and health facilities in this area more than others? †</p> <p>- What do you think about the free maternity mandate?</p>	<p>religions/not corruption (bribes, nepotism, favoritism)</p> <p>organization/coordination continuity of care number/rotation of providers infrastructural issues, supply chains Night v. day Management structures should change Management challenges Delivering at home</p> <p>community attitudes about facility conversations and facility environment corruption (bribes, nepotism, favoritism)</p> <p>Trust and accountability Expectations met/promises kept Rhetoric, concerns and benefits of free maternity Need to educate/empower communities and women Mechanism for feedback Increased transparency in facility decisions/spending</p> <p>Provider challenges and constraints Provider background and motivation Blaming the health worker</p> <p>Power dynamics within facility (doctors, midwives, nurses, management) Power dynamics in community health system Trusting expertise/ deference to providers Blaming patients for non-cooperation Professional codes of conduct; rights and obligations of patients and providers Decentralization and county-level re-organization gender norms (general) and gender norms around delivery (specific)</p>	<p>Perceived ability of provider Discrimination (deny personal engagement) Corruption (deny personal involvement but agree that it happens)</p> <p>Health facility factors (agree with women & community perspectives – expand in challenges) Responsiveness in emergencies & “good services” Physical environment & cleanliness Navigability of processes Management & oversight Discrimination Corruption Coordination amongst providers</p> <p>Community factors (agree with women & community perspective – care seeking evidence of trust) Reputation & social history Corruption Informational channels (social networks, CHW promotion, media) Maternity care literacy</p> <p>Accountability (agree with women & community) Actions align with expectations Adapting to policy changes Community voice Intra-facility feedback</p> <p>Provider challenges Mental fatigue & working conditions Motivation and support Supervision Teamwork benefits and challenges</p> <p>Structural factors as cross-cutting issue (in facility and community units) Institutional hierarchies</p>
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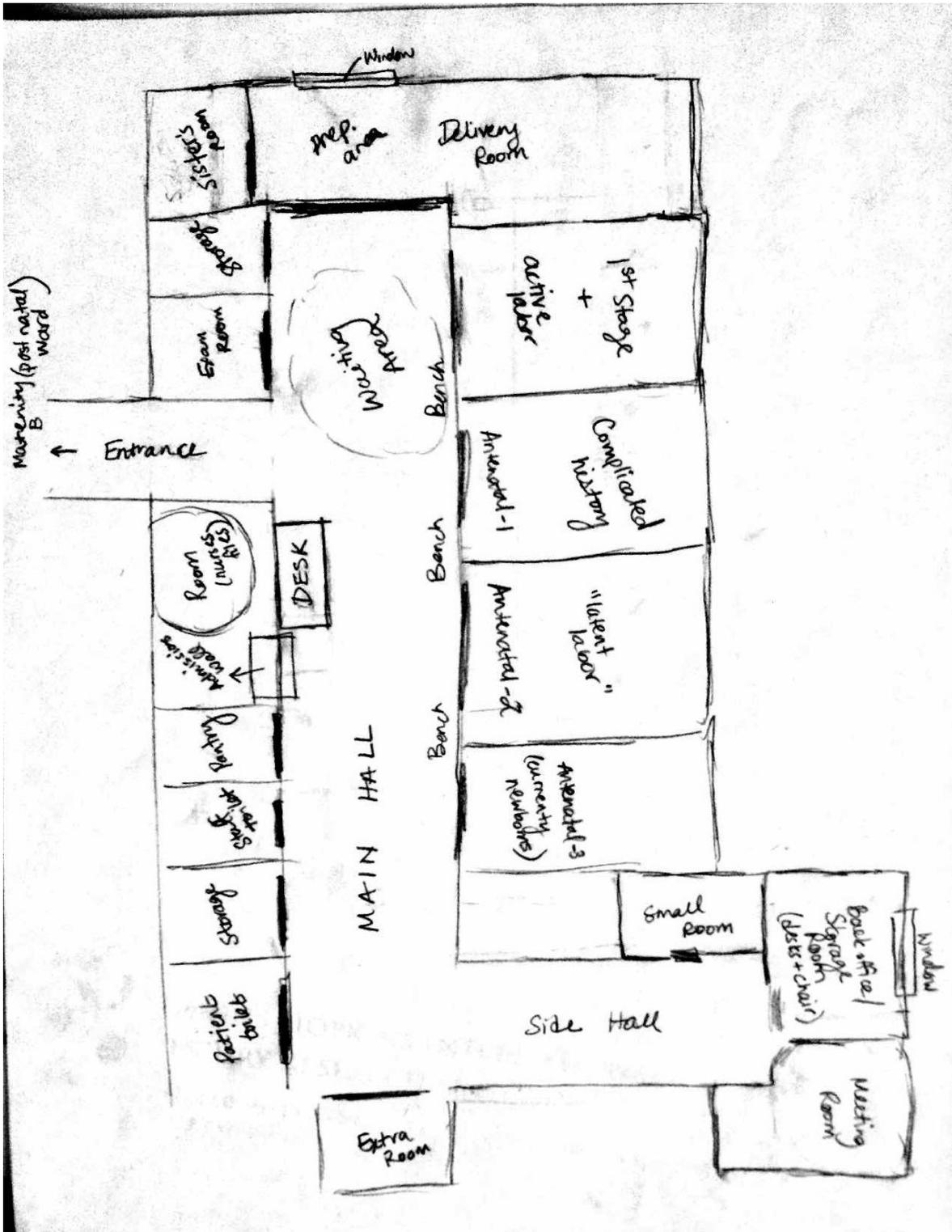
			Policy and professional codes Devolution
VII	<p>- How do you think we can build trust between patients and providers?</p> <p>- How do you think we can build trust between patients and facilities?</p> <p>- How do you think we can build trust between communities and the health system overall?</p> <p>- How do you think we can build trust between cadres of providers?*</p> <p>- How do you feel ethical or professional codes could be changed? *†</p> <p>- Tell me about the work you currently do around improving quality of maternity care in Kenya?</p>	<p>Enables trust</p> <p>Need to educate/empower women and communities to seek facility-based maternity care, to know their rights and report violations of those rights, ask questions and demand information</p> <p>avenues for reaching women and community</p> <p>Medical education/re-training/experiential learning</p> <p>Provider education, reputation, contracts and sanctions for non-compliance</p> <p>Communication quality</p> <p>Providers challenges and constraints</p> <p>Trust/distrust in provider</p> <p>Trust/distrust in health facility</p> <p>Management of facility should change (relationships with government, patients, community)</p> <p>number/rotation of providers</p> <p>infrastructural issues, supply chains</p> <p>privacy</p> <p>supervision</p> <p>adequate funding</p> <p>government follow-up</p> <p>Role, nature and gender of CHWs</p> <p>Patient feedback</p> <p>Community feedback</p> <p>Community-facility relationship</p> <p>Blaming the health worker/health worker rights/ security & protections</p> <p>role of facility staff</p> <p>role of government</p> <p>role of the provider (role of doctor - CO v. MO, role of nurse)</p>	<p>Patient/individual & community mechanisms</p> <p>Increase awareness of patient rights to RMC and empower communities to realize (via questions and demanding) these rights</p> <p>Promote maternity care and reproductive health literacy by educating women & communities prior to their labor & delivery</p> <p>Use appropriate information relay channels (i.e. involve key community stakeholders)</p> <p>Provider mechanisms</p> <p>Enhance interpersonal skills (training)</p> <p>Educate and deploy more nurse-midwives to public maternity wards</p> <p>Routine meetings</p> <p>Financial and non-financial incentives to motivate frontline workers</p> <p>Counseling</p> <p>Health facility mechanisms</p> <p>Increase and rotate human resources</p> <p>Support supervision and disciplinary actions</p> <p>Promote social and work-related interactions to improve inter-cadre dialogue</p> <p>Improve infrastructure (private spaces) and material resources (e.g. beds, drugs)</p> <p>Enhancing transparency of management decisions, processes, and fee schedules</p> <p>Accountability & Structural</p> <p>Monitoring and feedback of experience, complaints, and rights at all levels (patients and providers)</p> <p>Strengthen community-facility linkage</p> <p>Continuity/sustainability</p> <p>Stakeholders</p>

*Appreciative inquiry lens

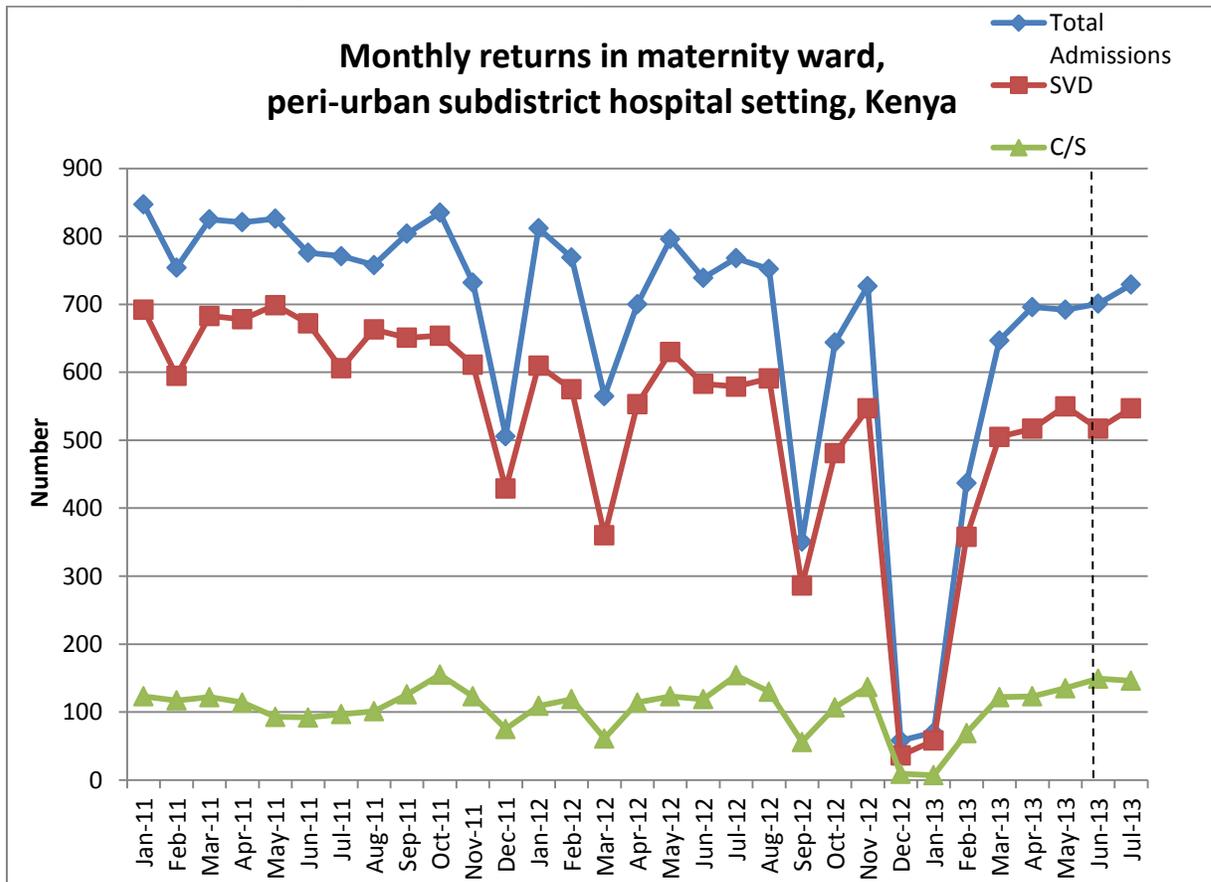
†Critical questions/Institutional ethnography lens

‡Health systems trust: content area framework-informed

Appendix 5. Sketch of Maternity A (main obstetric ward for labor and delivery)



Appendix 6. Deliveries per month at sub-county facility between Jan 2011-July 2013



*SVD=standard vaginal deliveries, C/S=cesarean section

* Dashed line indicates when the Free Maternity Policy was instated by the Kenyan government

Appendix 7. Nursing and Citizen's Service Charters (posted in maternity ward)

Mat. A

DEPARTMENT OF NURSING SERVICE CHARTER

VISION
Best nursing services comparable to those in high income countries, through empowered nurses.

MISSION
Promote wellness, Prevent illness, alleviate suffering, restore health, prolong life and ensure peaceful, dignified and pain-free death.

OUR OBLIGATION

- Create a safe and healing environment for patient care.
- Protect patient confidentiality and privacy.
- Promote patient's welfare and rights through multidisciplinary approaches.
- Make ethical and moral decisions on patient care.
- Provide and promote needed expertise in nursing care for both the sick and the well.
- Manage resources efficiently and facilitate accessibility and utilization.

CUSTOMER'S OBLIGATION

- Understand personal health problems and be honest about everything related to sickness.
- Engage in positive health seeking behavior and lifestyle.
- Follow nurses' instructions and keep appointment dates.
- Respect and cooperate with nurses to ensure continuity of care.
- Respond to questions honestly and completely, and express feelings for effective implementation of nursing process.
- Inform nurses about changes noticed or felt during care process.
- Be considerate to other patients and ensure minimal noise or any other inconveniences.
- Care for personal hospital records and produce them when requested for.

HUDUMA BORA NI HAKI YAKO

MAT. A

**IDARA YA UUGUZI
MKATABA WA WAUGUZI KWA HUDUMA YA RAIA**

MAONO
Huduma bora zaidi ya uuguzi inayolinganisha na ile ya mataifa yenye mapato ya juu kupitia wauuguzi waliyo wezesha

LENGO
Kukuza uzima, kuzuia magonjwa, kupunguza maumivu, rejsha afya, kuongeza maisha, na kuhakikisha kifo chenye adhama, amani, na kisicho na uchungu.

JUKUMU LETU

- Kuunda mazingira ya uponyaji kwa ajili ya huduma kwa wagonjwa.
- Linda siri na ubinafsi wa mgonjwa
- Kukuza masilahi ya wagonjwa na haki zao kupitia huduma za idara zote za matibabu
- Kuunda uamuzi wenye mambo ya adili na tabia njema kuhusu huduma ya wagonjwa.
- Kuwasilisha na kukuza ujuzi unaohitajika wa huduma za uuguzi kwa wagonjwa na wale wasiyo wagonjwa.
- Kusimamia rasimali vizuri vilivyo na kusaharisha kupatikana kwa matumizi.

JUKUMU LA MGONJWA

- Elewa shida za kibinafsi za afya na kuwa mwadilifu kuhusu kila kitu kinachohusiana na ugonjwa.
- Husika na mienendo mizuri ya kutafuta afya na kuishi kwema
- Fuata maagizo ya wauuguzi na kutilia maanani tarehe zakurudi kuonekana.
- Heshimu na kufanya kazi pamoja na wauuguzi kuhakikisha kuendelea kwa huduma.
- Jibu maswali kwa uadilifu na ukamilifu, na kuonyesha hisia za kuanzishwa kwa huduma ya uuguzi.
- Julisha wauuguzi kuhusu mabadiliko unayohisi wakati huo wa huduma.
- Jali masilahi ya wagonjwa wengine na hakikisha umepunguza sauti na usumbufu wowote.
- Hifadhi tarakishi za hospitali na uwasilishe zinapo hitajika

HUDUMA BORA NI HAKI YAKO

**KIAMBU DISTRICT HOSPITAL
CITIZEN'S SERVICE CHARTER FOR MATERNITY A**

SERVICE RENDERED	REQUIREMENTS	TIME FRAME	USER CHARGES
Admission of patients from Home and Referrals	Patients file Cooperation from Client and Relatives	30 Minutes	Ksh.150 - 200
Bed Making and Bed Bath	Cooperation from Client	20 Minutes	Free
Observations of vital signs (Temperature, Pulse & Blood Pressure)	Cooperation from Client	15 Minutes	Free
Investigations	Cooperation from Client Request Forms	20 Minutes	Ksh 50-500 (Payable after investigations)
Drug Administration	Cooperation from Client	10 minutes	KSh 70.00 per day
Ward Rounds	Cooperation from Client Patient File	10 minutes	Free
Inserting I.V. Line	Cooperation from Client	20 minutes	Ksh.50 (Payable after Investigation)
Normal Delivery	Cooperation from Client	1 hour	Ksh. 2,000.00
Caesarean Section Elective	Payment Receipt Client's Consent	1 - 2 hours	Ksh. 4,000
Caesarean Section	Client's Consent	1 - 2 hours	Ksh 4,000
Feeding Patients	Cooperation from Client	20 Minutes	Free
Care of New Born Babies	Cooperation from Client	20 Minutes	Free
Resuscitation	Condition of Patient	30 Minutes	Free
Health Education	Cooperation of Client and relatives	10-15 minutes	Free
MTCT Services	Cooperation from client Patient consent	20 Minutes	Free
Discharge	Discharge Card	30 Minutes	As per service given
Transfer to Post Natal Ward	Payment Receipt Cooperation from Client and Relatives		

SERVICES: Health Services to Children Under 5 Years, Treatment for Malaria, TB, HIV/AIDS and Epidemics

WE COMMITTED TO COURTESY AND EXCELLENCE IN SERVICE DELIVERY
We do not confirm to the above standards or an Officer who does not live up to the commitment to courtesy and excellence in delivery should be reported to the Out-Patient Department Nursing Officer In-Charge or Any Hospital Administrator on the following

HOSPITAL / AMBULANCE NUMBERS: 066 2022191 / 066 2022739 / 0721 864 258

HUDUMA BORA NI HAKI YAKO

Ministry of Medical Services Headquarters Contacts
P.O. BOX 30016, Nairobi, Tel: 020 2717077,
Emergency calls: 0735 984 498, 0725 733 650
Emails: enquiries@health.go.ke or psmoh@africaonline.co.ke
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**HOSPITALI YA WILAYA YA KIAMBU
MKATABA WA WADI YA KUJIFUNGA KWA HUDUMA YA RAIA**

HUDUMA	MAHITAJI	MUDA	MALIPO
Utaratibu wa Kulezaa Vitei nyumbani au Ushirikiano wa Mjaja na Jamaa Zake	- Fali ya Mgonjwa - Ushirikiano wa Mjaja na Jamaa Zake	Dakika Thelathini	Ksh. 150-200
Kuwasilisha Kilanda na Kuishwa Kigandani	- Ushirikiano wa Mjaja	Dakika Ishirini	Bure
Kuaminiwa Joto, Pumbi, Kazi ya upigaji wa moyo kwenye mshipa wa damu na Shirikishi la damu	- Ushirikiano wa Mjaja	Dakika Ishirini	Ksh. 50 - 500
Uchunguzi wa Ugonjwa kwenye lebu/taabara	- Fomu ya maombi - Ushirikiano wa Mjaja	Dakika kumi	Ksh. 70
Kupika Dawa	- Ushirikiano wa Mjaja	Dakika Ishirini	Ksh. 50
Kuambwa Sindano ya Kupoteza dawa	- Ushirikiano wa Mjaja	Dakika kumi hadi kumi na tano	Bure
(Maji) Daktari kuona wagonjwa kwa Ushirikiano wa Mjaja	- Fali ya mgonjwa - Mgonjwa	Saa moja	Ksh. 2000
Kufungua kwa hali ya Kawaida	- Ushirikiano wa Mjaja	Saa moja hadi Masaa Mawili	Ksh. 4000
Upasaji wa Kufungua uso wa dharura	- Rishi ya Malipo - idhini ya Mgonjwa	Saa moja hadi Masaa Mawili	Ksh. 4000
Upasaji wa Kufungua, wa dharura	- Rishi ya Malipo - idhini ya Mgonjwa	Dakika Ishirini	Bure
Chalula	- Ushirikiano wa Mjaja	Dakika Ishirini	Bure
Huduma kwa Watoto Waliozaiwa	- Ushirikiano wa Mjaja	Dakika Thelathini	Bure
Kuhusha hali Mbaya ya Mgonjwa	- Hali ya Mgonjwa	Dakika kumi hadi	Bure
Elimu ya Afya	- Ushirikiano wa Mjaja kumi na tano	Dakika kumi hadi	Bure
Huduma za Litofaji wa uwambuzi wa Ukimwi kutoka kwa Mama hadi Mto.	- Ushirikiano wa Mjaja na idhini yake.	Dakika Thelathini	Bure
Kupewa Ruhusa Kwenda nyumbani au Kuhushwa hadi Wazi ya Waliojifungua	- Kadi ya Kuhurusiwa Kwenda Nyumbani - Rishi ya Tarakimu ya Malipo - Ushirikiano wa Mjaja na Jamaa Zake	Dakika Thelathini Huduma uliyopewa.	Kulingana na huduma uliyopewa

HUDUMA ZA BURE: Huduma za afya kwa watoto chini ya miaka 5, Matibabu ya malaria, kifua kikuu, Ukimwi na mirupuko ya magonjwa.

TUKO NA JUKUMU LA HISANI NA USHARIFU KATIKA UTEKELEZAJI WA HUDUMA
Huduma yeyote isiyoambatana na viwango vilivyowekwa au Afisa yeyote asiyeukuwa na jukumu la hisani na usharifu katika utekelezaji wa huduma, piga ripoti kwa Muuguzi Mkuu wa Kitengo cha OPD au Mkuu yeyote wa hospitali kwa nambari za simu zifuatazo;

HOSPITALI / AMBULANCE: 066 2022191 / 066 2022739 AU 0721 864 258

HUDUMA BORA NI HAKI YAKO

Wizara ya Huduma ya Matibabu
Mawasiliano ya Makao Makuu
S.L.P 30016, Nairobi, Simu: 020 2717077,
Simu za Dharura: 0735 984 498, 0725 733 650
Barua pepe: enquiries@health.go.ke au psmoh@africaonline.co.ke
© 2010 ALL RIGHTS RESERVED

Curriculum Vitae

POOJA SRIPAD

psripad1@jhu.edu

(978) 314-6199

15 Charles Plz. Apt #1507

Baltimore, MD 21201

EDUCATION

Johns Hopkins Bloomberg School of Public Health, Baltimore, MD

PhD Candidate, International Health

Yale School of Public Health, New Haven, CT

MPH, Concentration: Health Policy, 2010

Thesis: Intergenerational analyses of the influence of discrimination, social support and ethnic identity on mental health status and service use in ethnic minorities in the United States

University of Chicago, Chicago, IL

BA, Public Policy & Biological Sciences, June 2008

Thesis (Public Policy): Intermediation in improving government schools in India: A case study of Peace Child India and comparative analysis

EXPERIENCE

USAID TRAction, URC/CHS, Bethesda, MD

Consultant

8/2014-4/2015

- Support implementation research by Population Council in the area of respectful maternal care.
- Assist with the qualitative analysis and writing of peer-review publication on implementation process of interventions to address disrespect and abuse in maternity care.

Johns Hopkins Bloomberg School of Public Health, Baltimore MD

Research Assistant, Global Research Ethics Systems Survey (GRESS)

8/2014- present

- Supported tool development, conduct, and analysis of GRESS survey with Fogarty Bioethics Fellows to understand institutional research ethics capacity in a range of African countries.

Research Assistant, Road Safety in Brazil (RS-10), Johns Hopkins, International Injury Research Unit

8/2012 – 2/2015

- Managed, organized, and conducted analysis of data related to road traffic safety in Brazil.
- Supported the writing and editing of project reports with country collaborators & Baltimore team.
- Participated in writing a range of publications including peer-reviewed articles and newsletters.

Population Council, Nairobi, Kenya

4/2013 – 8/2013

Research Intern

- Coordinated, managed and conducted qualitative fieldwork in Kiambu, Kenya.
- Trained research assistants on qualitative research methods and basic research ethics for fieldwork.
- Supported PC activities and research on Respectful Maternity Care.
- Attended weekly meetings and presented initial findings to PC-Nairobi team.

Urban Health Initiative, Lucknow, Uttar Pradesh
6/2011 – 8/2011

Research Intern

- Conducted qualitative and quantitative data analyses of focus group and baseline survey data on men and women's reproductive health knowledge, attitudes and practices in urban U.P.
- Assisted on pretesting of behavioral films in slum-dwelling populations.
- Provided translation support for media coverage of innovative family planning promotional strategy.

Human Rights Watch, New York, NY
2/2009 – 6/2009

Intern, Women's Rights Division

- Researched international law as related to issue of maternal mortality and morbidity.
- Conduct literature reviews on maternal mortality and morbidity globally and in South Asia.
- Contributed to the Maternal Mortality in India report, *No Tally of Anguish*.

UNICEF TACRO, Panama City, Panamá
6/2009 – 8/2009

Intern, HIV/AIDS

- Analyzed & documented trends of HIV prevention indicators for adolescents in LAC region
- Summarized annual country reports on HIV epidemic in young people.
- Contributed to drafting HIV/AIDS prevention chapter for the Regional Stocktaking Report 2009.
- Supported ongoing work at UNICEF (e.g. Faith-Based Organizations and HIV, judged audiovisual submissions for World AIDS Day, and provided technical materials to HQ and country offices).

University of Chicago Hospitals, Chicago, IL
3/2006 – 6/2008

Research Assistant, Cardiology Project

- Conducted inpatient and follow-up interviews on Cardiology healthcare service quality.
- Performed medical chart abstractions, documented results, and entered data.
- Assisted in translation of survey material from English to Spanish.

Peace Child India, Bangalore, India
3/2007 – 8/2007

Intern

- Developed and presented health workshops to low income students in urban slums and villages.
- Taught English, participated in infrastructure improvements of government schools.
- Wrote policy brief on impact of integrating health education into public school curriculum.
- Organized, coordinated, and facilitated activities and service projects for temporary volunteers.
- Served as translator for staff, interns, and target populations during and after office hours.

Greater Lawrence Family Health Center, Lawrence, MA
Summer 2005 and 2006

Research Assistant

- Conducted diabetes prevention and wellness workshops with city's Latino adults and youth.
- Surveyed diabetic patients on quality of care and the Diabetes Self- Management Education (DMSE) program in English and Spanish; translated educational materials.
- Collaborated with health and social workers to develop a prevention and wellness youth curriculum.
- Compiled background information and data for article on DSME program

TEACHING AND TRAINING

Johns Hopkins Bloomberg School of Public Health, Baltimore MD

Teaching Assistant, Health Systems Program Seminar

1/2014 – 5/2014

- Assisted in coordinating guest speakers, managed course website and monitored attendance.
- Supported faculty/student presentations.

Teaching Assistant, Issues in the Reduction of Maternal and Neonatal Mortality in LMICs

10/2013 – 12/2013

- Assisted faculty with class organization, coordination of guest speakers, and course management.
- Mentored students, graded assignments, and provided feedback to both students and faculty.

Teaching Assistant, Health Systems Research

10/2011 – 5/2013

- Participated in discussions with instructors around course objectives, design, content & structure.
- Assisted in identification and compilation of reading materials.
- Managed course website, facilitated class discussions, mentored students and shared faculty responsibility for grading assignments and providing feedback

Teaching Assistant, Case Studies in Management Decision-Making

1/2012 – 3/2012; 1/2013-3/2013; 1/2014 – 3/2014

- Assisted in preparing class materials and communicating course information to students.
- Coordinated guest speakers, facilitated break-out sessions & performed course management activities.

Teaching Assistant, Health Systems in Low and Middle Income Countries

10/2011 – 12/2011

- Assisted in class material preparation, communications/administration, and guest lecture coordination.
- Mentored students and answered a range of course-related queries throughout the duration of the term.
- Graded class assignments, final papers, and provided timely feedback to professor and students.

Yale University, New Haven, CT

Teaching Assistant, Health Policy and Health Systems

9/2009 – 12/2009

- Assisted professor in preparing class materials and communicating course information to students.
- Conducted review and biweekly discussion sections & mentored students throughout the semester and during group projects.

Phillips Academy, Andover, MA

7/2008 – 8/2008

Teaching Assistant, Economics and English as a Second Language (ESL)

- Assisted in planning and teaching Economics and ESL classes to high school students.
- Evaluated student performance and discussed teaching methods with other teachers and interns.

PROFESSIONAL ACTIVITIES

Respectful Maternity Care Advisory Group (member)

Health Systems Global (member)

PUBLICATIONS

Aguilera, S.L.V.U., Sripad, P., Lunnen, J.C., Moysés, S.T., Chandran A., Moysés S.J., “Alcohol consumption among drivers in Curitiba, Brazil,” *Traffic Injury Prevention*, 2014.

Calhoun, L., Speizer, I.S., Rimal, R.N., Sripad, P., Chatterjee, N., Achyut, P., Nanda, P., “Provider imposed restrictions on clients’ access to family planning in urban Uttar Pradesh, India: a mixed methods study,” *BMC Health Services Research*, 2013, 13: 532.

Sousa, T., Lunnen, J., Goncalves, V., Schmitz, A., Pasa, G., Bastos, T., Sripad, P., Chandran, A., Pechansky, F., “Challenges associated with drink driving measurement: combining police and self-reported data to estimate an accurate prevalence in Brazil,” *Injury*, Vol. 44 (Supp. 4) S11-S16, 2013.

Ozawa, S. & Sripad, P. “How do you measure trust in the health system? A review of the literature,” *Social Science & Medicine*, Vol. 91, 2013.

Woolf, J., Rimal, R.N., Sripad, Pooja, "Understanding the Influence of Proximal Networks on High School Athletes’ Intentions to Use Androgenic Anabolic Steroids," *Journal of Sport Management*, Vol. 28 (1), 2013: 8-20.

Janevic T., Sripad P., Bradley E., Dimitrievska V., “ ‘There’s no kind of respect here’ A qualitative study of racism and access to maternal health care among Romani women in the Balkans,” *International Journal for Equity in Health*, Vol. 10, No. 53, 2011.

Human Rights Watch, *No Tally of Anguish*, October 2009. Acknowledged for research support.

CONFERENCES

Sripad P., Abuya T., Ozawa, S., Merritt, M., Warren, C., “Exploring trust in maternity care: a qualitative study in peri-urban Kenya”, The Third Global Symposium on Health Systems Research, Cape Town, South Africa, 2014. (Oral presentation)

Rimal, R.N., Sripad, P., Speizer, I., Calhoun, L., Velu, S., Chatterjee, N., Marwa, S., Nanda, P., "Use of Modern Contraceptive Methods in Uttar Pradesh, India: The Role of Normative Influences and Interpersonal Communication," ICA 2013 conference “Challenging Communication Research.” London, U.K. (Paper)

Woolf, Jules, Rimal, Rajiv N., Sripad, Pooja, "Understanding High School Athletes’ Use of Androgenic Anabolic Steroids: The Role of Source Proximity in the Theory of Normative Social Behavior," ICA 2013 conference “Challenging Communication Research.” London, U.K. (Paper)

Rimal, R.N., Sripad, P., Chatterjee, N., Trivedi, G., Rook, K., Safi, B., Nanda, P., Calhoun, L., Speizer, I., “Using the Theory of Normative Social Behavior (TNSB) to Understand Women’s Use of Modern Contraceptive Methods In Uttar Pradesh, India,” abstract accepted into the FP Conference 2011, Dakar, Senegal. (Oral presentation)

Janevic T., Sripad P., Bradley E., Dimitrievska V., “How do racism and discrimination affect access to prenatal and maternity care among Romani women in Eastern Europe? A conceptual framework using qualitative data,” The Science of Research on Discrimination and Health Conference, Natcher Conference Center (NIH), February 3, 2011 (Poster)

Maternal Mortality: A Human Rights Approach to a Public Health Problem, Connecticut Amnesty International Meeting. Yale University. October 19, 2009. (Oral presentation)

Co-Author, *Immigration in Chicago: Reports on Policy Issues*. The Public Policy Studies Symposium. University of Chicago. June 3, 2006. (Oral presentation)

AWARDS & FELLOWSHIPS

Robert & Helen Wright Award, Department of International Health, Johns Hopkins Bloomberg School of Public Health (2013)

Awarded in support of conducting dissertation fieldwork in Kenya

Health Systems Awards for Doctoral Research, Department of International Health, Johns Hopkins Bloomberg School of Public Health (2012)

Awarded for “Exploring health systems trust around maternity care in Nairobi, Kenya”

Global Health Established Field Placement, Johns Hopkins Center for Global Health (2011)

Awarded in support for Urban Health Initiative’s reproductive health project in Lucknow, India

Overlook International Fellowship, Yale University (2009)

Awarded in support for summer internship at UNICEF TACRO (Panama)

Eduardo Braniff Fellowship, Yale University (2009)

Supported summer internship at UNICEF TACRO (Panama)

Susan Bliss Scholarship, Yale University (2008, 2009)

Richter Grant, University of Chicago, (2007)

Awarded for internship and independent research in Bangalore, India

SKILLS/LANGUAGES

- **Computer:** Proficient in Microsoft Word, Excel, & PowerPoint, STATA, Atlas.ti
- **Languages:** Fluent in English, proficient in Spanish (reading, writing, speaking) and Kannada (speaking), basic knowledge of Hindi (speaking)