

# **QUALITY OF PRENATAL CARE AT BARATON MATERNAL CHILD HEALTH CLINIC**

Access, advice, counseling and the scope of diaconia referencing hope and dignity afforded the patients as elements to assess the variable of quality

Beatrice Wambui Wainaina  
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Diaconia University of Applied Sciences  
Degree Program in Social Services  
Bachelor of Social Services (UAS) (+  
Qualification for Option in Diaconia Prac-  
tice)

## ABSTRACT

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The aim of this research was to find out if there is existent at the Baraton University Maternal Child Health Clinic a high standard of quality of prenatal care. Therefore the research question became much effectively, what is the quality of prenatal care the Baraton MCH?

The author utilized literature review to define the meaning of quality using five elements which are counseling, advice, access, dignity and hope. Consequently equipped with these definitions of quality, the author set out to collect data, and used these derived meanings that define quality as a measuring tool to measure the attained standard of quality at the clinic. This was achieved via critical analysis of the findings using the defined measures of quality. Thereafter, a hypothesis was derived from this critical analysis of whether the prenatal care offered at the Baraton MCH has attained the standard of high quality prenatal care.

Data was collected via interviews with eleven mothers selected by the clinic, after which the recorded interviews were transcribed and a system of coding designed to embellish the inductive approach synonymous with qualitative research. Consequently, the coding entailed using the key terms social work, diaconia and availability. Thereafter, these three key code names were further broken down into the five indicator variables as follows: advice and counseling derived from the capstone social work, hope and dignity from diaconia, and access from availability.

Based on the aforementioned critical analysis, it was articulated that the quality of prenatal care at the Baraton MCH is somewhat in need of revision. It needs to be improved and developed albeit while maintaining culturally sensitive perspectives and models with regards to the quality of prenatal care. This hypothesis will be delved into thoroughly in this study, in section four of findings.

Moreover, ideas and recommendations in realm of the future aspect were proffered by the author with regards to the roles and possibilities of a social worker in the clinic. There is much room for growth and development, to achieve a standard of high quality of prenatal care at the Baraton MCH.

Keywords: quality of prenatal care, counseling, access, advice, dignity, hope, literature review.

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## 1 INTRODUCTION

The aim and topic of the study changed numerous times over the course of my research process, because while my first topic of interest was street children in Nairobi, this was not feasible due to permits and the limited time that an international placement allows.

This created room to therefore subsequently be able to study and research the topic of quality of prenatal care in Kenya, another topic that has generated much interest over the course of my studies. The personal interest is based somewhat on the fact that I am Kenyan, and the high rate of maternal and perinatal deaths currently ranking Kenya in the top hundred is a current affairs issue that requires to be addressed. I felt that this study could be part of a global dialogue to work towards reducing these staggering numbers, while advocating for the empowerment of women (Partnership for Maternal, Newborn and Child Health.)

With this in mind, the topic of research was hence arrived at, and the study the author decided to implement to reflect this expressed interest would attempt to answer the question of the quality of prenatal care offered at a strategic facility in Kenya. The term strategic here is used because in the early stages of determining and understanding the purpose of the research, the facility of study in Kenya was not yet established.

This is how I ended up at the University of Eastern Africa Baraton University (UEAB), a university located in Eldoret and in the Rift Valley Province of Kenya. This university has a collaboration with Diaconia University of Applied Sciences (DIAK), but until summer of 2015, no other student from Diaconia University's social services program had implemented Bachelor's degree work studies on location at the campus of Baraton University; the study was carried out in the Baraton University's Maternal Child Health Clinic (MCHC) that is located in the compound of Baraton University (University of East Africa Baraton & Diaconia University of Applied Sciences 2015.)

In the course of this research, I hoped to acquire some insight on the practice and quality of prenatal care in Kenya, utilizing literature review and existent research as the weighting scale for defining this quality.

In 2012, a staggering 40,010 perinatal and maternal deaths were recorded in Kenya (World Health Organization).

This is therefore a topic that has continued to generate not only personal interest but also worldwide attention, been considered a crisis. This study hopes to generate some insight on what to do to cater to these statistics, albeit from a social work perspective, one not much emphasized in this region there-before. While a research based on the sphere of social services generates only a single side of the vast phenomenon, hope abounds in that research has been known to reveal facts that can be used to cater to different aspects of the epidemic and serve as a source for statistics on other studies of the same phenomenon; this research could be a stepping stone towards the direction of finding a concrete solution to this widespread pandemic that has not been awarded the attention and research it deserves. Furthermore, as a social worker, it has always been much important to denote that women need empowerment especially in Kenya, because it is a patriarchal society (Machira 2013.)

In addition, this research will attempt to justify the minimal role of social work in Kenya, and how a much improved role could improve the mentioned circumstances. Moreover, the effect of culture in the field of social work and hence quality of prenatal care will also be referenced. Most importantly, the author will answer the referenced quality of prenatal care focusing on the indicators of access, counseling, advice, hope and dignity.

The main aim of this research is to study the quality of prenatal care at the Baraton MCHC. This is also the research question, which this research will attempt to answer utilizing the above mentioned elements of access, counseling, advice, hope and dignity. The dynamics of culture will help to ascertain the values of that quality of care, utilizing the five indicators mentioned above as modes of evaluation of current practice based on literature review. Consequently within

this study to define what quality prenatal care entails, Literature review was utilized to define the aspect of quality using the five elements; these definitions rendered a picture of what good practice looks like and with this in mind, the author set out to compare current practice with these established definitions. Thereafter, based on what the finding was after this comparison, a hypothesis was derived and presented in the study.

The method of data collection was interviews, where the author interviewed eleven mothers but ended up using only ten interviews to preserve client privilege after one mother opted out of the study. Furthermore, the process of research entailed a nuanced theoretical background prefacing the study of the quality concept in the whole realm of the study. Subsequently, terms of the indicator variables were defined, and their concepts derived, to create a background that would be the foundation for the latter analysis in the scope of the topic: to reiterate as stated previously, these definitions also encapsulated detailing the standard utilized to denote and measure quality of prenatal care, as established through literature review.

The diaconia concepts of hope and dignity were used to assess the quality of the prenatal care from a church standpoint, analyzing the concept of the standard of prenatal care using these two indicators as tools of analysis. Consequently the results of the data collection were then analyzed using definitions of dignity and hope derived via literature review, existent Christian writings that denote a Christian perspective.

Previous research addressing the issue of prenatal care as a whole abounds, but as the specialization narrows down towards the aspect of quality of the care, not as much research exists; however, a few researchers have produced literary works on the topic; this research will therefore have its place within the few, more specifically with regards to Kenya, continuing in the precedent to establish the topic of research on the quality of prenatal care not only at the MCHC but in Kenya as whole. This is especially relevant because previous research in the realm of the quality of prenatal care in Kenya are few.

After the research, the author arrived at the following definite conclusions: counseling and advice which are vital elements in offering quality prenatal care were absent at the clinic. Furthermore, because there was no professional or social worker on personnel at the clinic, the mothers did not have access to such a professional. However, the study did find that the mothers interviewed have a healthy spiritual wellbeing, denoted by the presence of hope in most of the clients interviewed. Furthermore, also denoting spiritual health and wellness from a diaconia perspective, is the dignity the clinic afforded to the mothers; the study found that the mothers were regarded with respect and thus, dignity.

In conclusion, the main task of this research is to answer the following question: what is the quality of prenatal care at the Baraton MCHC? This will be done by defining the meaning of quality utilizing the five aforementioned elements using literature review. Through critical analysis of findings, utilizing these derived meanings from literature review, the author will then present a theory of existent quality of care at the Baraton MCHC; finally, the future scope of social work at the clinic will then be covered, and a recommendation based on this scope will as a result be given.

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## 2 THEORETICAL BACKGROUND

### 2.1 Background and premises for the study

Lack of access to a social worker or professional in this cultural context, as well as the lack of the social work services of counseling and advice for prenatal mothers has been a troubling phenomenon as demonstrated by IRIN. In their article titled, KENYA: Healthcare hurdles in Nairobi's slums, they detail in harrowing detail the low standard of quality prenatal care available to the women living in this areas (Integrated Regional Information Networks 2015.)

This therefore, while it is yet another reason and incentive to do this study, forms a strong basis for its importance and relevance which begins the laying of the foundation for the author's premise of this study; the social work concept in Kenya is not one that is as developed, strategized or implemented in Kenya as compared to her counterparts with more established social systems such as the United States. Furthermore, a close observation of the status of social work education in Kenya reveals very slow growth (Spitzer, Twikirize & Wairire 2014, 93-96).

While Kenya is in the top ten of Africa's leading economies and was recently ranked as a middle-income country by the Forbes magazine, it takes time and strategy to establish a social work system that is government backed and works towards bettering the lives of its citizens (Gundan, 2014).

In addition, the social work implementation system in Kenya is a growing phenomenon. While it exists, it requires time, work and a backing economy to allow it to thrive to levels where the citizens of Kenya will be able to fall back on an established social work system for support, which is largely not the case at the moment (Spitzer, Twikirize & Wairire 2014, 217).

It therefore goes without saying that social work in the field of prenatal care needs more professionals to not only cater for the ever rising numbers of peri-

natal and maternal mortalities, but to offer good social work practice that might with time and development circumvent these numbers altogether (World Health Organization).

Furthermore, a prenatal mother experiences a vast reality of emotional and psychological changes, and this is where a social worker's role is crucial to the wellbeing of the mother. During social visits, prenatal mothers can talk about these feelings of wellness or the lack thereof with a professional or social worker, can get sound advice and counseling because this professional has specifically been trained to handle situations such as this. Could the absence of this professionals and therefore the services of counseling and advice have also contributed to this poor standard of care previously mentioned in paragraph one of this section? It is a fact that when a mother has all round wellness which the social work profession is supposed to cater for, thoughts of suicide, depression and maternal negligence have been subverted (Spitzer, Twikirize & Wairire 2014, 173-175.)

Since the social work system is in the development stage in Kenya, this means that a vast majority of mothers have no access to anyone of professional capacity that could offer the services of counseling and advice during this stage. Moreover, in addition to the absence of a professional social worker, a vast number of Kenyans, 21.5% in 1997 and a staggering rise to 33.6% in 2005 would consider that a minor problem, having to live and survive with a meagre 1.90\$ a day being the major problem (World Bank 2015).

This therefore brings about the conclusion that a staggering number of Kenyan prenatal mothers lack not only the crucial role of counsel and advice from a lack of access to a social worker in the prenatal stages, but do not have the economic means by which to get to a prenatal clinic. In addition, the prenatal system in the rural areas is barely functional or even absent in most cases. Furthermore, those clinics or hospitals that are reputable and offer good quality of prenatal care services for prenatal care are not accessible to the slum mothers, who can barely make enough food for their families to get by (Integrated Regional Information Networks 2015.)

This is the basis behind the author's study, and the possibility to perform such a study was only availed by the Baraton MCHC, whereby the study could also have access to the women who live in the slums of Baraton Center, who visit the MCHC.

It is of essence within this research to express the premise within the diaconia confines of hope and dignity. It was important to understand how the prenatal mothers in the explained circumstances feel, from a Christian perspective.

Do they have hope towards the future? What about dignity, do they feel they are treated as worthy of respect and equality? Moreover, do they feel that their lives matter and as a result can demand for their God-given human right to be protected from poverty because it robs humanity of dignity?

It was therefore crucial for this study to analyze and reveal how being in this particular situation might encapsulate personal defeat, and affect their individual spiritual wellbeing. Furthermore, from a diaconia standpoint, it was crucial to iterate how their overall wellbeing affected the feeling of not only being an entity worthy of respect, but how the lack of the providence of the services of quality prenatal care affected their holistic person-centered wholeness and worthiness (De la Porte, 2013.)

Furthermore, it deemed crucial to understand the complexity of what gives the mothers a concept of spiritual wellbeing. This is where the dynamic of hope becomes evident, the faith towards the future despite the lack of physical attributes that would be the key concept of what entails quality prenatal care (Kylma 2005.)

## 2.2 Study interface with professional practice and theory

The question arises of how this research intertwines with the reality of professional practice and by extension, theory. This section will explain in detail how this study interfaces with good professional practice in conjunction with theory.

Firstly, professional practice dictates that a prenatal mother should have access to a social worker or qualified professional with whom she can discuss issues regarding her personal wellbeing which is referred to as counseling, as well as receive concrete and sound advice, which is common practice in countries such as Finland (infopankki 2014).

In the context of this study, the author gained understanding in practical terms outcomes of lacking access to a social worker or professional on the subjects as well as the scope of social work. During the research process, the author observed lack of wellbeing, expressed in the interviews, excerpts of which are presented in detail in section four. Mothers need advice, sound advice, and they need counsel, and since there is no professional to provide this, they rely on the informal mode which is not always helpful to them as revealed in the interviews.

Secondly, this study is essential for the development and evolvement of existent social work strategy, which is part of the work description and development scheme of a social worker, an essential part of good professional practice. Most models of social work have evolved over time, and this was only plausible because social workers in adherence to good practice continued to contribute to the field by taking part in research and implementing the results of research in betterment to already existent structure; this is the premise of researchers during research, and the author of this study was able to take part in developing a study that could progress the reaches of social work not only within this clinic, but also in Kenya. In fact, based on this study, perhaps new methodology at the clinic could be employed, including a social worker on personnel, which is a major contribution by the author to the field of social work (Jamtvedt, Young, Kristoffersen, O'brien & Oxman 2006.)

Thirdly, as a social worker, it is crucial to possess the skill of listening, reading between the lines, and understanding body language; this is part of the skillset of a good social worker and is in line with good professional practice. This allows the social worker to understand his/her clients at an advanced level and allows for effective parallel communication (Jamtvedt, Young, Kristoffersen, O'brien & Oxman 2006.)

During this study, especially during the interviews, it was crucial to perceive when a mother felt a certain topic was too personal, comprehend what was of most importance to them and understand when she felt a certain topic was off the record. Furthermore, I as the professional needed to be able to improve the atmosphere so that the mothers felt comfortable enough to talk freely. This was not easy at first, and the first interview was short and uneasy for both the client and the author lasting only about five minutes. However, after the first interview, I began to understand the way I could do things differently to make the women more comfortable, and implemented an ice breaker: the second interview was more successful and forthcoming! This is an asset I will continue to utilize in the future within the field of social work as I relate with clients on a personal level.

Fourthly, listening to the stories of the ladies was rather emotional- some of the stories shared in the interviews were sad and as a researcher objectivity was crucial and mandated in order to present valid research; I was able to capitalize on the skill of empathizing as opposed to sympathizing. This is in line with theory in social work as well as good professional practice, which emphasizes the skill of empathizing, and not sympathizing. This is because sympathizing, as widely covered in the theory of social work, could lead not only to transference but also to burn out and stress fatigue (Mathieu 2007.)

The final and fifth point in the analysis of how this study interfaces with professional practice and theory has to do with the virtue of a social worker to empower his or her clients. Good professional practice calls for a social worker to fight for social justice, equality and to empower his or her clients through existent resolution measures. In addition, a good worker strives to assist his or her clients in becoming independent, teaching them how to find their voices in the process of finding their own solution. Furthermore, he or she teaches his or her clients how to establish lasting solutions to their direct problems, which is what empowering is all about. When this empowerment is effective it promotes community development with its core values of social Justice, self-determination, working and learning together and sustaining communities (Porkka & Penttinen 2013, 103-124.)

Based on the fifth point, the author of this research undertook vast steps to promote community development by conducting this research: the women will be empowered if the suggested recommendations by the author are implemented. Furthermore, to arrive at this recommendations, the author allowed the women to have a voice in implementing their own solution by listening to them in the scope of the interviews, as they shared what was important to them. In addition, the women were participant in finding a solution to the existent need of a social worker, because the study would not be possible without the voices of the women. Finally, when the recommendations are implemented, the women will feel a sense of achievement at having been part of this undertaking that changed a society for the better; this was a good example of working and learning together while sustaining this community and that is the essence of empowerment and community development.

## 2.3 Results from earlier research

In 2014, research carried out by Spitzer et al suggested that culture plays a vital role in the implementation and development of social work.

One feature of social work in African countries is its struggle for appropriateness: to overcome the legacy of imported, Western-based models of intervention which are too often unsuitable with regard to the distinctiveness and complexity of African cultures (Spitzer, Twikirize & Wairire 2014, 15).

Based on this research by Spitzer et al, methods that have been employed in other environs would not necessarily work in establishing the quality of prenatal care relevant to the MCHC.

Furthermore, research has also shown that the quality of prenatal care that a patient acquires or has access to is directly related to her socio-economic status. Women ranked lower in income levels are less likely to seek prenatal care, endure higher stress levels, and are more prone to premature births (American Psychological Association 2015).

The American psychological association assertion is relevant to the study at the MCHC because most of the women interviewed for the study were from a lower socio-economic status and therefore were displaying higher levels of stress as compared to the two women that were college graduates. This is a fact well documented in the section of findings, section four, which details the feelings of the women from both socio-economic standpoints through their narrations.

Thirdly, existent research addressing access to a social worker, counseling and advice indicates that in a similar social setting, when accompanied by professional knowledge of utility and empowerment, these three elements of prenatal care can circumvent unwanted and stressful situations. For example, counseling and advice from a social worker could prevent unwanted pregnancies and challenge patterns of behavior such as promiscuity that promote excessive use of contraception which could lead to infertility; this could save a young woman some painful days ahead if she has a desire to have a baby in the future. Furthermore, Moos et al continues to explain that the availability of these three elements in social work practice also promotes overall mental wellness, which in turn could promote the ability of a client to make empowering decisions that she previously thought were inaccessible; in addition, some of those decisions the client may not be able to visualize alone, and needs the services of counsel and advice from an accessible professional (Moos, Bartholomew & Lohr 2003, 116-117).

In the scope of diaconia work, the author of this study came across a few existent literary articles of research on the topic of quality of prenatal care, that were addressing the elements of dignity and hope:

Research carried out iterated that hope dynamics are crucial in the balance of getting out of one's shell versus shutting down mentally, psychologically, physically and spiritually; hope defines the faith one has towards the future, and for a prenatal mother, this is crucial not only for her all round wellbeing but also for the unborn baby, because worry and stress about life's realities can impact also on the baby's health. In essence, the ability of one to have a healthy all round mental and psychological wellbeing, positive outlook and a sense of hope and faith towards the future is essential in assessing the quality of prenatal care from the Christian perspective (Kylma 2005.)

Recognizing constructive possibilities in one's life situation and believing in a life worth living during the present and in the future... Hope is an essential element of human life, human spirituality and illness. It is as a basic resource in human life, and contributes to the continuity of life by giving the strength to live and carrying the person through difficult times. The consequences of hope are good life, wishes, and pleasure (Kylma 2005, 623-624.)

Kylma explains above the importance of hope dynamics, in this case for a prenatal mother. Without this hope, mothers in stressful situations such as presented in the interview process and detailed in section four would not have the desire nor the strength and capability to go on living life. Subsequently, this would affect not only them, but the unborn child. This is a situation Kylma refers to as hopelessness and despair.

Furthermore, Angela M. Sabates concludes that one reason behind hope lies within the finding of more advanced optimistic theories and extrapolations of the human life and existence that can be pertinent through the lens of Christianity with regards to condition of being human. She asserts that being a Christian allows for the human condition of despair to be overcome by believing in a higher being; this belief in a higher being, she continues, allows human beings to have a hope that is based on the Christian Premise of God. It is this belief in the promises of God that gives a Christian hope despite hard realities that could be present in the life of that Christian, and changes the mentality of that Chris-



tian to view life through the lens and perspective of a God guided life towards faith and hope in him (Sabates 2012, 73-74.)

The second diaconia concept of human dignity has been researched in detail by a few writers including but not limited to Vorster, De la Porte and editors Esko Kähkönen & Teemu Pauha. This study will present research on dignity from all the three works as follows:

The first author Vorster explains that the three most fundamental components of dignity from a theological perspective are, equal respect, the right to life and autonomy. The following are the three components in detail:

Equal respect refers to the concept of being treated with equality, because man is created in the image of God, and as a result we are all equal and should be treated and regarded as such. In his explanation of what the second component of dignity, the right to life entails, he emphasizes that from a Christian standpoint, God gives life, therefore he prohibits in his word killing be it intentional or unintentional. Furthermore, he argues, the right to life means that humanity needs the means for subsistence necessary because this is the basic requirement for a dignified life.

Autonomy, the third and final component of human dignity is also referred to as liberty and freedom in his writings. Vorster asserts that liberty is bestowed upon human kind by God as gift despite the fact that human beings are all sinners. Therefore, if he is the one that has granted this gift of free will, and he is the author and creator of life, then no one has the right to take it away other than him, its author (Vorster 2012.)

The second author Porte in his research pertaining spirituality and health, concluded that the dignity of a human being, lies in choosing for oneself a belief system that not only empowers, but allows the human being to find meaning in life and define herself in her own spirituality or religious views that allows her to feel she matters; this also allows her to feel that she is relevant not only to

community, but to a 'remote' God as perceived within the African concept of the understanding of God (De la Porte 2013.)

And last but not least is research on the topic of dignity availed by Esko Kähkönen & Teemu Pauha:

A thorough perusal through their writings will highlight an understanding that preserving dignity is the reason behind advocacy work, social work and the fight for human rights. The authors continue to explain that to preserve the dignity of all human beings alike, the fight against poverty must continue because dignity cannot grow nor thrive in exclusion and poverty. Furthermore, poverty hinders the implicit and explicit understanding of human dignity and how those living under poverty comprehend what it entails (Esko Kähkönen & Teemu Pauha 201, 7- 210.)

## 2.4 Definition of key concepts

In research it is crucial to define key concepts, in order to reiterate within which context they are utilized within a study. The elements used in this research, counseling, advice, access, and the two diaconal concepts of hope and dignity are some of the crucial concepts utilized in this study and their definitions will be offered. Furthermore, care will be taken to maintain contextual link in these definitions by offering meanings in context of what the utility of the terms quality and culture entail. The definitions of the context of culture and the meaning of quality will be offered in the conclusion of this section.

Firstly, the author will define the concept of counseling as present in prenatal care. It is defined as the information that is available to a prenatal mother that is pertinent to her welfare and needs of wellbeing, relates to birth including emergencies, healthy ways of life including diet and home practice. Furthermore, counseling teaches the mother the skill of paying attention in order to recognize danger signs to seek care in timely fashion. Counseling also includes but is not limited to offering advice to the mother to promote the aforementioned wellness

and wellbeing. In addition, counseling entails opening and reinforcing communication methods effectively between the professional and the mother to allow for the mother's ability to be understood and to feel that they benefit from the professional and are listened to and encouraged to actively participate in their overall mental wellness and wellbeing (Jennings, Yebadokpo, Affo & Agbogbe 2010, 7-13.)

Secondly, the concept of advice in utility within this study refers to the actions of the professional that take place before tests and after tests that assist the mother in the decision making process (Jaana Tilli, personal communication 3.2015). Furthermore, Wertz & Fletcher (Eds.) define advice as the instructions and recommendations given to the pre-natal mother by the professional before, during, and after the pregnancy that promote the all-round wellbeing and wellness of the mother and her unborn child that she would otherwise not be privy to (Wertz & Fletcher (Eds.) 1989).

Access is the third concept that will be defined by the author, as utilized in the study: within this study, access refers the physical access and availability of a social worker or professional to the prenatal mothers. Furthermore, such a professional would be in a position to offer the aforementioned elements of counseling an advice to the prenatal mothers that are essential for high standard of quality prenatal care (World Health Organization.)

And now the author will offer concrete definitions for the two final concepts utilized in the study, the diaconia concepts of dignity and hope:

Fourthly, hope is the interactive alternation between the conjoined feelings of hopelessness, hope and despair. Hope traverses how changes in the balance of reality are handled due to the dynamic opposite realities of negatives and positives when learning how to deal with an overwhelming reality. He continues to iterate that hope defines the ability to recognize endless positive probabilities within a situation while maintaining the belief that life is worthy of living not only presently but in the coming times (Kylma 2005, 623.)

The fifth concept in utility within this study is the concept of dignity. Nico Vorster in his research on this topic opined that since God created all human beings, they belong to him, the Creator. Therefore, people do not belong to other people and they have the God-provided ownership in the property of their self. Furthermore, this means that one has a right to any God-granted right. In addition, he continues to define dignity as composite of three components which are the right to freedom, life and equality. He iterates that dignity is the human being's greatest property at a basic level, because it is based on the image of God, having been created by him in his image. Therefore, all human beings are worthy of being treated with concern and respect, and as outlined in the Old Testament, the New Testament and Pauline literature, Christ has been depicted as the perfection of God's image, destined to be human. This means that since Christ, the highest personification of God is in the human being's persona, then this human being must be worthy of the highest degree of regard and respect for his person (Vorster 2012.)

In conclusion, other concepts utilized in the study that are privy to definition are the concepts of quality and culture, for the purpose of understanding the depth of the findings and understanding the study in context:

In referencing culture, the author is referring to the current debate surrounding social work in the continent of Africa; case and point: For effective social work in Africa, there must be Precautions to overthrow legacy of adapted western oriented models during intervention which disregard the complexities and uniqueness of African culture. Furthermore, the aim of good social work practice after all is to venture into establishing effective social work models and to pioneer new territory in social work which avails relevant answers to the necessities and needs of those thriving in the grassroots (Spitzer, Twikirize & Wairire 2014, 15-26).

Finally in this section is the definition of quality as utilized in this study; by asserting quality of prenatal care, the author means to denote the standard of that care as is available to the mothers. A question then arises, what is the criteria used to determine what is high standard versus what is not? Furthermore, how

can this study affirm that this used criteria is legit? This is where literature review comes in sufficiently, and it defines what is meant by quality prenatal care within this study. Based on this assertion, it goes without saying that there are different ways therefore to assess this quality that cannot be realistically utilized in one study. This is the reason behind the author's use of the five elements of counseling, advice, access, hope and dignity to define what a high standard of quality prenatal care would look like. In such a scenario, all these five elements would be present in the care, aligning distinctly with the manner in which they are defined above (Corwyn & Bradley 2002, 373-377.)

## 2.5 Research problem and research question

Kenya is a patriarchal society as mentioned earlier on within this study. Therefore, as a social worker, it has occurred to me as good practice that more studies with regards to women's issues in Kenya need to also be at the forefront of the current affairs dialogue.

As it is, social workers are not an evolved part of the social work process in Kenya, and most clinics and hospitals do not have a social worker or professional in the team. This issue therefore requires widespread attention, because without such a professional, prenatal mothers have no access to crucial social work services such as counseling and advice. Furthermore, this impacts on the mothers' dignity owing to this omission and circumvents hope towards the future. Without proper social work services the women's rights are infringed upon hence impacting on dignity. In relation, without these services of counseling, advice and access to a professional, the overall all round wellbeing of the mothers is at stake, which could affect hope. This study therefore has its place amongst the few that have been carried out by other researchers on the topic and it is not only crucial, it is relevant in developing today's social work practice (Spitzer, Twikirize & Wairire 2014, 91-161.)

Consequently, having established this foundation for this study, the research question becomes clearer: the research question is, what is the quality of prena-

tal care at the Baraton Maternal Child Health Clinic? Utilizing this research question, the author is attempting to analyze how well the five aforementioned elements of counseling, advice, access, dignity and hope are present in the process of the prenatal care at the clinic. The level of the presence or absence of these elements in the care will then answer the question of standard of the quality of prenatal care present at the clinic; this is the basis of this study.

The purpose of this research therefore is to find out if the mothers surrounding the Baraton area who have had their prenatal visits at the Baraton MCH have received quality prenatal care. Consequently, the standard of quality will be assessed through the aforementioned five elements: counseling, advice, access, dignity and hope.

The definition of the quality aspect will be determined through literature review, critically assessing standards achieved using each of the stated elements, passing them through the lens of the acceptable standards outlined in the literature review. After the findings, the author will then offer some future recommendations to the clinic.

In addition, this study aims at shedding light on this issue regarding the standard of prenatal care that has not been awarded much attention in the current affairs of Kenya. Women's issues are not as equally regarded as men's issues, and with the staggering figures in maternal and perinatal mortality rates, it is crucial that the issue be addressed through not only dialogue but research to come up with advanced ways to combat the pandemic facing prenatal mothers (United States Agency for International Development 2015.)

While this and the few other studies underscoring the same phenomena are just the beginning in the focal dialogue underscoring women's issues, change begins with one a step in the right direction (Kotter International).

### 3 METHODOLOGY

In this section of the study, a point by point analysis of the process of the research will be discussed. Furthermore, critical definitions of quality via the five elements through literature review will be conveyed.

#### 3.1 Literature Review

Literature review was utilized to define what high standard of quality entails in prenatal care as mentioned on numerous occasions previously. For the study to analyze and give a recommendation on actual quality of the prenatal care, it would have to be based on some assessing tool which defines this aspect of quality: literature review is that tool of definition (The University of North Carolina at Chapel Hill 2010-2014.)

##### 3.1.1 Standard of counseling, advice and access through literature review

For prenatal care to not only effective, but ultimately of high standard, counseling and advice are key elements that need to accompany clinical visits for the duration of the pregnancy. Furthermore, prenatal mothers must have access to a social worker or professional with whom they can receive guidance on matters related to the social work practice of prenatal care, such as but not limited to counseling and advice according to the American academy of family physicians.

The American Academy of Family Physicians (AAFP) in a myriad of their journals have discussed the standards of counseling and advice that can be categorized as high standard of quality of prenatal care for pregnant mothers. Furthermore, additional journals from different writers will also be used to define what high standard of quality prenatal care looks like with regards to access:

Firstly, according to AAFP, there should be integration of leading evidence in the field on advice and counseling methods through the shared model of making decisions. Expectant mothers should receive counseling regarding dangers

associated with dangerous habits such as but not limited to the use of drugs, smoking, alcohol intake that are harmful habits to the wellbeing of the mother and unborn child. Furthermore organized teaching programs that advice on technique and encourage breastfeeding have been noted to be successful in offering a high standard of prenatal care.

In addition, the AAFP denotes that the importance of tests and their associated risks including their limitations and implications on the psychological wellbeing of the mother should be addressed.. This can be done through counseling initiatives and established information programs that groups advices according to specific needs per individual mothers. The programs should be a source of pertinent advice proven to be crucial to prenatal mothers. Furthermore, these programs which allow for two way communication networks should be designed and encouraged to allow for maximum access to the information the mother needs.

Thirdly, various advices with regards to the care and lifestyle of the mother, and the impact of that lifestyle on the mother's all-round wellness and that of the baby should be readily available for prenatal care to be regarded as of high standard of quality (American Academy of Family Physicians 2005, 1307.)

It goes without saying that access to a professional to assist in the mentioned all-round wellness of the mother is a vital concept for the quality of prenatal care at any facility to be considered of high standard. The availability of a social worker or qualified professional within reasonable accessible domain must be ensured, to insure that a pregnant woman is able to discuss detrimental developments to her wellbeing such as but not limited to depression, anxiety, being overwhelmed, psychological and emotional issues as well as extreme mood swings. Without direct access to a professional with whom she can discuss these issues freely, the mother could develop stress and fatigue both emotionally and physically which are not healthy for her wellbeing and that of the unborn child (Allison, Crane, Beaty, Davidson, Melinkovich, & Kempe 2008.)



### 3.1.2 Standard of dignity and hope defined through literature review

For the purposes of this study as referenced in the introduction, the standard of prenatal care at the Baraton MCH will also be assessed through the lens of diaconia. It is therefore fitting to define the standard of care categorized as high standard utilizing the elements of hope and dignity:

Firstly, the author will utilize literature review to define the standard of hope then subsequently also utilize literature review to define the standard of dignity:

Hope in this context of prenatal care:

Jari Kylma explains that hope is evident and thriving, if a mother can recognize built in probabilities and or possibilities of positivity in her life. Furthermore, she must have a staunch belief that life is worth the essence of living, not only in the current circumstances but in the future.

Moreover he reveals and explains that the absence of hope is hopelessness, and this feeling is the detrimental feeling of defeat and quitting; feeling an emptiness inside in the reality of an illusion that the future will cease to exist, disintegrating mentally while being in a state of paralysis with no cause for continuing to fight for life. The presence of the latter is the absence of the former (Kylma 2005, 623.)

Dignity in this context of prenatal care: First by Vorster and finally a secular outlook offered by the writings of Esko Kähkönen & Teemu Pauha:

From a theological standpoint according to Vorster, dignity is comprised of three components which are autonomy, right to live and respect without prejudice – equal respect.

The first component is the right to life: It is an affront to God the creator to destroy human life, because that decapitates his communion with that entity. Furthermore, a prenatal woman not only bears one but two lives. The right to life as an aspect of dignity is addressed in the Pentateuch law, which warns against

endangering negligent actions to life. This right to live propagates the right of development passed down from generation to generation and a desire to pass on life which is the basis of the future nations.

As a result cultural growth is maintained to support these generations and this adheres with the right to live. Finally, life's significance alludes that all humanity has right to basic needs of subsistence, since that's the most basic requirement to live a life of dignity. God being the author of life dictates in his word the preservation of this life, and the work to eradicate poverty is not only in obedience of his word but also helps promote this right to live because as explained, the basic needs are a prerequisite to live a life of dignity (Vorster 2012.)

The second component of human dignity, liberty, is God's gift to the human being his or her sin notwithstanding. The person is a free agent, upon whom free will has been bestowed to multiply, choose, cultivate, act and labor. Freedom therefore is a virtue of being human that is inviolable. Furthermore, the right to liberty's core content is formed by the right to self-expression, self-fulfillment and self-realization. In addition, the concept of liberty as a Christian concept possesses a positive dimension in that the person's liberty must go together with the community's freedom; hence the statute of social character in the existence of humans.

This liberty contains a communal sphere –crucial relations between freedom and the covenant of God and man. Suffice it to add, freedom is not an end there and of itself, but is determined by God's will and fellow human's interests and is therefore always practiced in the structure of justice. Finally, the freedom of persons and communities are correlated concepts and must be stabilized in such a way that does not interfere with the dignity of the person or community (Vorster 2012.)

The third and final component of dignity according to Vorster is equality: equality is a position that God gives people, and not a characteristic of human beings that is inherent. All people, because they have the image of God therefore, are alike and should be treated with equality.

In the Old Testament, this impression of equality is understood in the domain of justice. This theological analysis behind concern for the weak and poor lies in that inequality precedes bondage and that is an offence to freedom. Furthermore, love is portrayed as the most crucial tool of God's justice. In the absence of love justice cannot prevail, and true love is the driver of justice. Since love stretches to all humanity, its character is specified as 'treating other people as you want them to treat you'.

It appears that treating all equally is seen as a feature of the understanding of biblical equality. Equality requires the dissemination of social barriers because the work of Christ to liberate man goes beyond differences of gender, culture and economy. Having the grace of God which one does not deserve, relegates one not to exalt him or herself at others' expense, but to be respectful of one another, serving one another in humility as Christ did for human beings.

He also denotes that equality of a human being or human beings are the same in singular or plural respects. Therefore, the most core position of respect with reference to which persons should be treated equally is dignity. Equality in dignity dictates that jurisdiction and power one has over another is not only mutual but reciprocal and is therefore a close relation to justice which entails being treated fairly. Within this circumference, if human beings are not regarded with equal respect, liberty is disregarded and they are robbed of dignity (Vorster 2012.)

In conclusion of this literature review, as stated earlier will be offered the secular dimension on dignity by editors Esko Kähkönen & Teemu Pauha in their report for the conference proceedings of Faith-based social action in combating marginalization held in Helsinki in 2011:

Tony Addy explains that human dignity is sabotaged by a life lived in poverty. He asserts that human dignity is also an element of social exclusion; therefore, all services for assistance combined with opportunities to allow for successful participation are a crucial component of dignity (Addy 2011, 19-22.)

Furthermore in the conference, there was a discussion surrounding the fact that the EU Fundamental Charter of Rights uses dignity to chronicle a basic right, despite the fact that the concept is largely undefined. It is used with regards to human rights and for moral, political and ethical discussions to denote the in-born right to ethical treatment and respect. Social services and diaconia in eradicating poverty therefore must be examined to ensure that human dignity is maintained and understood accurately by those who need this assistance. Furthermore care must be taken to develop ways in which this human dignity during the process of social assistance can be emphasized and improved (Kähkönen & Pauha 2011, 7-17.)

Finally, in this secular definition of dignity, the editors contend that dignity helps to maintain the identity-citizenship of communities and individuals. This is because it not only designs communities' resilience to poverty but it also furnishes a steady foundation for advocacy work globally, nationally and locally and this entails the fight for justice (Kähkönen & Pauha 2011, 16-17.)

High standard of quality of prenatal care is comprised of a balance between the five elements: counseling, advice, access, dignity and hope as defined above. See model as represented by the figure 1 below:



Figure 1: model that describes high standard of quality of prenatal care

### 3.2 Study population and sampling

The study population refers to the collective individuals who took part in this study (Explorable 2008-2015).

The study was focused on prenatal women visiting the Baraton Maternal Child Health Clinic facility located in the compound of UEAB. The women were from diverse backgrounds, ages and socio-economic status. Furthermore, most of the participants of the study were from the surrounding areas of Baraton center, living outside of the campus. Eleven interviews were conducted with the prenatal mothers and only ten were utilized in the study because as discussed earlier the mother withdrew consent after the interview.

The sample size and study setting had already been predetermined by the Baraton MCH staff, who selected the candidates for the interviews and briefed them on what my research was about. Therefore, by the author's first meeting with the prenatal mothers, they had already been briefed.

Participants of the study were selected randomly based on availability, willingness and relevance to the study topic in terms of knowledge and understanding of the Baraton MCH practice. The last statement about knowledge of practice refers to how many times the mother had visited the maternal clinic previously.

Furthermore, personnel at the MCH clinic informed me that I could not be granted access to a group of prenatal mothers who visit the clinic because they felt it was a conflict of interest, such as lecturers (Personal Communication Baraton Maternal Child Health Clinic Personnel May 2015.)

### 3.3 Data collection and filtering

The data collection process required meticulous planning and patience which is conversant with the practice of research. For instance, I had to rewrite and change my interview questions a number of times as suggested by the supervi-

sor of the research. In addition, I had to find assistance on the ground with regards to my diaconal studies.

Interviewing was used as the only method of data collection because that was the only permission granted after my proposal to the organization. Furthermore, the consent form designed by the author to be given to the mothers and attached in this study as appendix 3 was not used in the study research. This is because the personnel briefed the mothers before the author was allowed access to them, therefore informed consent was granted to the author by clinic personnel.

During the interview process, the author needed to understand how to better create a comfortable environment where the mothers could talk freely, since the first interview was not very forthcoming. Therefore in the break after the first interview, a conversation with a worker revealed that if I was to introduce an icebreaker into the conversation, it would make the mothers more comfortable. This helped much because the following interviews went as planned, and the author was able to collect relevant data.

Furthermore, I altered the questions after the first three interviews to be more open ended to allow the women to tell the stories in their own words, as opposed to asking the original directly phased questions. I conducted eleven interviews lasting about twenty to thirty minutes and I recorded all the interview sessions. However, I had to disregard one interview because after the interview process one woman informed the author that she was not comfortable with the contents of her conversation, and wanted it nullified.

Nine of the interviews were carried out in Kiswahili whereas the other two were carried out in English. All quotes that will be utilized in this study from the Kiswahili interviews will be represented in the footnotes, whereas their translations into English will be used as the in-text direct quotes. In addition, quotes from the interviews with the two women that were carried out in English will be offered as is, with no footnotes required since they are already in English.

After the interviews began the long process of transcription, which when complete produced about seventy and a half pages. Thereafter, I used the method of coding to break down the research data into manageable and cohesive workloads with regards to topic by element, and consequently utilized the inductive approach associated with qualitative research to develop hypothesis as follows:

I developed three code names to first break down the massive writings into somewhat manageable size: social work, availability and diaconia. These were still rather broad, but could now make some sense out of the general idea under each of these code names. I highlighted all the three code names with different colors of highlighters. I then copied and pasted all the three color highlighters into different locations, to make it easier for the next process.

Consequently, I now had three different volumes of writings to break down even further into the five elements of the research as follows: I went through each volume of writing under each code name and from social work derived counseling and access, from diaconia dignity and hope and finally from availability access.

This is how I accomplished the above process: I went through each code name again with different colors of highlighters to represent each element, thick yellow for counseling, blue for advice, green for access, red for dignity and thick pink for hope. Furthermore, I used transparent colored stickers to mark places in the text that even though highlighted under the specified colors, I felt needed emphasis. These portions of the text marked with stickers I would later copy and paste into a different location under the subheading of each of the five elements. The portions of the text marked with highlighters I would then copy again onto this new location under the text from the stickers, but under additional notes of the element. This is how I was able to differentiate key points from the rest of the writings under each element (Päällysaho 2014, 1-16.)

This study would be remiss if the author did not point out that this process is not done in one seating. It takes time, reading the text over and over again, to en-



sure that no important points were transferred to additional notes of the element or missed altogether.

At this point, the work was almost done, with the remainder part being to figure analytically what the research findings were of this developed text. To do this, I had to read the information under each element derived from the transparent stickers and figure out analytically what the interviews were revealing with regards to the element in question. I repeated this analysis for all the five elements, and was able to establish concrete and research based findings.

The question of relevance now arising based on the interviews, will be addressed in the following section, 3.4 under validity. This section will explain in detail how valid these interviews and hence findings were in answering the research question of quality of prenatal care at the Baraton MCH (Päällysaho 2014, 2).

### 3.4 Data validity

The most lingering questions is that of the validity of the interview questions based on if they were able to achieve the aim the study. How can the author of the study be sure that the interview questions prepared and authorized beforehand will actually be able to generate the real existent situation at the clinic? Furthermore, how well were the interview questions interpreted by the participants?

The above is a dilemma of qualitative research and this is the reason behind the care taken to adhere to recommendations from supervisors about the interview questions. They were altered as many times as was necessary to ensure that valid questions were being asked in the interviews. Furthermore, the author ensured that the interview questions were open ended so that the women would answer in their own voice, without guidance or leading from the author. Therefore, the research is valid and paints a picture that is based on reality of the existent quality of prenatal care at the Baraton MCH (Holliday 2007, 57.)

The second issue of validity lies with the author, in establishing the objectivity of the author. Care was taken by the author to ensure that objectivity was maintained and all personal ties to the study were relinquished in favor of establishing a study that is not only reliable academic, but one that will prove to be useful in the future betterment of social work practice in Kenya on a national scale (Holliday 2007, 57-58.)

The third issue arising to challenge the validity of this study is the issue of objectivity in the study sample. It is difficult in qualitative research to depict how authentic participants of the study are especially in the interview process. However, there is a way to verify facts as was established by the author, which was to compare the answers provided by the different women with regards to the same questions such as access, counseling, ways and types of advice (Holliday 2007, 58.)

Finally, this study is a qualitative study, therefore the process could also be biased as it is derived by the author, despite the fact that the author also references previous research. There remains the chance for human error and personal inflections in the process of the research from commence to completion such as the recommendations offered at the end of the research process. This corrects itself in that qualitative research is not meant to give definitive answers. This means that there are different ways to solve a plausible problem, one of which is the one provided by the author as a recommendation. Furthermore, this is how the social work field will grow to be more developed in Kenya, when different authors of research offer different perspectives of the same research, perhaps with time revealing what models work best. This is what qualitative research is all about Holliday (Holliday 2007, 60-65.

All these dimensions and questions of the validity of data in qualitative research as explained in this section are addressed by Adrian Holliday in much more detail. Furthermore, he addresses many more dimensions on the validity of qualitative research and emphasizes that in all such research the findings are not always expected to be 100% accurate (Holliday 2007, 47-59.)

## 4 FINDINGS OF THE STUDY

This section discusses the research findings at the clinic, in the context and framework of cultural factors. In the following section 5 that critically presents the finding of the study, a more concrete view of the findings as they affect both social work and the practice of counseling and advice will be offered. Furthermore, the author will address the findings of hope and dignity as they relate to diaconia work in this section, and offer a concrete finding of the same diaconal scopes also in the following section 5.

### 4.1 Presence and significance of social work and influence of culture

Data collected revealed that there is no social worker on staff at the Baraton Maternal Child Health Clinic. Furthermore, there is no qualified professional at the clinic which would also suffice and would be relevant and good social work practice. This relevance of such a professional is based on citing the established social work models in Kenya that are culturally relevant and sensitive to regional and structural differences between the West and Africa as a continent.

Therefore, the women at the Baraton MCH do not have access to a social worker or professional, nor do they have a professional to offer the services of counseling and advice.

This practice of using trained professionals in the practice of social work, among other social work practices is also not specifically ultimately developed in the region. It is in the developmental and implementation stages as is the field of social work practice in Kenya (Spitzer, Twikirize & Wairire 2014, 15-88.)

This lack of access to social work professional at the Baraton MCH is confirmed by Mary who offers the following insight:

We here would very much appreciate a worker such as the one you described to me. Someone you can see at a professional capacity

such as you described. That person should not be from around here....we need our family secrets intact ...but you know someone like that coming to work here ...we might have to unlearn some of the ways we used to do things, but am sure it would be good for the women (interviewed client one, personal communication 2015.)<sup>1</sup>

In the course of this study, I realized the challenge of the concept of social work in this cultural domain. This is because there still exists, in some aspect of the sample size, the erroneous assessment of the current system of social work at the clinic through Western viewpoints. This is a way of thinking adapted in part, as explained previously by set- ways of doing things by the system that introduced social work to East Africa. It leads to a place of adapting Western viewpoints of social work and implementing them in a cultural setting such as the clinic. This is done without regard for the indigenous existences as well as cultural, religious and other differences that obviously exist within the two cultures. These Western methods of social work not only become ineffective within this context, but results and conclusions arrived at and derived utilizing these methods become irrelevant (Spitzer, Twikirize & Wairire 2014, 16.)

Case and point, a direct observation rendered in the interview by one of the college graduates:

Perhaps it would be more effective to offer training and bring in expatriates from abroad to better the current social work situation in Kenya... training should be done by these expatriates at a national level since the system in the West is already up and running (Interviewed client four, personal communication 2015.)

The above dilemma of model implementation and interpretation then tenders the scenario: since the expatriates would be trained abroad, how conversant would they actually be on a cultural level, so that they can offer relevant training

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<sup>1</sup> "Ingekuwa mzuri sana tungekuwa na mfanyakazi kama huyo, yule utakuja na umwambie haya maagizo yote uko nayo kwa akili na amesomea kazi kama tu vile wewe unasoma...na tafadhali huyo mtu asiwe ni mtu wa hapa karibuni ...akicheka...tunataka siri za nyumba zetu zisiwe mashakani. Mtu kama huyo kuja hapa ingebidi tubadilishe jinsi ya kufanya mambo but kweli jambo kama hili litatufurahisha sana"

using models that would work in this cultural context? This obviously proves the author's former assertions that some of the perceptions of what social work in Kenya entails need revision to reflect the more accurate cultural dimensions defined by Spitzer, Twikirize & Wairire.

For instance, despite the fact that there is no social worker on the staff at the clinic, were there on this staff the more culturally relevant professional, this would still have sufficed in determining the quality of prenatal care existent at the clinic. Furthermore, this professional would have been assessed on the same merit and criteria that is used to assess a social worker. Care must be taken to ensure that models of social work from the Western perspectives are not quantified to be more superior and more relevant than those that are currently in utility within this indigenous context (Spitzer, Twikirize & Wairire 2014, 16-24.)

It appears that women have access to counseling and advice. However, the organizational structures present that provide this advice fall short of high standard of prenatal care as defined by literature review. This is because these existent structures do not qualify as professional. See the short excerpt below:

I have my great aunt, she has been a blessing to my sisters and I. Most of the issues that are difficult to speak with my mom we have gone to her. At the beginning it was very difficult for me to accept this pregnancy, and I remember going to her house in the middle of the night (interviewed client two, personal communication 2015).<sup>2</sup>

While the aunt of this client is a source of counseling and advice, she is not a qualified professional, and therefore does not meet the required standard that defines high standard of prenatal care. In addition, in the process of the interviews, this was discovered to be a common practice: elderly women in the community, midwives, aunties and other relatives traditionally offer counseling

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<sup>2</sup> "Si ndio, niko na yule sistake nyanyangu, ameleta baraka tele sana kwa familia yangu. Unajua hii maisha tunaishi, huwezi ukauliza mamako mambo ingine. Ile siku mimi nilisha jua nime sha kuwa mja mzito, niliogopa sana, nilikuwa na wasiwasi mingi, niongee na nani? Nakumbuka nikikimbia usiku wa manane kwake huku nakia.."

and advice to some of the pregnant women at the clinic. As mentioned and explained in detail, this falls below the defined expectations of high standard of quality prenatal care and requires revision. These revisions will be proffered in form of future recommendations in the conclusion section 7.

A worker at the clinic also has been known to offer advice and when a woman needed that sort of support, as stated by one woman as seen below. However, this too, falls below the high standard of prenatal care as defined by literature review, because the worker is not a trained professional:

I have had many times when I've asked advice from the nurse, and she was willing to offer some input. (Interviewed client four, personal communication 2015).

The surrounding area of Baraton location and Chemundu sub-location, part of Nandi County, houses another major hospital, Kapsabet District Hospital. The women explained that when they do feel they need to speak to a professional or social worker, they can go to the Kapsabet District Hospital and request to speak to one. However, the process takes time, is long, and sometimes they end up never meeting this professional whose services they were seeking (Baraton Maternal Child Health Clinic Worker, Personal Communication 2015.)

This discussion with one MCH worker emphasized the point that women do not have access to a professional or social worker at the clinic, and this is why they have to go to the neighboring hospital. This is also not in alignment with the definitions of access set by the high standard of prenatal care. The women need access to a professional or social worker at the clinic, and this can be implemented in a number of ways, as explained in detail in section 7 at the conclusion of the study.

In the context of culture, counseling may be affected somewhat by the perception of the women about what it entails. The author noted also in the course of this study that some women seemed uncomfortable sharing their feelings of wellness when they were negative. In the cultural context within which these

observations were made, it may seem petty to complain about feelings when there are far much bigger and more complex issues the pregnant woman may be facing such as poverty, domestic abuse, and family issues.

The quote below shows an example of this claim:

Some of these issues even if such a person did come to work here, I wonder how I can open up and share my most secret fears ...laughs nervously...and they are many...am sure you...addressing me...can understand this because you were born in Kenya. Some things you just don't talk about around here, you bear it, pray ....and trust God to bring you through it (interviewed client three, personal communication 2015.)<sup>3</sup>

This cultural concept can greatly affect counseling as a result, and emphasis of this cultural aspect should be greatly considered when implementing counseling and advice models in such a setting.

Furthermore, in the writings of Spitzer, Twikirize & Wairire, they explain that it is generally not the norm within the context of this culture to share some personal issues with a 'stranger'. This is the phrase these writers use to denote how some of the locals might view a social worker or professional working in this context (Spitzer, Twikirize & Wairire 2014, 22-24.)

Moreover, as the above quote three asserts, when asked about what they would want to talk about with a professional or social worker a common answer revolved around rooted spiritual elements of culture and the Faith of Christianity. Again, for any model of social work with regards to counseling and advice to work in this setting, considerations of this aspect of spirituality in the culture must be considered. Otherwise, such a neglect would render any attempts at counseling and advice and the access to a social work professional irrelevant and inconsequential.

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<sup>3</sup> "Mambo yote wajua hata kama mfanyakazi kama huyo ataja kufanya kazi hapa, waweza aje kufungua moyo wako kisha ukaongea na mtu tu yale majaribu u nayo...anacheka...na ni mengi...najua wewe mzaliwa Kenya waelewa haya...akiongea nami... mambo mengine..."

In addition, as previously showcased in quote two above, advice is passed down from generation to generation within this context. Some of the pregnant women might not always see the relevance of seeking advice from a professional or social worker, since they already have what they perceive to be sound advice that worked for their mothers, and grandmothers before them.

A few of the women explained that if they needed to speak to someone about wellbeing and emotional issues, they had an elderly family friend or relative whom they talked to and whose advice seemed relevant since it has sufficed over time and yielded good results. It goes without saying therefore that this perception of what advice is about would greatly influence social work practice. Therefore any models implemented at the clinic to cater for this advice and by extension counseling, should greatly consider this cultural concept.

This would be a good example of social work in the region incorporating models that are cognizant of different cultural aspects of society. An analysis of how this incorporates into the whole social work system in the clinic and in Kenya by extension will be given in the conclusion and finding section (Spitzer, Twikirize & Wairire 2014, 22-24.)

In continuum, most women expressed that depending on how counseling is phrased, some might shy away from it because they don't want others to think they have a problem, or that they are not able to handle their issues. Much was said about being raised to be strong, and believe in God and while you could ask for advice when unsure, it is always good to trust that you can get through any situation without necessarily having to talk to someone about it. This assertions are well supported by the different quotes provided and referenced in the previous paragraphs.

Finally, these assertions are a major indicator that culture does influence heavily the effectiveness of counseling and advice offered at the clinic, seemingly even if the services were to be offered by a professional, as asserted in a previous quote. Therefore, for any social work models implemented at the clinic to be effective, while they would comprise in part of the services of counseling and



advice, the success of those models would be rooted entirely on how well they would be able to incorporate this cultural aspect.

## 4.2 Access

Most of the pregnant women mentioned during the interview sessions that they were aware of a professional or social worker in the nearby Kapsabet hospital, but none was available at the clinic. Prompted to explain this further, a revelation was arrived at that the ladies would in fact want to speak to a professional, and one woman who is a graduate mentioned a social worker by name.

She mentioned that she would want to have some answers from a professional perspective that the 'old' ways of doing things such as referenced in the previous section, might not suffice. With the changing times for instance, belief and sexual practice in younger women has changed, and these younger women might not always want to discuss these topics with an elderly relative.

The younger woman, who also happened to be a college graduate had the following to say about access to a professional or social worker at the clinic:

Some questions of wellbeing and sexual practice you don't want to talk to the male doctor that has been treating you all these years. What will he think about me? Every so often I need answers to questions about sexuality that I cannot even voice in his presence, what if he talks to my mother...this is why someone that is trained in these issues, a social worker for instance, who will not be judgmental and understands the changing times and adheres to the code of confidentiality is much needed in a place like this (interviewed client four, personal communication 2015).

Moreover, when the author implored some of the women to discuss why they felt that the access to such a professional was important, the following issues were raised:

Issues of wellbeing were mentioned by some women, others mentioned advice such as one of the college graduates, while yet others referred to wanting professional perspective and guidance before and after tests. Furthermore, almost every mother mentioned emotional care proven by most of the quotes already provided in previous paragraphs. In addition, some had questions about cultural ways of doing things that they felt were no longer relevant. The excerpts below are direct references to some of these issues that I have mentioned.

In example of wellbeing and emotional care issues, Jane said:

A mother has children at home, a husband, and a newborn on the way. This brings many thoughts to her mind. Even sometimes you can find this mother with so much worry because she is wondering who can she tell of all her problems that she has in her mind...how will they be able to raise all these kids, and the father hasn't that good job.. (Interviewed client three, personal communication.)<sup>4</sup>

In allusion to needing advice and a professional perspective the college graduate asserted:

It helps to have professional input when making some life changing decisions. I've had one or two of those and knowing that the person you're working with knows what they're talking about gives one some sense of peace. That can be the thing that changes one simple happening (Interviewed client four, personal communication.)

The woman with an educational background, with regards to having questions about ways of doing things that have evolved over time is quoted on page 45. In

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<sup>4</sup> Mama ako na watoto nyumbani, na bwana, kisha ako na mtoto mwingine njiani, ako na mawazo mengi. Hata saa zingine unapata huyu mama ana huzuni nyingi kwa sababu ana shangaa anaweza kuambia nani haya matatizo ako nayo kwa akili....wataweza kuwatunza na kuwalisha aje hawa watoto wote, na baba hana kazi ile...wajua

this quote, she explains that sexual practice has evolved over time and it would be beneficial to have access to a professional who understands this concept without being judged (interviewed client four, personal communication 2015.)

The above examples shows that most of the women recognize the need to have access to a social worker or a professional who will render the evidenced much needed services of counseling and advice at the clinic. This is very much highlighted throughout the findings of this study.

Furthermore, with regards to the women who come from the slum areas, access to such an individual would be beneficial to their overall wellbeing and this is why: the incorporation of such a professional on the staff personnel at the Baraton MCH would mean that this professional or social worker could also pay home visits to the women at their homes. This would promote wellness because having someone of professional capacity visit them at home as opposed to them walking far in their already stressed state of mind would be beneficial to them.

Case and point, client six, who shared that:

I have to walk very far to get here, because I live on the lower end of Baraton Center (slum area near Baraton University). If there was someone...she asked me to explain what a social worker does..., she would very much want to talk to that person about how their three children have changed what used to be their beautiful life – her marriage, maybe she can help get back to the way things were (interviewed client five, personal communication 2015.)<sup>5</sup>

While the mothers living in this area would still have to walk the distance to seek other prenatal care services that are healthcare related, having access to the services of a social worker at home could help raise their levels of wellness by

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<sup>5</sup> "Natembea kutoka mbali sana ndiyo nifike hapa sababu naishi huko mtaani. Kama kungekuwa na mtu kama huyo ningependa sana kuongea na yeye jinsi bwanangu alibadirika watoto wetu watatu walipo zaliwa. Siku hizi hata naona kama yule bwana aliye nitafuta tena sana hayupo. Vile tulikuwa, mapeni ni kama iliisha watoto walipotusili."

relieving stress, encouraging them, and offering all other services that a social worker can offer at a client's home, that were there-before not present, which is a positive.

### 4.3 Findings in Diaconia

#### 4.3.1 Dignity

During the interviews, an aspect of the interview questions allowed the pregnant women to answer in their own words how much control they felt they had over the treatment they received at the Baraton MCH.

Firstly, most women explained that they did indeed feel that they were in charge of their own treatment, and when they asked questions, they felt the questions were answered to satisfaction and when they could not be answered, a good reason was given by the professional of why that was the case.

Furthermore, when asked by the author if they got an opportunity to share with the acting professional freely some actions they did not feel were appropriate during the course of the care or those that made them feel less of a participant in their own care, most answered that they felt they had honest conversations with the professional, and they were listened to and allowed to be self in the course of the treatment. This signifies that the women were regarded with respect and given the right to autonomy.

The following excerpt is a quote from one of the English speaking mothers:

Here I can be myself...I feel I understand what happens to me here, yes, the doctor takes time to explain these things to me, although sometimes I might not understand... he is patient with me and I am crucial to my own care (interviewed client six, personal communication 2015.)

Secondly, is the aspect of care that expresses the lives of the mother and that of her unborn child are important, the second component of dignity which emphasizes the right to life as defined by Vorster:

Questions directed to the women during the interview process with regards to life revealed that they believed the professionals at the clinic cared for their lives as well as those of their unborn children. Furthermore, they believed that if there ever was an emergency, the professionals would do all in their power to maintain the life of the mother and that of the unborn child. In fact, one or two women specifically brought up the topic of abortion, and how they felt that since the atmosphere at the clinic was a Christian one, that route was an unacceptable route. They felt that the clinic personnel would be responsible in sharing this core truth of adherence to Christian doctrine, and would not give this as a choice for a mother in a dilemma.

One of the women had this to say with regards to the aspect of right to life:

I once came to the clinic a while back wanting to discuss abortion because I saw that as my only option at the time. I was very angry with the nurse who took it upon herself to inform me of God's view of the erroneous decision I was about to make (interviewed client six, personal communication 2015.)

In a different cultural setting, this reaction from the nurse might be seen as infringing on the dignity of the mother. This is because, the mother is pouring her heart out to a worker while she is in a dilemma and it seems that the worker might be ridiculing and judging. However, in the context where this conversation took place, this is not the case. Most communications in this cultural context are not implied or covert. Most communication is direct and explicitly saying what one means is considered respectful as opposed to implying meanings. Therefore while the mother was angry because she did not receive support for the answer she was looking for, her sense of dignity was not infringed upon.

Thirdly, I will discuss the final component of dignity as defined by Vorster and as referenced during literature review - how the women felt they were regarded in terms of being treated as equals. Essentially, equality as a component of the prenatal care that denotes dignity:

Mary and Jane reside on the other side of Baraton Center, the side where the slum is situated. Their stories were similar in that they both feel that they come from a lower socio-economic status and have no education and established means. However, they shared that they felt at the clinic they were respected and not looked down upon. The workers did not talk down at them during sessions, but talked with them, having conversations with them with regards to their care as opposed to making decisions for them.

These are Mary's words with regards to the treatment she feels she receives that allows her to feel she is respected and treated with equality as measure:

While here I feel am among friends who genuinely care...about me and my children ...sometimes he has asked about my husband... I feel we are colleagues and as you know, colleagues talk to one another, not at one another, but this could be because we share the faith... (Interviewed client three, personal communication 2015.)<sup>6</sup>

Furthermore, most of the women in the interview process shared that they felt the workers as part of a team, the team that ensures that they are safe in a community where that is a rarity outside of the university. Some of the women in essence, went on to mention some workers' names and denote they felt that that worker was not only a professional in their opinion, but a friend; Mary's words above attest to the fact.

The findings in this study on dignity would be remiss if I did not include shortly in this findings section the secular component of dignity as studied at the Baraton MCH. Literature review, in defining dignity from a secular standpoint, emphasize-

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<sup>6</sup> "Nikiwa hapa nimo kati ya marafaki, kweli wana nitakia mema, mimi na watoto wangu. Hata saa zingine, huyu daktari anameniuliza mara kadhaa jinsi bwanangu alivyo. Tukiongea wanaongea nami kama mmoja wao. pengine ni vile sisi tunaenda kanisani pamoja

es that dignity strives to maintain the identity – citizenship of communities and individuals. Furthermore, it designs communities' resilience to poverty while promoting the understanding within the community of what dignity entails, as well as promoting its growth. This is not only advocacy work but also a definition of what the fight for human rights entails, which is what the Baraton MCH is attempting to do:

The clinic helps empower the women who come from the outskirts of the Baraton community. These women from the slums interact with women from the Baraton community as well as personnel, and this not only promotes cohesion in community but promotes these women's dignity as well. This not only promotes a positive identity for these women, but is a form of advocacy for their right to social inclusion and belonging, breaking barriers of social class.

See the quotation below from one of the English speaking mothers in direct reference to work being done at the clinic in reference to empowerment:

In here we are all the same. The women coming from Baraton Center- the slums- and more educated clientele, we are all equal here and receive the same care. Life in the slums is difficult enough as it is and for that I am grateful that with work like this we can break such new ground (Interviewed client six, personal communication 2015.)

This quote emphasizes the work being done by the clinic to liberate the women from the throes of poverty that is their lives and existence in the slums albeit from an emotional place. It is a form of advocacy and fight for the human right of social inclusion, giving these women a voice in the larger community. Furthermore, work at the clinic is breaking down the mentioned barrier of social exclusion due to poverty by creating an environment where the women from the Baraton Center slum can interact with women from more endowed social statuses. This will promote their understanding that essentially, we are all not that different: we are all equal –advocacy in action.

With regards to the above allusion to social inclusion empowerment and advocacy work, Jane had this to say:

Out there, someone like me would never be able to have access to the services provided here. I wouldn't even know where to look and even if they did, they would not let me go in because they know I cannot afford it (Interviewed client three, personal communication 2015.)<sup>7</sup>

#### 4.3.2 Hope

Emphasizing the earlier definitions of hope availed in the section of literature review, the author observed the very close connection of religion in the daily lives of the women I interviewed. There was a general consensus that God cares, and as a result he would provide a means to make the end a positive despite the hard circumstances of the present that some of the women were experiencing. The interviews revealed that some of the women, especially those from the slums, were battling issues such as poverty, domestic misunderstandings, and a general lack of mental wellness. This is well documented in the direct quote excerpts provided in this section previously, depicting the voices of the women.

However, despite this rather hard existence, this is what one of the women had to say:

Despite all this, you know God is faithful. He has continued to guard us even if things are the way they are. We have not slept hungry, and I continue to pray for my husband to come see that these words are true. But what I pray for most, is God to give us the abil-

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<sup>7</sup> "Humo nje mama kama mimi singewezza kujua niende wapi kupata hospitali unishughulikia kama hii. Hata nikiipata, watanikubali aje niingie bila kulipa"



ity to educate our children, to become better than we ever were (Interviewed client three, personal communication 2015.)<sup>8</sup>

The above is evidence of hope, a hope towards a better future and a belief firmly rooted in faith. A focused and deeply rooted belief that the future is not only positive because God is in control, but a lack of despair in that things will not always be this way.

Yet another woman shared that the only thing that keeps her sane having to raise two children by herself and a third on the way is the hope she has in God, and she quoted the following verses in English:

God is faithful. If you trust him in all your ways, and lean not on your own understanding, he will make your paths straight, he will not leave you to be ashamed (Interviewed client four, personal communication 2015.)

This woman has not lost hope, and she definitely has faith towards the future, which is obviously rooted in her faith in God.

To conclude, another woman explained that her mother had taught her that faith in God and believing in the good of people is what keeps one positive and expectant. She explained that knowing that the future while it might be uncertain is in the hands of God I reason to have hope and believe. Furthermore, she explained, he can cater for his creation albeit not in the way we would like. This is an astute evidence of hope and faith towards the future.

My mother has always been a firm believer in people and God. He has brought us this far despite the hard life and he is the reason we have hope that he will always be there for us. This does not change

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<sup>8</sup> "lakini wajua Mungu yu mwema. Ameendelea kutulinda hata jinsi mambo yalivyo. Hatujala njaa, na ninaendelea kuomba bwanangu aje kuona haya ni maneno ya ukweli. Lakini ile naomba sana, ni Mungu anipe uwezo, mimi na bwanagu, tuweze kuelimisha hawa watoto wetu, waje kujitengenezea maisha bora kuliko ile mimi na mzee tumeweza kuwapatia."

that we live a poor lifestyle, but he provides all we need (interviewed client eight, personal communication 2015)<sup>9</sup>

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<sup>9</sup> "Mamangu maishani yetu yote amemwamini Mungu na akatufunza kutafuta uzuri wa watu. Maisga yetu ngumu na bado twaishi kati kati ya makazi duni, Mungu ameendele kutulinda na kutujalia mema."

## 5 CONCLUSION AND FINDING

There is much room for growth in the quality of prenatal care given at the Baraton Maternal Child Health Clinic. The findings will be presented and delved into in detail after the following preamble:

Firstly, the women need a professional to oversee their overall wellbeing, which as depicted in the findings section requires professional care as most of them are dealing with not only the pregnancy but also issues of psychological wellbeing.

Secondly, the women are in much need of a professional to offer the lacking services of counseling and advice, as evidenced in the findings of the myriad of issues most women are combating.

As it is, the women do not have access to such a professional, and rely on informal methods of counseling and receiving advice, which while they are not bad practice, are not of high standard of quality of prenatal care.

Concrete Finding: the Baraton MCH needs to incorporate into the care of the mothers the presence (access) of a professional or social worker who will cater for the services of counseling and advice for the mothers.

The most positive findings in this study are:

Firstly the innate faith of the women attending this clinic, which gives them faith towards the future which is hope that the future will be better. Secondly, the strong foundation of empowerment that the women can depend on that has been established by promoting human dignity in all the workings of the Clinic.

Same model in section 3, to reflect interview findings to give a real-life representation of the standard of prenatal care present at the Baraton MCH



Figure 2: The standard of prenatal care present at the Baraton MCH

## 5.1 No professional even in the utility of culturally sensitive models

There is no professional or social worker at the clinic as stated earlier; therefore, the women do not have access to such a professional or a social worker. Furthermore, as a result, the women do not have access to the important social work services of counseling and advice incorporated into the prenatal care they receive at the clinic, rendering the prenatal care offered to be in much need of development, as is conversant with referenced requirements of quality prenatal care.

By extension this means that even in consideration of the cultural context, the advice and counseling received from other sources other than a professional or social worker does not meet the required standards of quality prenatal care. A professional with regards to culturally sensitive models or a social worker should offer these services for the care to be referred as quality care. Furthermore, that professional should be readily accessible to the mothers, which is not the case at the moment.

This conclusion was arrived at even after considerations of practice of the evolved concept of what social work entails in Kenya. In addition, times have changed; case and point, sexual practice, belief systems, availability of mental support models of social work that cater to cultural and indigenous domain, and finally, not to mention that some of the advice offered by the informal sources might no longer relevant.

It is pertinent to keep in mind that had there been a professional, to assist with the counseling and advice normally effected by the social workers in the Western model of social work, the standard of care would have been evaluated on the same criteria utilized to assess the quality of care offered by the western definition of what a social worker entails (Spitzer, Twikirize & Wairire 2014.)

A conclusion is derived therefore, that had there been on the work personnel staff at the clinic a professional filling the capacity of social worker, the standard of care would still be acquiesced as revering quality; as it is, there is no such professional,

Therefore, there is still much room to improve the quality of prenatal care offered at the Baraton Maternal Child Health clinic with regards to counseling and advice.

## 5.2 No professional, no access

As explained in the previous research findings section, there isn't available on personnel a social worker nor a professional in the clinic from whom the women can receive counseling and advice. Therefore, within this element of access to a professional or social worker, the author found that the clinic falls short, and the women's overall wellness would do well with the incorporation of such an individual on the personnel list at the clinic.

This conclusion is arrived at based on the findings that the overall wellness of the women is lacking and is jeopardized even further by the fact that such a professional does not exist who can guide the women in their daily lives as they deal with the issues detailed in the findings section.

## 5.3 Scope of diaconia

While the assessment of the quality of prenatal care at the clinic as detailed above mostly relies on the physical attributes of the care for assessment, the author noted how spiritual care from a Christian perspective for the women elevated the quality of life and thus the quality of care present at the clinic. Of essence to note is that the Baraton MCH is located in a Christian environment, the Seventh Day affiliate University of Eastern Africa Baraton. The following is a

detailed analysis of this quality care availed because of what the organization represents from a Christian perspective.

### 5.3.1 Dignity foundation at the clinic

The quality of prenatal care from a Christian spiritual perspective is sound and of high standard; the women's lives and those of their unborn children are regarded with the utmost care. Furthermore, they are afforded respect from the personnel and treatment as equals despite the many obvious differences prevalent between them. Finally, the women felt they were afforded an autonomy, liberty so to speak to take part in their own prenatal care, and to express in moments when that was called for, where their hope and support to continue derived from; this despite the poverty in the lives of some, calamity in others, and cultural dissonance with regards to certain aspects of care in others - the women all felt they regarded with dignity, as referenced by literature review.

The women's foundation of dignity is solely rooted in the workings of the clinic as advocate, as well as their beliefs. As a result, despite the lack some may experience in other physical attributes of the care, they feel the quality of care from this spiritual perspective is not only uplifting, but vital to their survival and wellbeing since it is the one thing that they can truly rely on, that is not dependent on other factors other than others, self and God. This is what the component of dignity that entails advocacy work thrives on, making all equal and as a community.

Therefore, the quality of care with this regards to maintaining the dignity of the women is not only of high standard, it has stayed culturally relevant. As detailed in another section, social work in East Africa cannot be separated from the cultural setting that is rooted in belief and spirituality, so that in order for social work to be successful in such a setting, a professional or social worker needs to be conversant with the indigenous belief systems and Christian Spiritualism and guiding principles that are its foundations (Spitzer, Twikirize & Wairire 2014.)

### 5.3.2 Hope and faith towards the future

Is there faith towards the future? The quality of prenatal care also assessed from a Christian perspective utilizing hope as a tool of analysis revealed that the women have a hope towards the future.

All of the women I interviewed, while they had varied backgrounds and were in the midst of different circumstances, had one thing in common: they all believe in God, and the fact that he holds the future, and because of this fact, all things will turn out well. This is evidenced by a glance at most of the quotes availed by the author, which demonstrate a staunch belief in God and a faith in his sustenance: A play by play of each interview almost ends with the same remark from every woman that God is in control. This is obviously in line with the observations of Spitzer et al that for any approach to social work in Kenya to be effective, any model implemented would have to first appeal to the core and basic principle of the culture, which is spirituality.

It is this hope towards the future that life is worth living that is vital to the all-round mental and psychological wellbeing of the mother and unborn child. This is the cushion of support that is available at the clinic due to its religious affiliations. It stands that while some physical attributes to the quality of care are in absentia, the hope dynamics availed by a staunch belief in God across the board set up the background to what is high standard and thus good quality of prenatal care from a Christian and spiritual perspective (Kylma 2005.)



## 6 CONSIDERATIONS

In this section, some considerations with regards to ethicality and meaning in context in the course of the research will be discussed.

Care and precaution was taken by the author to insure that the study's research was carried out ethically following all organizational requirements, research study procedure and accountability measures (Schlenker & Forsyth 1977).

The author of the research complied with all requirements, including but not limited to submitting a study proposal inclusive of the interview questions and methods of research to the research facility. After permission was granted, the author drafted a consent form for the participants of the study, the women taking part in the interviews, but the form was never used because informed consent was granted to the author by personnel who informed and talked to the women before the researcher was granted access to the clients. Also, all rules and regulations cognizant of regional, cultural and the study facility guidelines were adhered to from an ethical standpoint.

The second consideration to ensure accurate understanding of findings is the context in meaning of the quality of prenatal care as detailed in the study. A very concrete understanding of the social work concept iterating and incorporating indigenous and cultural relevance in the practice is outlined by Spitzer et al, in their informative research titled 'Professional social work in East Africa: Towards social development, poverty reduction and gender equality. As presented in this book, this study throughout its writings offers a detailed analysis of cultural understanding of social work and towards this regards only, is the prenatal care discussed in context.

When the author points out meaning in context, with regards to the quality of prenatal care present at the Baraton MCH, what does this mean? This refers to the analysis of the standard of care present currently at the facility, utilizing literature review to define quality, while emphasizing care to not disregard cultural

relevance of what social work practice at such a facility would entail. For instance, within towards this end, while there is no social worker on the personnel at the Baraton MCH, had there been a professional of the same job description on the personnel, the process of determining the quality of care for both scenarios would have been the same.

That is incorporating meaning in context, interpreting research findings within a cultural, regional or structural framework so as to be relevant and developmental to the society in question. In essence, if you incorporate social work models that work in other geographical locations, they have to be altered to fit the new geographical location with regards to the aforementioned relevance factors (Schlenker & Forsyth 1977.)

## 7 FUTURE ASPECT AND RECOMMENDATIONS

Based on the findings of this research, the author had a few recommendations that could be the starting point of developing social work backdrop at the clinic. These recommendations are hereby discussed:

The author recommends within the framework of cultural context, that the facility or Baraton, Maternal Child Health Clinic, incorporate a professional in the personnel to cater for the work implementation of social work practice. This is especially with regards to counseling, advice and having physical access to such a professional. While the women have available to them advice and counseling from an informal approach, good practice entails having a social worker, within this context a professional who has the certifiable training and credentials to be able to offer quality counsel and advice that is conversant with quality prenatal care guidelines as described in the literature review section.

Incorporating this professional into the Baraton MCH is implementable in one of two ways:

The first way would be by the University of Eastern Africa, Baraton incorporating a degree program in social services under the currently existent degree program of the School of Humanities and Social Sciences. In this scenario, students enrolled in this new school program would then undertake their practical work placements also known as internships at the Baraton Maternal Child Health Clinic. This would not only ensure the beginning of the development of professional capacity in social work at the clinic, but it would also make a provision for students conversant with ground practice at the clinic after placement to find work at the facility. This is referred to as designing, implementing and developing social work practice, and most of the Western countries that have developed social work systems began at such a strategic juncture for foundation (Chitereka 2009, 149-153.)

The second way would be to liaise with Universities around the country that currently offer degree programs in social services. Some of those universities and organizations include but are not limited to:

Public universities: Kibabii University College, Maasai Mara University, Moi University, Masinde Muliro University of Science and Technology, University of Nairobi, South Eastern Kenya University (Spitzer, Twikirize & Wairire 2014, 95).

Private Universities: Daystar University, St. Paul's University and Catholic University of Eastern Africa. Furthermore, the Kobujoi Development Training Institute and the Government Training Institute in Embu operated by Catholic diocese of Eldoret offer social workers' training at diploma level. In addition, there is a myriad of commercial colleges offering diploma and certificate level social work courses (Spitzer, Twikirize & Wairire 2014, 95-96.)

The MCH clinic heads and operators could liaise with any of the above universities and organizations, so that the students enrolled in the degree program of social services in any of the above universities could implement their work placements, internships, and or work practice at the Baraton MCH. As explained, with time, this would develop the concept of the presence of a professional on the work personnel that would cater on a professional level for counseling, advice and the concept of access.

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## APPENDICES

### Appendix 1: Abbreviations

UEAB: University of Eastern Africa Baraton University

DIAK: Diaconia University of Applied Sciences

MCHC: Maternal Child Health Clinic

IRIN: Integrated Regional Information Networks

AAFP: American Academy of Family Physicians

## Appendix 2: Interview Questions

Important notes to consider:

What matters most is the before and after care of the prenatal care. That is what qualitative research entails. Questions should address issues like:

Counseling received before and after the prenatal visits, Advice, Psychological evaluations given before and after

What is done with the results and by whom

Interviews carried out only with the patients

### INTERVIEW QUESTIONS: counseling, advice and access

(1.) What trimester are you in

(2.) How many times have you visited the Baraton (Maternal Child Health) MCH clinic?

(3.) What do you talk about with your doctor in the prenatal visits– are you able to tell your doctor all information concerning how you feel as pertaining to the pregnancy? Is he/she able to do something about it?

(4.) Have you received any counseling on hormonal related emotional changes? If so, please describe if/how you felt it was crucial for your personal wellbeing

(5.) When you submit to prenatal tests, do you then have a second visit where you discuss the findings of the tests with any worker? Who? Do you feel enough time is taken to explain results to you in a way that you understand?

(6.) When you submit to tests and have questions, are you satisfied with the care taken by the worker during the tests, do you feel the worker explains the

process clearly and does he/she take the time to answer any questions regarding the tests during and after the tests?

(7.) What kind of advice have you received in your prenatal care at the clinic? Who provides this advice?

(8.) Do you sometimes feel overwhelmed by the pregnancy emotionally? Psychologically? Physically? Do you have someone that you share with these feelings of being overwhelmed? Is the person a professional or a friend/relative? Do you feel this helps you cope better?

(10.) Is there a service that you would like to have but you feel is missing in your prenatal care at the clinic... (Ask the mother about source of pertinent information & who she talks to when she feels the need to talk to someone? Is this person at the clinic or?

(11.) What other kinds of advice pertaining your pregnancy have you discussed with anyone, who? Have you discussed why and how this advice is necessary for your care? (if this was not answered in 10 above)

(12.) how far away is the clinic from your residential home? Is it accessible via the public transport system? How far do you have to walk? This person whom you mentioned above in questions 7 & 11, how accessible are they – at the clinic? Where do you find them?

(14.) What kinds of prenatal tests have you partaken? Were the results clear to you? What was the follow up to the abnormal tests?

(16.) Have you taken a sonogram? Have there been any complications with the baby? What did you discuss in these complications? With whom?

(17.) Do you have access to a social worker in the prenatal clinic? A professional? What do you discuss with them? In the community who handles any

social, psychological and emotional issues that may arise as a result of your prenatal status if not either of these two?

(18.) Is there a social worker or professional that sometimes comes to your home?

### **Questions relating to Diaconia:**

#### DIGNITY as a tool of analysis

(1.) Do you feel like you are in charge of your own treatment? Do you have a voice in the kind of treatment that you receive? Discuss this. How do you make decisions concerning your own life during the care process? Are other parties involved?

(2.) When you come to the clinic, discuss how you feel you are treated and regarded (equality)

(3.) What do you feel the clinic is doing for your general wellbeing? How does it do that? How does the care you receive here promote your feeling of being valued/important? How has this changed your life overall? (empowerment & human rights)

#### HOPE as a tool of analysis

(4.) How is your general feeling of wellbeing? Do you feel that the future is promising? Tell me what is your faith towards the future, why do you have this hope? Discuss this source of hope and faith.

### Appendix 3: Consent Form

I \_\_\_\_\_ hereby ascertain that all the particulars of this interview have been clarified to me. I understand that I am taking part in a research study and hereby give my authorization and consent to use the information I provide during the interview process for the purposes of this research study.

Date: \_\_\_\_\_

Place: \_\_\_\_\_

Signature: \_\_\_\_\_