



**MOTHERCARE MATERNAL/CONGENITAL  
SYPHILIS CONTROL PROJECT  
QUALITATIVE RESEARCH REPORT**

**WORKING PAPER: 18**

**August, 1993**

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Of the nine interviewers, seven are trained Swahili teachers and cross-cultural trainers who were able to translate, interpret and to articulate nuances of meaning in language and behavior as needed. They are: Anne Tabu, Josephine Sika, Anita Atieno, Maina Nyaggah, David Maina, Geoffrey Maingi and Nashon Okeyo. Christopher Tsuma is a graduate in Anthropology with a minor in Swahili who was able to explain grammatical correctness in technical terms better than anyone. Fred Oyoo, a young man of great tact, diplomacy and street wisdom has, at the tip of his tongue a vast and detailed knowledge of Luo language and culture. He will soon embark on an undergraduate program in fisheries management, a great loss to future formative research. Among the interviewers, four are Dholuo speakers, two are Kikuyu speakers, one a Kikamba speaker, one a Kiluhya speaker and one a Kidabida and Coastal Swahili speaker.

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# MOTHECARE MATERNAL/CONGENITAL SYPHILIS CONTROL PROJECT QUALITATIVE RESEARCH REPORT

Donna K. Pido and Francoise Jenniskens

## BACKGROUND

It is estimated that some two percent of babies born in Kenya have been infected with syphilis at birth, leading to prematurity, stillbirth and congenital syphilis. Untold pregnancies end in abortion due to the mothers' infection with syphilis. Because syphilis is treatable in its early stages, these adverse pregnancy outcomes are unnecessary.

### Syphilis Control in Nairobi

The major public health care provider in Nairobi is the Public Health Department of the Nairobi City Council (NCC). Under the administrative control of the Ministry of Local Government, the Council operates Maternal and Child Health/Family Planning clinics in most of its 54 health facilities. These facilities are among the 154 registered health units in Nairobi. The population served by the combined 154 health units is over one million people, over 40 percent of whom live in periurban areas.

The prevention of congenital syphilis through screening pregnant women for syphilis has been a policy in the NCC for many years. A centralized system has been in place where women were bled for an RPR (Reactive Plasma Reagies) or Kahn test at their first clinic visit and the results were supposed to be sent back to the clinic. In 1987, Dr. Marleen Temmerman evaluated the program and identified some major constraints. The most important ones were the lack of transportation for the specimen and results to and from the clinics and the lack of supplies. The European Community then decided to support the infrastructure by providing test kits, needles, syringes, drugs and a car.

In 1989, an evaluation was carried out to investigate the effectiveness of the centralized screening system. The following results were found:

- 60% of pregnant women were screened;
- of these, 87% had their results registered;
- 9.1% of RPR positive women received adequate treatment.

Considering time, effort and money spent on this project and the little effect it resorted towards improving the health status of pregnant women and their unborn babies, a new strategy was developed for syphilis screening of pregnant women. A decentralized screening system was developed to be tested in ten NCC clinics, whereby women are bled on arrival, nurses are trained in performing the simple RPR test on the spot and a RPR positive woman is treated before she leaves the clinic.

The Canadian International Development Agency (CIDA) has implemented a syndrome-based sexually transmitted diseases (STDs) control program in five NCC clinics. These clinics are also part of the decentralized syphilis screening program and, in this study, are compared to the NCC clinics that did not receive any previous training in STDs control.

At this stage, MotherCare, an United States Agency for International Development (USAID) funded, non-government organization, came in as a donor for this program. The program started on June 1, 1992.

### **Project Overview**

The overall MotherCare Congenital Syphilis Control Project was designed to meet the following objectives:

- increase the number of pregnant women who seek antenatal care before 20 weeks of gestation from 25 percent to 50 percent;
- increase the proportion of women screened at the clinic from 50 percent to 90 percent;
- raise the percentage of RPR positive pregnant women (found to have syphilis antibodies) receiving treatment from 30 percent to 100 percent;
- increase the number of partners notified and treated by 10 percent.

To complement this effort a two phase project has been planned and partially implemented in clinics under the management of the Nairobi City Council.

The first phase of the project is clinic-based and includes as its cornerstone the introduction of the RPR test for syphilis in ten Nairobi City Council (NCC) clinics: Ngong Road, Riruta, Lang'ata, Kariobangi, Ngara, Mathare North, Kangemi, Baba Dogo, Dandora and Ofafa Jericho. To strengthen this clinical intervention, formative research was undertaken to learn more about clients' and service providers' knowledge, attitudes and practices regarding syphilis during pregnancy. Using the findings, counseling training for staff, counseling cards for clients, and leaflets about syphilis in pregnancy were produced to inform RPR positive clients of the need and regime of treatment, how to prevent re-infection, and how to negotiate similar behavior by their partners. This research endeavor is described in Part I of this report.

The second phase of the project is community-based. The first step entails formative research focused on general perceptions of prenatal care in the catchment areas of the ten project clinics. Among the findings of the clinic-based phase of this study was an indication that the need for early prenatal care clinic attendance was not shared by either the clinic staff or the pregnant women in the sample. With this in mind, the present study explored the women's perceptions of prenatal care, their choices from a range of care sources outside the NCC clinics, and the barriers and motivators to early prenatal care clinic attendance. Their perceptions of the NCC clinics was also explored, as some dissatisfaction with these clinics had been detected in the clinic-based phase. This study is highlighted in Part II of this report.

Public and private agencies concerned with family planning, acquired immune deficiency syndrome (AIDS) and the control of STDs have identified condom use as the most effective means of preventing the spread of STDs. A great deal of effort is being put into condom distribution, promotion and education regarding condom use. Because this strategy is also important in syphilis control, information regarding condoms and their use was gathered in the present studies.

## **The Nairobi City Council Prenatal Care Clinic**

Prenatal clinic attenders in the NCC clinics tend to be women of low economic status who have few or no alternative health services. Among these women, the syphilis infection rate varies from around five percent to as high as ten percent.

In recent months, clinic attendance in NCC facilities has dropped dramatically. The introduction of cost sharing, monetary inflation and general health system deterioration have contributed to women's seeking other alternatives for prenatal care and delivery services or resorting to home deliveries.

Prenatal care at NCC clinics is supposed to be free of charge; but because of drug and supply shortages, women are, more often than not, required to bring or go out and buy any needed cotton wool, syringes, drugs or anything else needed for their treatment.

In order to give birth at a NCC facility, a woman must have a clinic card. This document is issued at her first visit to the prenatal clinic and shows information about her blood pressure and other health indicators. Women who do not have a clinic card are turned away from NCC birthing facilities; some women reported having been rejected even when they were in labor. Women who plan to deliver at home or elsewhere also need this card, just in case something goes wrong and they have to go to an NCC facility to give birth. The clinic card is, therefore, a crucial factor in accessing proper care, especially in complicated or dangerous deliveries.

# **I. CLINIC-BASED QUALITATIVE RESEARCH**

## **A. Objectives, Methodology and Implementation**

### **1. Research Objectives**

For pregnant, RPR positive women:

- assess the RPR positive women's perceptions of, and experiences with, syphilis, including knowledge of causes, symptoms, prevention and consequences
- explore with these women the factors that influenced their own and their partners compliance or non-compliance with behavior and treatment recommendations
- identify specific barriers to compliance with recommended behaviors and women's ideas about possible means to address barriers
- identify demonstrated or potentially successful strategies to increase compliance
- identify potential motivating factors for use in communications strategy
- develop several case studies of the women to illustrate the circumstances and conditions which contributed to acquiring maternal syphilis, and describe the environment within which compliance or non-compliance with treatment recommendations takes place

For male partners of pregnant, RPR positive women:

- assess the perceptions of and experiences with syphilis among partner(s) of RPR positive women, including knowledge of causes, symptoms, prevention and consequences of syphilis
- explore the factors which influenced the partner(s) compliance or non-compliance with behavior and treatment recommendations
- identify specific barriers to compliance with recommended behaviors and men's ideas about possible means to address barriers
- identify demonstrated or potentially successful strategies to increase compliance
- identify potential motivating factors for use in communications strategy
- develop several case studies of partner(s) of RPR positive women to illustrate the factors which contributed to acquiring syphilis, and describe the environment within which compliance or non-compliance with treatment recommendations takes place

For clinic staff:

- investigate the behavioral, attitudinal, technical (skill/knowledge) and other factors influencing quality of syphilis/antenatal care provided by clinic-based health care workers
- identify perceived health-system barriers to providing each component of care for patients with syphilis (screening/treatment/education/partner treatment) among health care providers, and their ideas for possible improvements or changes in the care system
- document health worker's attitudes toward RPR positive women and their partners; their perceptions of the reasons for compliance or non-compliance with treatment recommendations; and their suggestions for improving compliance
- determine the extent and level of accuracy of technical knowledge and skills related to each component of care for patients with syphilis

## **2. Methodology**

### Sampling

In fulfilling the sample selection requirements of the qualitative research plan, the team discovered that in order to get the required number of partners in the appropriate categories, they had to interview many more clients and partners than had been anticipated. The following are the numbers and categories of respondents required, along with the actual numbers interviewed in each category. Non-compliant partners were scarce until the very end of the study period when a number of them were contacted outside the clinic setting. Partners who complied with assistance were very few and difficult to define. Within the sample of clients and partners, there are 23 couples and one trio, which forms part of a network and is the subject of ongoing follow-up.

Information was collected through in-depth interviews with:

#### a. Client

Twenty-five pregnant women recently diagnosed with syphilis at project clinics; half with partners who complied with partner treatment and half whose partners did not comply with partner treatment recommendation.

#### Actual

The team conducted 44 interviews with the following clients:

- 18 whose partners complied with treatment spontaneously
- 3 whose partner complied with assistance
- 6 whose partners were non-compliant
- 3 whose partners claimed to have been treated elsewhere
- 9 who had not yet had a chance to inform their partners or whose partners were away and had not been treated yet
- 2 whose partners had not been informed

- 1 with her partner, both complied with assistance
- 1 whose partner's treatment status is unclear
- 1 whose partner died before she was diagnosed

b. Client's Partner

Fifteen to twenty-five male partners of these "client" women were to be interviewed. One-third attended for partner treatment spontaneously, one-third complied "with assistance," and one third were notified by their partner of the need for treatment, but did not comply.

Actual

The team interviewed 47 male partners as follows:

- 21 spontaneously compliant with treatment
- 5 who complied with assistance
- 15 who were non-compliant
- 4 who claimed to have been treated elsewhere
- 2 whose compliance status was unclear

At least seven male partners were interviewed in the presence of their female partners.

c. Clinic Staff

Twenty STD/antenatal health care providers at project clinics were to have been interviewed, divided among the clinics as follows: 6 at the three CIDA-trained clinics; 4 at the two project clinics which have recently received MotherCare project syphilis training; 6 from the remaining project clinics which have not yet received MotherCare project syphilis training or previous CIDA/STD training; and 4 at NCC clinics which are not involved with any STD project activities.

Actual

The team interviewed the full complement in the appropriate categories according to the type of clinic: CIDA-trained, MotherCare-trained and not involved in STD project activities. However, it should be noted that because of staff movements to fill in during annual leaves, the team could not avoid interviewing staff members on loan from clinics in categories other than the category of the clinic in which they were serving at the time of interview. For example, one interview in a non-project clinic was with a Sister-in-Charge from a clinic which was both CIDA- and MotherCare-trained.

**3. Implementation**

Interviewer Recruitment and Training

Six interviewers, four women and two men, were recruited. Among these, one man and two women were Dholuo speakers, also fluent in Kiswahili and English. The others were fluent in Kiswahili, English and their mother tongues (Maa/Kikuyu, Taita and Kikamba). The Kikamba speaker is a trained counselor with British credentials. All the others are Peace Corps-trained, cross-cultural trainers and Kiswahili language instructors. They double as translators and interviewers, which

enhances their understanding of the work they are doing. The counselor on the team was able to give advice about approaching difficult interview situations and to interview Kikamba speakers in-depth as needed.

The translation of the original question guides into Kiswahili and Dholuo was used as an exercise in familiarizing the interviewers with the subject. Then they attended a one-day workshop in interviewing techniques, research design and general knowledge of syphilis.

Throughout the research period, the team had a half-day meeting each week to discuss and refine interviewing skills. When the interviewers were not busy in the clinics, they were learning to use the computer. It is expected that in future research projects they will have gained greater competence and will thus be able to transcribe and translate by computer rather than by hand, as they did during the present project.

### Information Collection

Kenya-based staff edited the original question guides and added the Interviewer's Guide section to the Client and Partner Question Guides. The team found that the number of questions in the final edition of the question guides for the clients and their partners made the guides lengthy and cumbersome. The addition of the Interviewers Guide sections enabled the interviewers to address broad topics during the interviews and then to enter the information onto the question guide forms.

Information was collected by interviews with individuals or, when absolutely necessary, with couples-though this was discouraged. Interviewers also observed the surroundings in each clinic and reported on the general physical conditions and on staff activities and personalities.

In addition to filling the interview forms, interviewers wrote a narrative report immediately after each interview. These reports contain the interviewers' observations not reflected in the questionnaires. Each interview tape, form and narrative was then gone over by an interviewer and selected parts transcribed and translated. Several interviews were transcribed completely.

### Analysis

Information was analyzed by the consultant who read and listened thoroughly and discussed most of the interviews with the interviewers. Particular issues were raised at each weekly meeting for clarification and comment by the whole team.

### Constraints

The team was trying to investigate several things all at once: find out about knowledge, attitude and practice regarding sex, STDs, condoms, communication between partners, antenatal clinic attendance, etc., each could have been the sole topic of a study.

The most serious constraint was time: there was not enough time to conduct a familiarization workshop with the clinic staff. Only a very short time could be spent on training the interviewers so that the team relied on their own capability, previous experience and the half-day meeting each week to get them through. In addition, there was unseasonable rains that slowed down the interview process.

The second most important constraint was the difficulty in getting the proper distribution of sample categories in order to fulfill the requirements of the Qualitative Research Plan. There were problems finding both assisted compliance partners and non-compliant partners. Many clinic staff members used delaying tactics to avoid being interviewed. The number of RPR positives was unpredictable, and, at times, there were none to interview. This and the rate of no-shows for interview appointments--plus the disappearance of several clients who had agreed to come with their partners--slowed down the interviewing process.

Third, Kenyan concepts of formality, respect and interrogative distance had to be taken into account, as did the relationship between the respondents, who were mostly from a lower socio-economic strata, to the interviewers. The interview team toned down their own appearance so as not to intimidate the respondents. The sensitivity of the subject matter, inhibitions about verbalizing sex-related matters and the general feelings of pregnant women also had to be taken into account.

In the interview setting--especially in an institution which represents authority, like a clinic--Kenyans tend to establish social and interrogative distance between the interviewer and the respondent and to maintain that formalized distance throughout the process. Knowing this, the team sought interview venues outside the clinics, but this proved an impossible task; so the interviews had to be conducted in the clinics.

The interviewers were perceived by clients and partners as superior. Many of them thought the interviewers were doctors and treated them with deference and respect. Respect in Kenya means avoidance--submerging one's own feelings, ideas, and needs in favor of the agenda of the person to be respected. It also means giving the right answers and saying only what will please the respected person.

Early in the interview process, the team discovered that it was better to assign one or two interviewers to a clinic and let them stay for a while to establish rapport with the staff and become familiar to the clients in general. In this way, the team was able to do things that would not have been possible otherwise. This was expensive in terms of the money paid to interviewers for the time they spent, but it paid off in the rapport that was established. Formality was the main problem in interview implementation.

The interview process went exceptionally well, due in no small part to the interviewers' interpersonal communication skills. They often had to draw out extremely reticent, shy or depressed respondents or had to deal with great hostility, anger and denial. But they were able, for the most part, to establish good rapport with the respondents and to elicit the data needed.

In some situations, there were no RPR positive women available, so interviewing had to be deferred until appropriate respondents came to the clinic.

There were mechanical problems in some of the clinics. Each interviewer was provided with batteries and electrical adapters in case of plug and socket non-matches and electrical failure or unavailability.

To summarize constraints, there were: (1) condensed time frame, (2) unseasonal rains, and (3) appointment foul-ups.

## **B. Characteristics of the Sample**

Characteristics of the antenatal clinic/RPR positive sample are described in Appendix C. The sample for the present study was taken from that larger sample. Ethnographic information not gathered in this investigation on this population is found in Appendix A.

The total sample of clients and partners interviewed is young, most of the women being in their early 20's and the men in their late 20's and early 30's. The men as a group tend to be slightly better educated than the women, though taking men and women together, most are severely limited in their literacy skills and some are actually illiterate. Very few of the women are employed outside the home and therefore are economically dependant on someone else's income, the notable exceptions being two commercial sex workers, a gardener, a maid and a small business woman. Two of the men report having white-collar jobs but do not live in housing that indicates this. Nearly all the rest of the men report blue-collar occupations of very low level on Kenyan pay scales. The few entrepreneurs in the sample are engaged in very small-scale businesses, like selling newspapers or second-hand clothing. One man reports being a farmer, but this information does not make sense for his ethnic group (Nubian) and his urban home. He is known to have lied about his marital status so may also have prevaricated regarding his occupation.

Nearly all of the sample live in single rented rooms with their entire nuclear families. Their residential areas are characterized by row after row of mud, wood or iron-sheet dwellings built on concrete bases or directly on the soil. Nearly all of them have iron-sheet roofing. Only the few respondents who live in police quarters have water and toilet facilities inside their homes. For the rest, water comes from taps at varying distances from the home. Some have a tap at their doorstep, some inside their compound and others have to walk up to 200 meters to get water from a tap. Many of the respondents have to pay one shilling (approximately \$.03) for about five gallons of water--a major expense, considering that their family incomes are likely to be under \$30 per month.

In the areas where this sample lives, there are few public latrines and public flush toilets. Other latrines are located within the compounds where individual landowners have built rows of rental rooms. Many of these private shared latrines are not well maintained by the landlords and are shared by up to 100 people. The public latrines are no better.

Very few of the respondents have access to a television set, though some of them report watching TV on occasion or regularly on weekends at a neighbor's or relative's home. A few of the women report having gone to the movies before they were married but no longer.

Only a few of the women report that they do not listen to the radio. Most of the women who listen say that they listen a great deal of the time. Most of the men report listening to the radio in the evenings or when they are not at work. (People normally tend to listen to their vernacular radio service when it is broadcasting and to the Swahili service at other times.)

On the whole, the men have lived longer in Nairobi than the women. However, the numerical information given by the women as to the length of their stay in Nairobi masks the fact that many of the women move regularly or irregularly from the husband's home area upcountry and the home in the city. For example, if a woman says she has lived in Nairobi for three years, that may mean the length of time that she has been coming and going from Nairobi, not the length of time she has actually been a full-time resident in the city. She may go to the rural area for several months at a time and come to the city only occasionally or she may live in the rural area and come once a month to pick up cash for family maintenance upcountry. (Spousal transhumance, or regular movement

between the urban and rural homes, is an important factor in lateral syphilis transmission and reinfection, as will be seen below.)

As to ethnicity, there were more Luos (24) than any other group. There were 17 Luhyas, 13 Kambas, 11 Kikuyu, 7 Kisii, and one or two each of Ugandans, Tesos, Nubians, Sabaots, and Kurias. A significant number were married cross-ethnically.

A very few of the respondents report that they speak and/or understand only one language, their vernacular. Most report two or three languages, while a few list four. Normally, a multilingual respondent speaks his/her vernacular, then Swahili, then English, though there are many exceptions to this pattern.

Two of the respondents are Muslim. Almost half of the respondents state that they are Catholic. Anglican, Presbyterian, Africa Inland and Pentecostal churches are represented by between three and eight respondents, while one or two each report that they belong to other Protestant or breakaway churches. These are Seventh Day Adventist, Legio Maria, Africa Israel Church of Nineveh, Roho Msambwa, Akorino, Church of God, Church of the Holy Spirit, Revival Maji Mingi, New Apostolic Church and Born Again.

Most of the women were late attenders at the antenatal clinic. However, it should be born in mind that "late" has a different meaning to most of the sample; for example, as those who came at around five months thought they were early.

### **C. Summary of Principal Findings**

Syphilis is neither known nor well understood as a distinct disease by antenatal clinic attenders and their partners. Though men expressed greater knowledge of the disease, the information possessed by both groups was equally mythological.

In general, linguistic and language-use factors inhibit adequate communication about syphilis and STDs. The topic is not normally discussed and the vocabulary is not, therefore, in common usage. Substitute terminology such as "to be burned" for "to have syphilis" is more common. Even in vernacular languages, vocabulary related to sexually transmitted diseases is little known.

Expressed knowledge of condoms is extremely limited among women. Men say they know about condoms, and some report having used them. Resistance to the use of condoms for disease control is high, and linkage with the family planning function of condoms makes them even less acceptable. Male resistance to condoms is on esthetic grounds, but there is also a component of feared mitigation of gender and social roles.

Interpartner communication regarding syphilis is influenced by gender, power and status anomalies. Women are in a deficit position in informing their partners and securing their compliance with treatment and post treatment prevention of reinfection. Women who are considered "real" wives rather than concubines have considerably more security, status and influence in communicating with their husbands about syphilis.

Antenatal clinic attenders start late and are motivated by feeling unwell or by the need for the clinic card which enables them to give birth in a clinic setting. They are not aware of the dangers syphilis

poses to themselves or their pregnancies, nor do they associate early clinic attendance with detection of disease unless they feel ill.

Clinic staff knowledge of syphilis is good but also has a mythological component. Care provision by those trained in syphilis RPR testing is good. Those not using the RPR test refer patients elsewhere. More training is needed in priorities of good care provision.

Barriers to syphilis control during pregnancy are linked to lack of information/understanding and social and administrative factors. Fear of AIDS, fear of social and marital complications and reluctance to give up multiple partners are important factors that interfere with prevention and care-seeking behavior.

Better information, focus on the family and improved service provision are the main enabling factors in syphilis control during pregnancy.

Limited preliminary tests of partner-notification documents indicate that they facilitate communication and partner compliance with treatment.

## **D. Synopsis of Findings by Topic and Population Segment**

### **1. Men and Women**

#### Syphilis Knowledge, Attitude and Practice

Many of the respondents who said they did not know what syphilis is **did** know that it has something to do with having sex with many partners or with prostitutes. Those who responded that syphilis was caused by dirtiness, uchafu, were presumed to be using the word in the behavioral sense, as is common in Kiswahili.

Many of the respondents who did know what syphilis is gave words in their vernacular languages that mean gonorrhoea:

kisonono - instead of kaswende - Swahili

gicununu - instead of gatego - Kikuyu

egesonono - instead of egechwene - Kisii

Luo respondents could only say nyach as the various STDs are not differentiated in Dholuo.

A significant number said that there was no word for it in their language and were not familiar with the Swahili word, kaswende.

When asked to name some symptoms of syphilis or to describe how they had been feeling themselves, those who responded gave overall coldness, painful urination, and abdominal pain as their own symptoms, and a few who described syphilis in general, cited insanity or deformed children as symptoms.

Only a very few knew that rashes were a symptom. Several respondents expressed surprise when told that the rashes they presented with were a possible symptom. Others recalled having overall body rashes in the past.

Only one couple, who were religious professionals, brought up supernatural causes for their infection. They explained that the husband had been tempted by a woman sent by the devil because the husband's father was angry at him.

## **2. Women**

### Syphilis Knowledge, Attitude and Practice

None of the women reported having had syphilis before, and only a few said they had ever had an STD. None reported anything about traditional or alternative cures.

A clinic staff member told a client she had bugs in her blood, using the Swahili word for insects rather than bacteria. The client was told to bring her husband and she went home thinking that the bugs were AIDS.

A client presented at the clinic a few months after being treated for syphilis at the same clinic. She said she was sure that she had been reinfected, but the staff refused to treat her.

### Partner Notification

Some women said that the partner notification card helped them. A few told their partners first thing in the morning when they were rested. The vast majority, however, waited for evening, until after the husband had eaten supper and was either sitting up or already in bed to tell him. They wanted him to be relaxed and have a full stomach before they broached the subject.

"When we are in bed before falling asleep."

"First I will give him nice food and then tell him when he is relaxed."

"First thing in the morning when we are getting up."

Many of the women respondents were not worried about what would happen when they told their husbands about having the disease. They felt that as wives, this was their prerogative and duty.

"I will just tell him."

"Because I am the wife."

### Condom Use

Clients were more willing to use condoms than their partners. Most of the women in the sample either had heard of condoms but never seen one or knew what they were used for but had never used one themselves. They reported having heard about condoms from friends or on the radio.

### Clinic Attendance

Women were surprised to learn that a first clinic visit at six months was late because they thought they were coming early.

The two recurrent themes in women's explanations of their early or late attendance were the need for the antenatal delivery card and their general state of health. Women who felt well during their pregnancies did not see the need to attend the clinic, while those who felt ill came earlier.

Many of the late attenders gave the interviewers several reasons why all women should come early to antenatal clinic, reasons such as the need to make sure the baby is healthy or in the right position. Nevertheless, few of them had come for those reasons.

Several of the late attenders stated clearly that they knew their delivery time was getting closer and that they needed the antenatal card for delivery.

A few said that if they had started coming early, repeated visits to the clinic would have been bothersome.

One stated that she did not see the need for ten clinic visits during the course of her pregnancy.

### **3. Male Partners**

#### Syphilis Knowledge, Attitude and Practice

Men were only slightly more knowledgeable about syphilis than women. Several men reported having had it before as well as having had other STDs. On closer questioning it became clear that at least two of these men were not sure whether they had syphilis, gonorrhoea or both.

Several of those who had syphilis before said that they had been treated by private doctors and had believed themselves cured. Two expressed annoyance that the disease was still with them or that they had been infected again.

No one mentioned traditional cures for syphilis except the two men who had consulted herbalists for treatment. One partner said that if he knew someone with syphilis, he would pray for that person to be cured.

A number of the men expressed anxiety for their own health. Among the spontaneously compliant partners, many were very concerned about the health of their wives and babies. The non-compliant, on the other hand, tended to focus their responses on denial of illness and to keep coming back to denial at every opportunity in the course of questioning.

Some argued that there is no such disease as syphilis.

#### Partner Notification

Several of the spontaneously compliant partners who had received uninformed notification were very angry when informed of the reason for being called to the clinic, but they stayed and were treated. For those who came on the strength of being told that the doctor wanted to see them about a matter concerning their pregnant wives, it is difficult to know how many would not have come if they had known that they were believed to have syphilis.

### Treatment Compliance

Responses from the men interviewed strongly suggest that concern for their unborn babies is a major motivating factor in treatment compliance. The main reason for coming to the clinic stated by the men who had been told before coming that they were infected, was that they came because of love for their families.

The men who refused treatment were characterized by strenuous denial of illness and argumentative tone in their responses. Their almost unanimously sarcastic response was that if they were sick, they would have symptoms. They argued that they had no symptoms, and, therefore, could not be sick. Many of them told the interviewer that they would go for treatment just as soon as they felt unwell.

Among the non-compliers, the police officers were especially adamant in their denial, and one of them even said he knew the wife was tricking him.

A non-compliant said he knew that the clinic staff was just using a ruse to compel him to appear before them. One man who refused to be interviewed accused the clinic staff of luring him there in order to force him to donate blood. He further accused them of selling his wife's blood.

Some of the men preferred to be treated elsewhere, either in hospitals or by private practitioners or traditional practitioners, such as herbalists or para-practitioners (former nurses and medical assistants who have left government service and set up private practices).

Among the few men whose compliance with treatment was assisted, most had simply laughed it off when their wives informed them and then had to be reminded. Some had to be convinced by the clinic staff or the interviewer that they should be treated. Two had to come for treatment when the wife's delivery time drew near and they had no antenatal cards.

### Interpartner Communication

Most of the men in the sample denied having outside partners and then confided to the interviewer that they did. One interviewer reported that several partners denied having outside partners and then asked him to turn off the tape before confiding in him that they actually did.

Men who asked for the tape to be turned off also reported that traditional ideas of husbands' dominance over wives is very much intact. Men who, with the tape on, said that their wives could refuse sex if they wanted to or that the wives could approach them sexually, reported quite differently with the tape off. They said that their wives wouldn't dare bring it up because that is a male prerogative and that the wives could not refuse because a wife is under the husband.

A number of the men also reported that the person they could best confide in was their wife, simply because she held the status of wife.

### Condom Use

The men definitely knew what condoms are but were reluctant to use them. A few said that they would not use them under any circumstances. Others, especially the spontaneously compliant partners, said that they would use them after being treated or during the pregnancy.

### Clinic Attendance

Male partners mostly saw clinic attendance as a matter for the woman to decide. Some said that women attend late because they are lazy, and one went so far as to say that women are lazy and dirty.

A few men suggested force or admonishment or going with their partners to the clinic as ways of motivating them.

## **4. Clinic Staff**

### Syphilis Knowledge, Attitude and Practice

All the staff seem to have a good grasp of the problems of syphilis diagnosis and treatment though their ways of describing the symptoms vary and some cite symptoms not usually associated with syphilis, such as abdominal pain or painful urination. A few clinic staff respondents reported painful urination and abdominal pain as syphilis symptoms.

They all felt that the RPR and STD training was very useful. However, one staff member said that he felt that the training was not enough because STDs were lumped together and not treated separately.

The major salient points from all the staff interviews are that after diagnosis and treatment, counseling is of essential importance in order to inform and make sure the patient understands the disease and the need for treatment, the risks involved, etc.

Counseling comes up repeatedly in the staff answers as an extremely important component of care. The contents of counseling include informing about the disease, risks, treatment, treatability, need for partner treatment and partner notification.

Nearly all the staff respondents identify Luos as the group most likely to have syphilis even though the interviewers did not prompt them that they wanted an ethnic group in response to the question. Several newly trained respondents gave answers identifying prostitutes and people with multiple partners as being at sexual risk.

Many of the answers that came up repeatedly sounded like they may be regurgitation of training materials. However, such answers do not necessarily mean that the respondents did not also believe what they were saying.

There was not much information given by this group about alternative treatments except one description of tetracycline and injections given by private doctors and bush doctors.

### Partner Notification

Staff who mentioned partner notification letters or cards report that the clients appreciate them very much; that is, that some document from the clinic helps in informing the partner.

One clinic staff member reported that when talking to the pregnant clients, he tried to guess how their partners would react when told; and on the basis of his guess that the partner would be violent or non-violent, he would either tell the client to tell the partner he had syphilis or would simply tell her to come back with her partner.

It was a clinic staff respondent who pointed out that the best way to get the partners in for treatment was to emphasize the baby's health.

The partner notification card has received high praise from staff as an aid to getting partners in for treatment.

### Treatment Compliance

The staff respondents all point out that a major barrier to treatment compliance is partner denial of illness for a number of reasons the most common of which are shame and lack of noticeable symptoms. They hint at an additional underlying cause of denial: the need to conceal one's outside sexual activity from an official partner.

The female clinic staff attribute the major barriers and problems in syphilis health care delivery to men. One of the male respondents places equal responsibility on both males and females.

### Clinic Attendance/Staff Attitude

All the staff interviewed both formally and informally during the research expressed genuine concern for their clients' welfare. Their willingness to report for work on Saturdays, when clinics are normally closed, just to make compliance easier for male partners, is a clear indication that, in spite of occasional shows of temper or disdain, the clinic staff are committed to a high degree of professional integrity and provision of quality care.

One of the Sisters-in-Charge stated that when the clinics had adequate drug supplies, attendance was high; but now that the clinics often are short of drugs, no one wants to come.

## **E. Interpretation of Findings by Topic**

### **1. Syphilis Knowledge, Attitudes and Practices**

In the sample under study, there is very little expressed knowledge of syphilis--perhaps in part because of the embarrassment of having to talk about it or to a genuine lack of knowledge.

In general, though based on the scientific belief system, the knowledge of syphilis expressed by this sample has been scanty and erroneous. Even native speakers of Swahili outside the sample did not immediately recognize kaswende or sekeneko, an alternative Swahili word for syphilis not used in Kenya.

A very few respondents gave ukimwi, or AIDS, as meanings for kaswende/syphilis, indicating that they associate syphilis with HIV. Several clients and their partners became very alarmed on being told that they had syphilis, thinking that they had AIDS.

This confusion is not surprising. If a man contracts gonorrhoea, he will know about it very quickly and will be able to relate the onset of symptoms to a particular event. He then goes to the doctor, receives injections and the symptoms go away because the disease is cured. Syphilis, however, is so subtle (many miss the lesion) that a man may not know he has a disease unless he seeks medical attention for rashes in the second stage when it is too late to associate the disease with a particular person or time.

If the man is infected with syphilis and gonorrhoea at the same time, the gonorrhoea drives him to seek medical attention. When he sees the doctor and is told he has kisonono, he is treated with a penicillin regime that cures gonorrhoea but not syphilis. His gonorrhoea symptoms go away, but he still has syphilis. Of course, the health care provider has identified gonorrhoea visually and by verbal description and may not go further to test the patient's blood for syphilis. (In overburdened public health facilities it is probably not feasible to test every STD patient for syphilis.)

Scenarios such as the above may be connected with some of the clients' partners' denial that they are sick and their subsequent refusal to accept treatment at least at the clinic. The combination of confusion about what syphilis is and general denial out of fear interferes with care-seeking behavior either because syphilis is not taken seriously or because fear of AIDS drives the patient into denial.

Another factor that presents problems for syphilis control, is polygamous families. It is not uncommon for two out of three partners to get treatment and then to be reinfected by the third partner who has not been treated. Sometimes men keep multiple wives secret from each other for many years. In fact, it is common for co-wives to learn of each other only after the husband's death when inheritance is being claimed. Since no man can be in two places at the same time and since many men with more than one wife keep them far apart, the possibility of infection by outside partners of wives is high--especially when a wife is away from her husband for long periods.

This is also true of monogamous marriages in which the wife's labor is needed in the rural area but the husband is employed in the city thus forcing them to live apart most of the time. Husbands then resort to commercial sex workers, casual and temporary relationships in the city, while wives may seek outside partners in the rural home. In this way, infection is passed from city to rural area and back, and networks of infection are established in such a way as to make tracing and treatment of all concerned virtually impossible. The trio in the present sample is an example of this phenomenon. A Kamba client and her Maasai partner in Nairobi each have other partners. Hers is a Luhya married man who has also been interviewed, and his is a wife in deep rural Maasailand some 200 miles southeast of Nairobi. The whereabouts of the Luhya male partner's wife is unknown as yet, but she may be living in the far west of the country, 250 miles in the opposite direction. That is, the network may have close to a five hundred-mile span.

Inferential evidence from reports and observable patterns across a number of respondents indicate that the separation of spouses due to social and economic factors may have an important effect on syphilis infection. One of the clinic staff respondents pointed out that the geographical distance of the home area from Nairobi may be a cause of the high rate of syphilis infection among the populations from Western Kenya because of the expense of travelling. This observation seems to be born out not only for those groups but for others who live apart for long periods.

## **2. Treatment Compliance**

The sample includes only a few more men who came to the clinic voluntarily and accepted treatment there than men who refused to come or to comply with treatment in the clinic. It is important to note, however, that about half of the partners classified as spontaneously compliant came to the clinic without knowing why they had been summoned.

The team assumed that only male partners would refuse to comply with treatment until one interviewer met with a client who herself denied that she or her partner was ill and flatly refused to be treated. After several follow-ups, it was still unclear as to whether she had sought treatment outside the clinic system. This incident raised two issues for consideration. One is the disappearance

or non-return of some RPR positive clients after diagnosis: perhaps some of them are in denial and leave the scene to avoid having to deal with it. Another is the role of risk management in the lives of women who are economically dependent on men who might react by throwing them out, as one client's partner did when she informed him that she had syphilis.

A large part of men's denial and refusal to accept treatment has to do with showing one's face at the clinic and being embarrassed by the staff. There is also a fear of being infected with AIDS by clinic staff through use of contaminated needles. People tend to be apprehensive about slipshod handling of needles in hospitals and clinics all over Kenya.

The antenatal card is held as ransom by some clinics to ensure partner compliance. In order to be allowed to give birth in a City Council clinic, for instance, antenatal attenders must have a card that verifies their status. Clinic staff withhold the cards of RPR positive antenatals until their partners come for treatment. Thus far, this tactic has proved to be highly successful in securing compliance. However, there is the possibility that a woman who cannot convince her real partner to come to the clinic might hire someone to come and pose as her partner in order to get her card. While this is a real possibility, none of the partners in the present sample seemed suspect in this way.

When partners are treated elsewhere, the clinic requires proof of such treatment. Some men may be forging proof, while others may be going to practitioners of questionable credentials. In the periurban areas of Nairobi, many of the medical practitioners are former assistants and nurses from government hospitals who, after many years of service, go into private practice. Many of these people are quite competent but may not know that Procaine Penicillin is not the drug of choice for syphilis.

During this study the team saw only one proof-of-treatment document. This was a note from a doctor in the Makina section of Kibera who said that he had found the patient, Kahn, positive and treated him with Procaine Penicillin. The patient went away thinking that he had been cured, as probably did the doctor.

Many men believe that taking tetracycline or other antibiotic capsules or tablets either just before or just after intercourse protects them against disease, especially AIDS (the capsules are called rangi mbili, meaning two colors, or Kanu Uniform, referring to the red and black uniform of Kanu Youth Wingers).

Other factors contributing to non-compliance of clients and partners are complex power relationships and self-image, fear of witchcraft, and distaste for environments where women dominate.

General system hostility to males in health care facilities may also be contributing to their non-compliance with treatment. The NCC clinics are staffed mainly by women who see streams of female patients whose difficulties are caused directly or indirectly by their partners. The staff themselves, more often than not, are having similar problems with their own partners. When a male patient presents at the clinic, he is subject to an inversion of the gender power anomaly as the female care giver assumes the dominant position and he often becomes the brunt of that care giver's hostility to men. In short, the clinic system is punitive toward males, especially in matters related to STDs.

Another serious impediment to male partner treatment compliance is time. Men who are employed are not easily able to come to the clinic and wait in a queue for treatment. Most of the men whose partners use NCC antenatal clinics are employed in low-paying jobs and work for people who would just as soon dismiss them as allow them time off. If a man has to take time off from work, he

probably loses the pay for that time at the very least and may lose his job. In most situations, he has to present proof to his employer that he is needed at the clinic. If the employer discovers the reason, the man risks dismissal. If clinics were open after business hours or on weekends, there would no doubt be an improvement in partner compliance. The Sister-in-Charge at Langata Clinic was planning to open on Saturday mornings in order to facilitate partner treatment. This was to begin just as our research was ending.

### **3. Condoms**

Evidence from outside the sample leads the team to suspect that the barrier function of the condom is not understood among people of the socio-economic-educational status that characterizes the present sample.

More work needs to be done on the connection between condom use and childishness which was expressed by several respondents. There is something--not clear as yet--about the attainment of full adulthood through marriage and mitigation of adulthood by using condoms. The man's entitlement, through marriage, to the wife's sexual services appears to be overriding the need to protect each other's health.

The image of the male condom user is one of a sick, weak or dirty person. A female condom user is seen as a prostitute.

In interviews with men, there was a clear association between condoms and hospitals. However, there is a strong indication that the respondents were patronizing the interviewers, who they thought were medical personnel.

Nevertheless, condoms are not yet widely enough available to the general population, especially in the poorer areas of town, to shift their association. Now they can only be obtained at the clinics--a cumbersome process requiring the client to get a card and see a staff member for a short-term supply.

As of this writing, condoms are not available in kiosks in the peri-urban areas. People who want them must go to the city center or a shopping mall drugstore and buy them. There are no drugstores in the periurban areas. People in the slums rely heavily on small kiosks for the distribution of food stuffs and over-the-counter drugs such as aspirin. The government licensing regulations classify condoms as a pharmaceutical which can be sold only in shops with proper storage facilities. Since a kiosk is, by definition, a temporary structure and cannot have proper storage for pharmaceuticals, distribution of condoms through the most widespread and easily accessible system is not permitted. However, the team did find condoms donated to the clinics by various aid agencies for sale under the counter in kiosks.

### **4. Interpartner Communication/Partner Notification**

The communication system among partners is complex and not yet clear to us--or at least not uniform. It is intimately connected with power relationships and constant jockeying for a stronger position vis-à-vis the other partner. Wives or girlfriends are constantly trying to gain an advantage over their male partners, who are always trying to maintain and reinforce their advantage over the women. Any knowledge in the hands of a particular partner becomes an advantage over the other. The knowledge imparted by syphilis and other STDs--that is, that there is another partner on the scene--gives an advantage that can disrupt a relationship, with great social and economic impact on

the partners. Likewise, the threat of disclosure of activities held secret from one's partner may trigger denial behavior that has adverse physical (i.e., violent) consequences.

Women have to plan carefully when and how to approach the man with the information or message from the clinic that he has syphilis and should come for treatment. Evening, bedtime and time in bed are generally considered the appropriate time for intimate discussions between men and women in Kenya.

A man who uses a condom with his wife is telling her that he has outside partners. A woman can't ask her husband to use a condom because this would mean that she either believes he has an outside partner or has one herself.

By denying that he has an outside partner and claiming that the wife must have got the disease from her outside partner, the man is also testing the wife to find out if she will crack and admit to having outside partners even though he may know full well that he himself has been engaging in extramarital affairs.

There was evidence in the sample that men are apprehensive about their wives discovering that they are active outside their marriages. One interviewer overheard two Luo men conversing on a bus. One was asking the other how he could get his wife to go to the doctor without letting her know she was infected with gonorrhoea. He had contracted it and had been examined and treated but, although his wife had not complained of any symptoms yet, he knew he must have infected her. Now the poor man was trying to find a way to get her treated without letting her know that she was sick and was seeking his friend's advice to develop a strategy.

From the denial of other partners to the fear of coming to the clinic and the trickery needed to get them in, it becomes clear that the men fear their wives in the STD situation. The major difference between men and women in this situation appears to be that the women fear physical violence and/or withdrawal of economic support.

## **5. Antenatal Clinic Attendance**

Most of the women were late attenders at the antenatal clinic. Three actually went into labor during their interviews. However, it should be born in mind that "late" has a different meaning to most of the sample, as those who came at around five to six months thought they were early. There is a widespread belief that if the pregnancy is not visible then it is too early to go to a clinic.

Looking at the deeper meanings of late attendance and staff refusal to provide service to women early in their pregnancies, the negation of an anticipated important event, such as having a baby, may be a factor in both. The staff may be seeing the early attender as claiming something for herself that she is not yet entitled to, while the woman early in pregnancy may not want to make a fuss about it lest her assumption and anticipation that the pregnancy will have a positive outcome undermine its realization.

Neither men nor women seemed to realize that traditional support systems for antenatal care that exist in the rural areas are not there in the city. So the husband does not participate to help his wife when she is pregnant because this is a female domain. But if she doesn't have female relatives nearby she is helpless because she can't turn to non-relatives for fear of witchcraft.

## **6. The Clinics**

Nairobi City Council clinics are difficult places in which to work. People who have been trained to a certain standard of good health care delivery experience practical, professional and personal frustration every day. Staff salaries have not been increased since 1987, while inflation in the national economy has made it impossible to live on salaries that were once not unreasonable. Drugs and supplies are not always available, thus placing stress on the medical and support personnel who are trying to do their work well.

A severe drop in clinic use since 1987 suggests that the public is not satisfied with NCC clinics. If the economy were in better condition, one would assume that this drop indicated that more people could afford to see private doctors. But the opposite is more likely to be true, that is, more and more people cannot afford any medical attention at all and are, therefore, not being treated or cured.

Based on observations by this research team, the Sister-in-Charge serves not only as the administrative head of the clinic, but by her personality, organization and general attitude towards her own and her colleagues work, influences staff morale and the delivery of clinic services. She can generate a sense of esprit de corps and cheerful performance, or she can foster intrastaff suspicion, negative attitude and general demotivation. Some Sisters-in-Charge play favorites, giving preference to their friends, relatives or co-ethnics, while others are fair to all clinic workers. This situation is not unlike intrastaff relations in any work place.

Sometimes staff adhere too rigidly to protocols at the expense of good care delivery, such as refusing to retreat a client who believes she has been reinfected. On the other hand, there are observable gaps between training and actual practice. In telling a client that she had bugs in her blood, the staff had used a word that non-Swahili speakers fall back on when they do not know the language well. This is both a language problem and a non-match between training and practice. Training is done in English, so the staff member may not know the correct vocabulary in Swahili and/or the client might not understand the correct Swahili in any case so that the staff thinks the message will get across using a substitute word. There is also a major communication problem in using Kiswahili with both clients and staff who do not understand it well.

## **7. Barriers to Syphilis Control During Pregnancy**

Based on the evidence at hand, the major barrier to syphilis control during pregnancy is a combination of lack of knowledge and understanding of syphilis among pregnant women and their partners, and the notion common to all, including clinic staff, that attendance at six to seven months of gestation is early.

Prevention of reinfection is hampered by poor understanding of transmission by untreated partners and rejection and unavailability of condoms. Rigid adherence to testing and treatment protocols that do not provide for retreatment for suspected reinfection also interferes with syphilis control at the clinic level.

The power anomaly and gained advantage that can be applied to personal antagonism constitute a barrier to examination, acceptance, treatment compliance and partner treatment. For example, if a woman goes to the clinic, only half of the couple is visually known to the people there. If the husband then goes, the clinic staff have an advantage over the couple because they know who they both are. Also, someone at the clinic may have seen the husband elsewhere and may know even

more about him. If either spouse brings an outside partner to the clinic, then staff gain even more advantage over all three because they can now tell the other partner who the outside partner is.

Client-centered service and information, education and communication (IEC) won't work as long as women do not have control over their own sexuality. Messages should be targeted at men as supervisors, as well as at women.

## **8. Enabling Factors in Syphilis Control During Pregnancy**

The partner notification card stands out as a very effective means of securing partner compliance with treatment without endangering the antenatal client.

For clients who cannot be certain of avoiding reinfection after treatment, there is the option of retiring to the rural home either of her own parents or of her husband's parents in order to wait out the pregnancy. This option can be explored in counseling.

Focussing the male partner's attention on the health of his baby appears to be the best way to convince those who need convincing that they should accept treatment and avoid reinfection.

Facilitation of male partners' treatment and reporting via outside care sources as acceptable alternatives to the NCC clinics would enable the clinic staff looking after the female partner's pregnancy to be sure both partners have been appropriately treated.

## **F. Conclusions and Recommendations**

### **1. Applying Research Findings to the Design of a Communication Strategy**

It is clear that any communication program must take a multilingual environment with a low literacy level into account. Materials should be in at least Kiswahili and Dholuo, and, if possible, in Kiluhya and Kikamba. Key audiences for tailored messages are the antenatal clients, their partners, the clinic staff, and the extra-clinic health care providers in the peri-urban communities.

Messages should include:

- Basic information about syphilis, including differentiation from other STDs, symptoms and implications for health for men and women.
- Need for condom use outside the trusted relationship and after treatment for a pregnant partner.
- Need for early antenatal attendance and redefinition of what "early" means for both men and women.
- Staff sensitivity to service delivery without interference from personal prejudices and frustrations.
- Information dissemination to local medical practitioners regardless of their official status. Establishment of dialogue between them and clinics regarding male partner treatment and quality control.

- Multilingual vocabulary list for clinic staff reference.

In addition to a communication program, efforts should be made to bring about the following:

- Contact with and training of private practitioners of all kinds in up-to-date treatment and counseling.
- Condoms made more easily available and their image softened to appeal to more men.
- Involvement of men in supporting timely antenatal care seeking.
- Enabling a man to comply effectively with treatment outside the clinic where his pregnant partner is a client.
- Making it easier for women to inform their partners by counseling them to reach a negotiated, realistic behavior before they leave the clinic.

The combination of lack of knowledge, communication problems and a health care delivery system that functions at a low level of efficiency are the major factors to be considered in planning the next step to be taken against the adverse pregnancy outcomes of syphilis in NCC clinics.

## **2. Lessons Learned from Research to Incorporate into the Training Module for Staff**

Staff need training in counseling and clarification of the relationship between administrative procedures, protocols and good service provision. Motivation and encouragement and an outlet for their own emotional stress should be provided--if not through training then by other means. Staff input in policy-making and decisions to start new projects would give them a sense that their professional input has meaning and that the knowledge they gain from ongoing practical application of their skills can be shared in order to enhance health care provision.

## **II. COMMUNITY-BASED QUALITATIVE RESEARCH**

### **A. Objectives, Methodology, and Implementation**

#### **1. Objectives**

- To assess knowledge, attitudes, and practices related to prenatal care among primiparous and multiparous women, male partners, clinic non-users and users, Dholuo speakers and non-Dholuo speakers, traditional birth attendants, community-based health workers, male partners, non-clinic medical practitioners and religious leaders in NCC clinic catchment areas.
- To explore the range of alternative prenatal care available and the preferences for various kinds, including perceptions of quality of care, cost factors, time and access factors influencing pregnant women's choices of care.
- To ascertain barriers to early care-seeking and clinic use and to explore factors that motivate early care-seeking and clinic attendance.

#### **2. Methodology**

The study was conducted using focus group discussions with clients and their partners. Community-based health workers, traditional birth attendants, non-clinic medical practitioners and religious leaders were interviewed individually, as were selected clients and their partners.

To ensure that samples were drawn from the target population served by the clinics, research was concentrated in the catchments of five NCC clinics: Kariobangi, Kangemi, Mathare North, Ngong Road and Langata. Catchments included in this study were selected on the basis of the rapport established in each by members of the interview team during the clinic-based phase of study and by personal contacts established by some interviewers who are resident in those catchments. The interviewers, working closely with local CBHWs and TBAs, set up venues and identified, selected and conducted interviews and focus groups with the women, their partners, the non-NCC practitioners, TBAs, CBHWs, and religious leaders.

In the earlier clinic-based phase of the study, the research team noted that women of Luo ethnic affiliation had different patterns of clinic attendance than non-Luos. They also had a higher prevalence of syphilis. In order to ascertain whether there actually is a difference in Luo women's attendance at prenatal clinics, a survey of 50 Luos and 50 non-Luos was made in each of three clinics. It showed that although Luo women were higher in attendance at first visit, their numbers dropped off for subsequent visits. Overall, Luo women attended prenatal clinics slightly one visit less than non-Luo women. This information led to adjustment of the study methodology to allow for a separate focus on Luo women's ideas about prenatal clinic attendance.

#### **3. Recruitment Criteria**

- Pregnant women
  - Total of eight focus groups with primiparous women in the third trimester of pregnancy or recently delivered (within the last 3 months):

Clinic users: ten non-Dholuo speakers and ten Dholuo speakers in each of two catchments for four focus groups.

Clinic non-users: ten non-Dholuo speakers and ten Dholuo speakers in each of two catchments for four focus groups.

- Total of eight focus groups with multiparous women in the third trimester of pregnancy or recently delivered (within the last 3 months):

Clinic users: ten non-Dholuo speakers and ten Dholuo speakers in each of two catchments for four focus groups.

Clinic non-users: ten non-Dholuo speakers and ten Dholuo speakers in each of two catchments for four focus groups.

- Total of four focus groups with partners of pregnant or recently delivered women

Clinic users: ten non-Dholuo-speaking partners and ten Dholuo-speaking partners of clinic users.

Clinic non-users: ten non-Dholuo-speaking partners and ten Dholuo-speaking partners of clinic non-users.

- Two Dholuo-speaking partners and two non-Dholuo-speaking partners of clinic users and the same number of partners of clinic non-users for in-depth interviews.
- Five community-based health workers who have regular contact with pregnant women, to be identified in the catchment areas of the ten NCC clinics for in-depth interviews.
- Five traditional birth attendants working in clinic catchments, to be identified by community-based health workers and NCC medical staff for in-depth interviews.
- Five religious leaders and church officials for in-depth interviews.
- Ten private medical practitioners serving the clinic catchment areas: two MD's, two nurses or medical assistants in private practice, two herbalists, and four non-formal or traditional healers.

Figures 1 and 2 summarize the recruitment of focus groups and individuals for in-depth interviews, respectively.

<b>Figure 1. Focus Group Discussions</b>			
	Clinic Users	Non-Users	Total
Luo Primiparous	2	2	4
Luo Multiparous	2	2	4
Non-Luo Primiparous	2	2	4
Non-Luo Multiparous	2	2	4
Total Focus Groups			16

<b>Figure 2. In-Depth Interviews</b>			
	Clinic Users	Non-Users	Total
Luo Primiparous			2
Luo Multiparous			2
Non-Luo Primiparous			2
Non-Luo Multiparous			2
Male Partners, Luo	2	2	4
Male Partners, Non-Luo	2	2	4
Medical Practitioners			10
TBAs			5
CBHWs			5
Religious leaders			5
Total In-depth Interviews			40

#### **4. Implementation**

Project staff and the interview team developed, reviewed and pretested topic guides (Appendix B) and interview schedules. The nine translator/interviewers who participated in the clinic-based phase of research were again recruited and received further training in focus group discussion methodology. They then set up and conducted the focus group discussions, monitored by the consultant, in the areas designated. Focus group discussions and in-depth interviews were conducted predominantly in Kiswahili and Dholuo.

Regular meetings were held with the project team and interviewers to discuss the progress of research and to ensure that the proper sample numbers were completed. In the course of research, the interviewers reported on general conditions in the catchments and provided insights into the particular

characteristics of each sample segment in their respective areas. Under consultant supervision, the interviewers collated and analyzed the data by hand, then did an additional cross collation by topic to ensure concentration of responses related to appropriate topics.

Research went much more smoothly in this second phase than in the first, probably as a result of the smaller numbers involved and the greater familiarity of all interviewers with the work at hand. In spite of the usual delays and no-shows, the sample was achieved.

## **B. Characteristics of the Sample**

### **1. Women**

- The women who participated in the interviews range in age from 18 to their late 30s. The multiparous women have between two and seven live births.
- All are slum dwellers in Nairobi's sprawling peri-urban areas, though within the slum communities they are differentiated by relatively higher or lower economic status.
- They represent all of Kenya's major ethnic groups -- Kikuyu, Luo, Kamba, Kisii, and Luhya. (These ethnic groups account for an estimated 85% of Kenya's population.)
- Their literacy level is not recorded, but is assumed to be low on the basis of data gathered in the clinic-based phase of research.
- Most of the women are married housewives
- The number of women employed outside the residence is much larger than in the previous phase of research.
- The vast majority of the women live with their nuclear families in one- or two-room dwellings in compounds containing from 5 to 25 families. They get water from outside near their compounds, and their toilet facilities are all shared latrines, either public or private.

### **2. Partners**

Among the men recruited, some are partners of women also included in the present sample and others are not.

- All are men of low educational and occupational status who, like their female counterparts, live in the sprawling new and old slums of Nairobi.
- Their literacy level and language sophistication are higher than that of the women, and they tend to mix English into their conversations in dialect much more.
- Ethnic distribution among the men is similar to that of the women.
- The men are generally older than the women.
- Many men who are employed have little hope of feeding their families on their earnings alone. Those who work only in casual and irregular employment are far worse off. (As wage earners, severe inflation and devaluation of the Kenya shilling has not been ameliorated by a comparable increase in salaries.)

### **3. Community-Based Health Workers**

- These are men and women who live in the communities they serve.
- They receive little or no monetary compensation for their work.

- Most of them have been trained by one of the many non-government organizations (NGO) or churches operating in the peri-urban areas. They liaise with the administration in carrying out public health education and mass exercises, such as child growth monitoring and deworming.
- They tend to have greater literacy skills than the community at large and are more competent in Kiswahili.

#### **4. Traditional Birth Attendants**

- TBAs live in the communities they serve and establish and maintain personal rapport with their clients.
- Most TBAs are women who inherited the job from their mothers or were recruited by accident.
- They see their work as a calling or special gift that they are obliged to fulfill.
- They are, for the most part, unpaid by their agencies or not affiliated with an agency, but they may receive some compensation for their services from their clients.
- A majority are women (and one man in this sample). The male TBA caters to women who cannot stand other women when they are pregnant and who prefer male caregivers.
- Nearly all of the TBAs in this sample have received training from World Vision, a U.S.-based NGO with religious affiliations.
- The TBAs workload has recently increased greatly following the collapse of the shilling and the subsequent deterioration of services in NCC clinics.
- TBAs are generally of very low literacy and have reasonable but not exceptional competence in Swahili.

#### **5. Practitioners**

This sample includes two medical doctors with clinics in the catchment areas under study, one nursing nun who runs prenatal care and delivery services at a church-sponsored clinic, two government nurses in private practice, three herbalists, one of whom practices Swahili medicine, and two traditional healers. All of these practitioners either specialize in gynecological services or see many pregnant patients. They have undergone various kinds of training and qualification, have relatively high language and literacy skills except for the female herbalists. One practitioner works in a Church operated clinic while the rest have their own private facilities in the slum areas and practice on a payment for service basis.

#### **6. Religious Leaders**

The religious leaders in this sample are drawn from the clergy and active laity of several Protestant, "breakaway" and fundamentalist churches. No Catholic clergy or lay people were available in the catchment areas during this study.

## **C. Summary of Principal Findings**

Key findings are presented by population segment: women, partners, CBHWs, TBAs, practitioners, and religious leaders.

### **1. Women**

Many of the women's responses suggest that they had been exposed to some educational materials regarding women's health during pregnancy.

Great consistency and similarity of responses are found in all substrata of women: Primiparous and multiparous women, clinic users and non-users and Luos and non-Luos.

Women who defined themselves as non-attenders express the intention to attend later in their pregnancies. Some who consider themselves to be attenders had gone only once and had no intention of attending an NCC clinic again unless they had complications in delivery.

Primiparous and multiparous women are similar in their responses, the only difference being the multiparous' greater self-assurance and personal experience.

The only significant difference in the responses of Dholuo-speaking and non-Dholuo-speaking women are the Luos' inclusion of concerns regarding "smart" appearance and nice clothes for themselves and their babies.

It is felt by some that a component of good prenatal care is the provision by the husband of nice clothes so that the expectant mother looks "smart" when attending clinic.

Some Dholuo speakers mention that their choice of delivery venue was influenced by the need to pressure their husbands to do "proper shopping" for the baby; giving birth in a hospital as opposed to a clinic or home would require "proper shopping."

The low quality of interpersonal skills (bad treatment) exhibited by NCC clinic staff toward clients pervaded the women's responses on quality of care. They mentioned rudeness, occasional violence, uncooperativeness, lateness and solicited payment. However, specific examples of good treatment were also brought up.

The women said that if a woman feels well and her diet is good, then there is no need to seek prenatal care until she is six to seven months along, when the pregnancy is quite visible. They believe the sixth or seventh month is the appropriate time to begin going to the clinic. However, if the woman feels sick and has too much pain or vomiting, she should go as early as necessary.

The women's reasons for attending the clinic are not necessarily those for which the clinic service is intended by the City Council or the caregivers in the clinic. The most important reason for going to prenatal care was the clinic card which enables them to deliver in a City Council facility. In addition, the women expressed concern about the baby's position in the womb, the need for tetanus immunization and any other inoculations. They are not so concerned about early monitoring of the pregnancy, nor do they seem to be aware of problems which may exist undetected by themselves at an early stage of the pregnancy.

They define as components of prenatal care good food, little housework and good treatment by the people around them--especially their husbands. They prefer personalized service in prenatal care. That is, they want to be attended by someone they know.

All of the women were distressed about the affect of the current economic situation on their ability to get good care. They were disappointed and angry about the lack of drugs and supplies in the clinics and their own inability to afford private care. They were outraged by the inconvenience and financial burden placed on them by having to go first to the clinic only then to be told that they must go out again and buy whatever was needed in the way of syringes, cotton and surgical gloves. And they complain of having to pay "extra" to clinic staff for service.

Most of the women were put off by the prospect of many visits to the clinic, citing distance, length of time needed and fatigue as reasons that this cannot be done. They see clinic attendance as an exhausting exercise. (A typical visit to the clinic involves a long walk to and from their homes and a long wait once they arrive.)

They did not like the idea of exposing their bodies to the clinic staff or of being examined in detail. They especially objected to the two finger vaginal examination. They fear episiotomy and the possibility that they will have to undergo a Caesarean section at the "whim" of a trainee physician who wants practice.

Women said they would like to receive their test results and more information about what is happening to them. They would like to have their questions answered in a civil manner by the clinic staff.

Many of the women avail themselves of more than one system of prenatal care. They combine the biomedical care and facility advantage of the City Council system with culturally familiar herbal preparations and massages dispensed by traditional practitioners and the personalized home services of the TBA. All parties to this multifaceted prenatal care make sure that the woman has a clinic card so she can be admitted to a City Council delivery facility in case of emergency.

Based on the many reports of last-minute changes in delivery venue, it appears that most women do not make adequate preparations for delivery and that they do not time their preparations well.

Some women, especially Luos, believe that a woman should be able to take care of herself and also to deliver herself at home. They said that women have done this for generations before clinics existed and they survived, so women today should be able to do the same. This may account, in part, for the high rate of first attendance at NCC clinics and then the drop in the rate, especially among Luos.

## **2. Partners**

The men did not know much about the prenatal care-seeking process. But some of the husbands reported varying degrees of participation in prenatal care, ranging from accompanying their wives to the clinic to deciding on where they would give birth.

The men's concerns tended to be more about their babies than their wives or partners. Some were open in saying that it was not the mother who counted but only the baby.

The men expressed fears that the pregnancy might not result in their having a living baby. They were concerned about the possibility that clinic staff would terminate the pregnancy or that the baby would

not be in the right position. A few also believed that the government was fostering population control to the extent of killing the fetuses of women who had several children already and giving them medicine to prevent them from getting pregnant again.

Some men saw force, or threat of force, as the best way to motivate their spouses to attend clinic regularly. Others felt that women are just lazy and need a push.

Some men were aware that their wives needed good food and tender loving care. They reported limiting their wives' housework and generally coddling them.

Men were very aware of the relative costs and the range of care and delivery options available. They were also very distressed about solicited payments to staff, high and escalating costs and their own inability to pay.

Men reported that they knew what care their wives were getting. This response included the care received at church clinics, private clinics, herbalists and TBAs. Several men reported that their wives were attending various NCC clinics or were intending to do so.

The men cited radio and barazas (community gatherings) as good channels of communication with pregnant women, and their responses underscored the importance of home visits and face-to-face communication to get ideas across.

### **3. Community-Based Health Workers**

This group saw prenatal care from the broader public health perspective, more than other groups interviewed.

They spoke more of kinds of women defined by certain characteristics, such as low language competence and recent migration to the city. They were able to relate prenatal care to grades of poverty and to other public health problems, such as sanitation and poor roads.

The CBHWs saw the importance of all the clinics and the TBAs in prenatal care and delivery services.

They expressed willingness to deal forcefully with people whose religious beliefs inhibited them from getting proper care.

They recommended the continued and increased use of face-to-face channels for communication, along with posters in the community.

### **4. Traditional Birth Attendants**

The TBAs expressed genuine concern for their clients and for the community as a whole.

They see their role as crucial in making the connections between the pregnant women and the biomedical system. In fact, their responses indicate that they often act as advocates for the pregnant women in trying to get adequate care for them from the NCC clinics. The TBAs serve the non-clinic-attending pregnant population and also fill in emergencies and situations in which the client's relationship with the biomedical caregivers has broken down.

The TBAs were quite specific in stating their own professional needs. They are acutely aware of their own limitations, and want more training and ongoing interaction with the rest of the health care delivery system. They wish to be more regarded as part of the system than they are at present and to be recognized for giving good, personalized service.

Ideally, they would like to have a delivery facility to share among the TBA's in order to provide better service at a centralized location easily accessible to the women in their areas. They also want basic equipment -- gumboots, raincoats, and flashlights -- that will help them in getting to night and rainy season home deliveries.

Their biggest fear is being called to deliver a woman whose blood pressure history is unknown to them. They want to be trained in the use of blood pressure gauges and to be provided with gauges and stethoscopes. They also spoke of developing kits with the supplies needed for delivery, such as razor blades, needle, thread scissors, and cotton wool.

## **5. Practitioners**

Responses from both the biomedical and traditional practitioners were colored by their need to promote themselves as service providers and their systems as efficacious.

## **6. Religious Leaders**

Although all the religious leaders spoke of the need for prenatal care, their knowledge of the prenatal situation in their communities was not as good as that of the TBAs, CBHWs and Practitioners. Their responses followed a pattern: whatever the church does is the best, most complete and final answer. So, when asked what activities are going on in their communities regarding prenatal care, their answer was that the church-organized seminars were enough for them.

## **D. Synopsis of Verbatim Responses -- By Topic and Segment**

### **1. Components of Prenatal Care, Understanding of Need, Risk Factors in Pregnancy**

#### Women

Women identified the following as components of prenatal care: good diet, lots of fruits, medicines at the clinic to increase strength, provision of good clothing by husband, dressing nicely to go to clinic, loose clothing, and flat shoes. Also:

- "In hospital the BP, blood test and weight should be taken properly and the patients should be told."
- "To be tested and examined to know how they are generally and how the babies are doing."
- "It's best to start with an herbalist and later go to clinic."
- "Herbalists have drugs to make the baby lie well."

#### Partners

Like the women, many men also expressed concern with the position of the baby in the womb and cited this as an important reason for needing prenatal care.

- "First pregnancy is dangerous. They don't know how to take care of themselves."
- "The baby should be examined. The whole thing is for the baby."
- "I think they should overlook the mother's health."
- "Caring for the unborn child."
- "Not clear, but I know she has to attend clinic every month."
- "To be examined, temperature, weight, and if there is any problem with the baby."
- "Maybe the baby is lying badly in the tummy."
- "I promise myself that she must get good food like meat, fish, green vegetables and fruits to give her good health."
- "It brings problems with money because you have to take good care of her so she won't be weak."
- "Giving her the right food and showing her you are together."
- "She should not wear high-heel shoes. She shouldn't take drugs, no heavy work. She should not get sick."
- "Experience of the first pregnancy: she had a miscarriage."

### Community-Based Health Workers

- "Eat good food and do exercises."
- "Proper diet and going to clinic."

### Traditional Birth Attendants

- "Most of them get prenatal care from the clinics."
- "...telling them what to eat."
- "...obtaining clinic cards and treatment of pain with herbs, which they believe is best."

### Practitioners

- "Taking history, and identification of problems; then we examine them physically."

### Religious Leaders

When asked about the components of prenatal care, this group spoke of educating women to attend the clinic but did not seem to know what prenatal care entailed.

## **2. When and Why to Attend Clinic**

### Women

- "So they know if the child is placed well in the tummy."
- "They just go to get the card and then wait for delivery day to go to hospital."
- "First pregnancy women go early to clinic but later become tired."
- "I felt fine so there was no need."
- "I'm now six months; I'll go next month."
- "I came early because of the problems last time."
- "I started clinic in the fifth month because of illness."
- "Women need to be near a clinic in case of problems, especially in delivery."
- "To monitor the baby's growth."

- "I hear that for the first baby it is not good to give birth at home." [Therefore, it is important to go to clinic to get the delivery card.]
- "It is good to go to clinics so as to know whether you have twins or one."
- "...so that if you have a problem, it can be solved."

Most of the women's responses indicate that early attenders start because of problems, while late attenders start late because they feel fine or just want to obtain the clinic card for delivery. Many women expressed the feeling that going early means that they have to make too many clinic visits overall. Although they feel that monthly and then weekly visits to clinic were fine, they also expressed boredom, fatigue, and dissatisfaction with having to go every month.

- "Without problems, it's not necessary to go many times or to start early."
- "Nurses turn away two- to three-month pregnancies, so they lose hope."
- "Once a month is OK."
- "It's only three months; I have not gone because I'm still not showing."
- "I'll go when I'll be six months; that's when the tummy will be showing."

Women recognize the need for early care, but don't go to NCC clinics because of demands for bribes, demands for previous baby's clinic card, and hostility to early pregnancies by staff.

### Partners

Various men stated that women should start care at 3, 5, 6, and 7 months and that thereafter the doctor should advise them when to come for care. All the men reported knowing when their wives started prenatal care, and several said that they either accompanied their wives on the first visit or encouraged them to go to the care source. They know that women go for prenatal care once a month, but were not sure that this was the best regimen.

### Community-Based Health Workers

- "All women need prenatal care but the primiparous women more."
- "They should all do [go to the clinic] because the child could be in a bad position."
- "Immediately she knows she is pregnant."
- "As early as possible,  $\pm$  3 months."
- "Need to be immunized."

### Traditional Birth Attendants

All agreed that women should go before five months but "before five months you will be chased away because you are not pregnant. They [clinicians] say, "if you think so, then where is it?"

- "The baby may be in a bad position."
- "We want women to be vaccinated for tetanus at two months but we are always chased away [from the clinic]."
- "...at the clinic two times a month from the seventh month; before it's once a month."
- "Any time they come (to us) this depends on how they feel."
- "The second and third months are good for a start."
- "At three months if unwell and five months if well to go and get the clinic card."

### Practitioners

- "After three months."
- "As soon as she finds she is pregnant."
- "If she is sick, three months, but I recommend five months if she is normal."
- "Early in the pregnancy."
- "I refer my patients to the clinic to get cards."

### Religious Leaders

- "To get the ANC (antenatal clinic) card."
- "The church advises them after one or two months to get the clinic card and know their next appointment."
- "As soon as they know they are pregnant."
- "Three months."

## **3. Range and Quality of Care**

### Women

Women recognized and mentioned private hospitals, Kenyatta Hospital, NCC clinics, private clinics, private practitioners (especially herbalists as a parallel, alternative or superior care source to NCC clinics), traditional birth attendants, and no care source other than themselves. They also note that they are required to give their husband's postal address at the clinic but if the husband is unemployed, he has no postal address and this prevents them from gaining access to services.

- "They ask you to come in at six a.m., but they themselves start work at nine and they are never in a hurry."
- "If you know about herbalists, then you go to them, but if you don't know, then you can decide whether to stay at home or go to the NCC or other clinics."
- "She is cheap, friendly, tells the women how the baby is lying...you pay whatever you can, but Nyangulu doesn't demand money." (both quotes refer to a well-known herbalist in Kibera.)
- "Prefer private because you can go any time and are treated nicely and questions are answered."
- "At one time I had many questions I wanted to ask the nurse, but she told me to do what everyone is doing and keep questions to yourself. I would rather go to private and get best treatment than go to NCC and be abused."
- "TBAs should have a clinic so that anybody who wants to deliver can just walk in and pay and deliver."
- "Women go to NCC clinics because they have qualified doctors."

There were repeated expressions of fear for physical abuse meted out by staff if you show fear or make noise and complaints. Some complained about going to the clinic and then being sent back to buy cotton or whatever is needed.

- "When you are being bled, if you show fear, you are slapped."
- "If you are sent to buy things and you don't have money, you just stay at home."
- "If you get there and you are last in line, they take the first ten people and then you are told to go away."

- "I went to Mathare North to see the doctor and when he saw me, he knocked me on the head and said, 'why do you keep on spreading your legs and giving birth irresponsibly?'"
- "If it is your fourth delivery, the nurses abuse you and ask why you don't plan."

Some complain about not being given their test results so they can't know or inform an alternative caregiver of any problems discovered in the clinic. Many women feel that clients should be told what is happening.

All the women expressed frustration or anger at the administrative setup at the NCC clinics, the lack of drugs and supplies, the staff behavior and the cost.

- "They should talk to me like a human being, not like a cow."
- "Nurses should have a welcoming approach."
- "The nurses should learn to handle pregnant women because these are special cases, as they are not sick."

There were several complaints about mishandling in clinics, especially the use by staff of trainees and the unnecessary resort to Caesareans.

### Partners

Convenience of access and qualified staff were cited as reasons for choosing the care source. Men's perceptions of the choice of care source were related to the poor quality of service at Kenyatta Hospital, the high cost of other care sources and the belief that the chosen care source was the best. All said that they either decided on the care source or participated in the decision.

### Community-based Health Workers

- "Private clinics because there is not mistreatment and everything is available there."
- "They seem to prefer clinics but some go to TBAs because they are nearer."
- "In the clinic they can be treated, examined for any diseases and there are lots of services."

All said that the mass deworming exercise twice a month was the best opportunity to contact pregnant women. One CBHW mentioned talking to pregnant women during the child growth-monitoring exercises.

### Traditional Birth Attendants

TBAs expressed their own need to be contacted by other members of the health community so that they can keep updated in providing good service. They also reported a sharp increase in the number of deliveries they have been performing since the beginning of 1993.

- "Apart from the TBAs, they (the women) are helped by the CBHWs, who are doing a good job in the slums."
- "Most of them go to the clinic before they come to me."
- "I examine them, but I insist that before coming here she has to go to the clinic."
- "They prefer TBAs because we are always available."

### Practitioners

- "I tell them to go for treatment at the clinic and hence get a card, but when sick, I treat them with my herbs." (herbalist)
- "Getting a card and going to the clinic as per instructions from the doctor, that's the only condition for me to keep seeing them." (midwife)
- "If she knows about traditional medicine, she will go for it."
- "They try to go to NCC clinics but after failing to be treated properly they come to me." (traditional healer)

### Religious Leaders

- "Clinics [are the best] because even the bible quotes that."
- "There is qualified staff [in NCC clinics]."
- "The services are good [at a church clinic] even though you have to pay."

## **4. Barriers and Motivators to Early Clinic Attendance**

### Women

The clinic card for delivery in an NCC facility appears to be the most significant motivating factor in clinic attendance, at least at the first visit. Many would be motivated to attend if there were faster service.

- "Some women only go for the card, so they don't care about whether it is early or late. Some say it's getting close to delivery, time to get the card."
- "I would go to clinic if I received 'kito kidogo' (a bribe) for going."

Women who defined themselves as non-users of NCC clinics reported that they spend more money but feel satisfied by their care source. Some women expressed a desire to deliver near home or expressed the need for weekend services for working women. Some suggested the use of posters and barazas (community meetings) for information about the benefits of early attendance. Several suggested home visits to slum dwellers as a channel for communication about early prenatal care.

- "If you have to pay, then the services should be good."
- "The idea of something small (a bribe) is really giving us a big problem."
- "Abolish cost sharing. Avoid Chai (bribes). Abolish abuses by the nurses and beatings."
- "If the husband is earning a low income, then you can't go to hospitals."
- "Why should women have to pay and also bring all the supplies they need?"
- "You should be able to go and be given the card and the injection without paying."
- "It is embarrassing to be turned away because of lack of money."
- "You might be feeling very sick, then you decide to go to the clinic. Then you are told that you go to buy syringes but because you don't have money, even though you are sick, you can't be treated."

Women felt that failure to go for prenatal care is related to distance from clinics, ignorance and multiparity. Distance and convenience are major factors in the choice of care source. Most of the women walk to their care sources, sometimes via treacherous paths or roads. Going to clinic was

considered a fatiguing exercise--walking, waiting, returning. Fatigue was cited as a barrier to regular attendance and a reason for late attendance. Some women objected to detailed examination and disrobing.

- "I don't like the hospital because it is very expensive and also people will be cut there. I will go to Pumwani (Maternity Hospital) because you are helped there."
- "The inserting of two fingers inside the uterus is not smooth; it hurts."
- "Because the nurses abuse them so much that it reaches a stage when they can't stomach it anymore."
- "Why go to clinic when you can deliver at home with no problems?"

The combination of poor service and lack of drugs and syringes discourages women from NCC clinics.

- "Mostly Pumwani is very bad because when you go there they refer you to a clinic near your home." (Refers to sending away women in labor.)
- "You take a pregnant woman to Westlands at night, and they tell you the case is complicated so you must go to Pumwani. Reaching Pumwani, you wake up the staff who are sleeping and they ask for your card. They see that Westlands is written, and they tell you to take her back there."
- "I was told to take her to a private clinic of one of the NCC staff."

#### Community-based Health Workers

Word-of-mouth communication was cited as the best motivator. CBHWs make home visits and urge women to attend clinic. They also give them information on good diet and care during pregnancy.

- "Organized women's groups should sell their baskets and give each member enough money for prenatal care."
- "There are some religions that refuse their followers to go to the hospital. If we know these religious followers, we go to the chief and he gives us a policeman to catch them and take them to the hospital by force."
- "Women believe that there is no medicine at the clinic, so they don't go."
- "Women who go to the clinic and are delivered by a male attendant do not go back for the next pregnancy."
- "Countryside women don't know where to get services and religious women believe everything is God's will."

Other barriers cited were fear of abuse by staff, muddy roads during rainy season, distance and transport problems.

- "Prostitutes and office workers don't have time to go to clinic."
- "At Langata (NCC clinic) the number to get cards is limited to ten per day, which they fear is too small, considering the number of women that go and are turned away each day."
- "In Riruta (NCC clinic) they take all that come."
- "When one is sick (at an NCC clinic) you get attention by being referred to bigger facilities."

### Traditional Birth Attendants

When interviewed individually, nearly all the TBAs stated that home visits and casual conversations in the communities are the most effective means of motivating women to attend clinic. Many also cited posters and barazas as effective means of communication.

Among the barriers that TBAs reported are transportation problems, previous experience, husbands' unwillingness to pay, treatment by staff, and religious and cultural considerations.

- "Lack of good roads, lack of cooperation with the nurses."
- "Women's husbands are not willing to pay."
- "Women are afraid of going to the clinic for fear of being embarrassed and asked how many children they have."
- "Those who have been operated on, we advise them to go to the clinic."
- "They like giving birth at home."
- "The women who become pregnant at an older stage are jeered by the younger nurses."
- "The askaris (security guards) tell you to pay 10 shillings."
- "The nurses just sit and make their sweaters, take their tea and gossip. They are very proud (arrogant)."

### Practitioners

- "We need to walk around and talk to them."
- "Private clinics give services throughout the day."
- "Some are brought by TBAs."
- "If they come to private clinics, they are given personalized attention, which makes them happy."
- "Most of them don't have money."
- "They say the (NCC clinic) staff harass them and they are told to buy things like gloves."

### Religious Leaders

- "The treatment she gets on the first visit determines whether she will come back."
- "The church organizes meetings and home visits; discussing with them the risks of not going early."
- "As religious leaders, we encourage our women to attend."
- "Fear of being insulted at the clinic for unplanned births."
- "Men think it's a waste of time or suspect that women go to hunt for other men."
- "Some illiterate women are given dates to come back, but they are not explained why they should come back."

## **E. Recommendations**

The following recommendations are based only on the information collected during the present research, and address types of need: supplies, facility, training and information, and education.

### **1. Supplies, Salaries and Facilities**

Clearly, the acute shortage of drugs and supplies in City Council facilities is a serious impediment to proper delivery of services. It is also a major contributor to the frustration, friction and antagonism between caregivers and their clients. The supply situation needs to be addressed, as the shortages are demoralizing to all concerned. Supplies should also be made available to private, traditional and para-practitioners through legitimate channels in order to discourage informal distribution systems that, at present, are draining the government's meager stock.

Traditional birth attendants need basic supplies (gumboots, raincoats, flashlights, delivery kits, blood pressure gauges and stethoscopes) to enable them to better attend deliveries. These could be supplied in conjunction with the training mentioned below.

CBHWs and TBAs need to be paid at least a small amount so that the time they devote to their work will help to support them and their families. Better salaries and terms of service for City Council employees are also necessary to bring about a real improvement in service delivery.

As long as clients have to buy their own supplies, they should be able to get them conveniently in or near the clinics or should be informed of what they should bring before their clinic visit. Clinic clients and women preparing for delivery should be able to purchase ready-made sanitary packets of the appropriate tools and materials at reasonable cost. Preparation and sale of clinic and delivery packets could be an income-generating activity of women's groups in the slum areas or of the TBAs or selected entrepreneurs. Such a project would require a brief study of supply sources and costs, design and pretest of the packages, identification and training of prospective producers and development of financing, repayment and accounting strategies to ensure sustainability and continuity.

It is difficult to recommend that more clinics be built when the existing facilities cannot be adequately run or maintained. However, it is worth pointing out that existing facilities have come under increased stress as shanty towns and other slum communities have mushroomed in Nairobi. Kibera, for example, is a slum community as old as the City of Nairobi. However, it has long been underserved, and has recently grown so rapidly that Kibera women now have to cross a treacherous river to get service in Lang'ata clinic, in middle-class Otiende Estate. Umoja, Riruta, Mathare North, Kangemi, Lang'ata and Kariobangi clinics now serve slum communities that did not exist five years ago.

Respondents in the present sample have repeatedly expressed the desire and need for facilities closer to them.

### **2. Social/Cultural**

Because of the importance of personal contact in society and communication in Kenya--especially among rural-urban migrants, co-ethnics, and people of low literacy--there is a need to personalize prenatal and delivery services in order to make them more acceptable to the clients and their families.

This means concentrating effort on the traditional birth attendants and private practitioners of all kinds as key groups to motivate and service the demand properly.

The biomedical community's denial of the validity of alternative systems works against effective care delivery to pregnant women. More work needs to be done to calm the formal health services' complaints of the alternatives.

Program managers should make efforts to learn more about alternative care systems and to identify their efficacious components.

Cultural factors that could promote or that interfere with sound prenatal care, such as the belief that "a strong woman would be able to deliver herself," need to be identified and used by program managers to plan communication strategies.

### **3. Training**

The traditional birth attendants' skills and capabilities should be enhanced through appropriate training. Where illiteracy is a barrier to training, appropriate methods for information and skills transfer should be developed.

CBHWs can also benefit from more training in how to communicate and in correct information about pregnancy and delivery as they are in direct contact with the potential clients.

Religious leaders, because of their enormous influence, can benefit from training in health and communication skills. Since religious belief is often an obstacle to care seeking and delivery, dialogue should be established between church leaders and health care providers to increase mutual understanding and cooperation.

Private practitioners of all kinds need occasional, in-service training through updating seminars and exchange of experiences and ideas. Two way communication with this group would also enhance planners' understanding of conditions in the slum communities.

Biomedically trained staff in the NCC clinics urgently need retraining in appropriate behavior toward clients, counselling and communication skills. They desperately need a means to vent or sublimate their frustration through regular discussion groups, seminars and workshops which will repair their damaged self-esteem while enhancing their knowledge and skills.

### **4. Information and Education**

Women and their partners need information and education on options for prenatal care, components of prenatal care, expectations they should or should not have of the care source, and administrative structures and procedures.

Women and the community at large need more education on pregnancy. They especially need a better understanding of the need for earlier prenatal care seeking.

Women need to know that pregnancy monitoring is not only for those with perceived problems but that there can be problems that they themselves cannot detect so it is for everyone. They need more information on reasons for episiotomy and two finger examination.

Birth control needs to be distinguished from prenatal care.

Populations at risk such as teenagers, primiparous women, grand multiparous women, migrants and employed women need encouragement and enablement to seek prenatal care.

The monitoring of preparations for delivery should be introduced into clinic visits in the last month of pregnancy in order to reduce the number of deliveries in accidental or emergency locations.

Interpersonal communication should be through home visits with known people. Barazas, church sermons, women's group discussions, radio and posters are also good channels for getting messages across.

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## APPENDICES

## APPENDIX A

### ETHNOGRAPHIC OVERVIEW

#### Ethnicity

Kenya is a country of some 42 African ethnic groups, plus a number of transplanted Indian and European groups. In addition to its resident population, it hosts contract labor from other countries in the public and private sectors and several hundred thousand transient tourists, sailors and business people each year. In the past 20 or so years, Kenya has been politically more stable than any of its neighbors and thus has received an influx of population, as refugees from Ethiopia, Somalia, Tanzania, Uganda and the Sudan--as well as from other countries in the region, such as Rwanda and Zaire, that do not share borders with Kenya. Of the refugees, those who are eligible for resettlement elsewhere or for return to their own countries leave Kenya, while those who cannot go, cannot be forced to leave.

The largest ethnic groups in Kenya are (in order by number):

- Kikuyu
- Luo
- Luhya
- Kamba
- Kisii
- Kalenjin

The Luhya and Kalenjin groups represent clusters of smaller ethnic groups who speak mutually intelligible languages. The president of Kenya is a member of a very small sub-group of the Kalenjin called Tugen. In Kenya, ethnic affiliation is significant culturally, politically and socially. As will be seen below, language and circumcision are linked to ethnicity and to the wider social context. In Nairobi, antenatal clinic use appears also to be linked to certain ethnic groups. For reasons not yet clearly understood, the Luo seem to use Nairobi City Council health facilities in greater numbers than the other groups, and they are more prominently represented among the RPR positive antenatal clinic attenders. Luos in general have a higher rate of STD and HIV infection than the population as a whole, both in Nairobi and in their home area around Lake Victoria.

Many of the clients and partners who present themselves in Nairobi City Council clinics as Luhya are actually Ugandan from several different ethnic groups. They are resident in Kenya and posing as Kenyans to avoid discrimination and repatriation, because they cannot live in Uganda but cannot prove political or religious persecution in order to become bona fide refugees.

#### Language

While Kiswahili and English are the official languages, English is used primarily by the educated and by officialdom. Kiswahili is more widely spoken but less often used for official business. The indigenous languages belong to three language families: Bantu, Nilotic and Cushitic. Kiswahili is a Bantu language with a heavy Semitic input from Arabic. It is the mother tongue of the Swahili people who live at the coast and make up less than 1% of the national population. For everyone else, Kiswahili is a second or third language. While other Bantu speakers can hear cognates in Kiswahili and have relatively little trouble learning to communicate in it, Nilotic and Cushitic speakers are disadvantaged when forced to use Kiswahili. The largest ethnic groups in Kenya and those most

represented in the present sample are, in order of population size, Kikuyu, Luo, Luhya, Kamba and Kisii. All of these, but the Nilotic Luo, are Bantu speakers. The home areas of the Luo, Luhya and Kisii are in the far west, near the Uganda and Tanzania borders.

### **Social Organization**

Two hallmarks of Kenyan social organization are gender and age stratification. Age stratification is institutionalized in the Age Grade System. This means that there is a progression of grades through which all members of the group pass in their lives. Cohorts that pass through the ascending age grades together are called "age sets." Age sets are corporate groups that have internal structures and remain cohesive throughout their lives. Nuances of this system vary from group to group, but all groups mark a severe break between childhood and adulthood at initiation, which for most groups is circumcision.

### **Circumcision/Initiation**

All Kenyan ethnic groups--except Turkana, Luo, Teso, Non-Muslim Indians and various Europeans--circumcise men. Most peoples also circumcise women in one of several different ways. The Turkana, Teso and Luo have physical ordeal initiation of different kinds but, nevertheless, observe the break between childhood and adulthood; and the Turkana, at least, have a very clearly structured age set system.

A circumcised person is an adult; an uncircumcised person is a child. In order to be circumcised, one must be intellectually complete. Therefore, after circumcision, a man, especially, cannot be seen to be intellectually incomplete; that is, he may not reveal that he does not know something or that he is unsure about anything. Since rules of gender stratification require that a man always be more knowledgeable, correct and powerful than a woman, the possession of information by one or the other either reinforces or disrupts the system.

During the ceremonies that accompany circumcision, both in traditional settings and in hospital, initiates receive training in gender roles, sex and other matters from their circumcision sponsors. These people pass on the secrets or special knowledge of their ethnic group and also instruct the initiates on how to conduct themselves as adults in life in general and in marriage in particular.

Circumcision is a very important political issue in Kenya. Circumcising peoples do not wish to be led by uncircumcised leaders. As a result, uncircumcised people are often the brunt of jokes and are not infrequently given short shrift by service providers who come from circumcising ethnic groups--not just in the health field but everywhere. A great deal has been said about the connection between the high rate of HIV and STD infection among the Luos and the fact that they are not circumcised. Luos' insatiable sexual appetite is often cited as another factor in rapid disease transmission. Luos probably do not have intercourse more than other people; this kind of folklore about 'other' peoples is common worldwide.

### **Migration/Population**

The Western Kenya peoples, Luo, Luhya, Teso, Turkana and Kisii, are located right next to Uganda, which has a very high rate of HIV infection. The major truck routes to the interior converge at several points around Lake Victoria, bringing population movements to and from the wider East and Central African region into the home areas of Luo and Luhya peoples. Note also that the Kisii and

Luhya, as well as Sabaot, are circumcising groups; the Luo, Teso and Turkana are not yet. The Teso and Turkana do not have a significantly higher rate of HIV/STD infection than others.

The western communities--especially the Luo and Luhya--have for three generations been transhumant between Nairobi and their home areas. South Maragoli, a Luhya location in Western Kenya, for example, is often referred to as a bedroom suburb of Nairobi. The Kikuyu and Kamba who come to Nairobi are more easily able to go home on weekends and holidays than these farther west groups. Men can keep their wives at home or bring them to Nairobi for short visits. They can even buy a plot and build a house in Nairobi or periurban areas and know that they will be able to get home whenever they want to. But men from Western and Nyanza provinces have a more difficult time visiting home because of the distance and cost of travel. They are more likely not to see their wives for longer periods and, therefore, to indulge in casual sex in the city. They are also less likely to set down permanent roots in Nairobi by buying a plot and building a house, as they know that it will be very difficult to maintain both the Nairobi home and the Western Kenya home as they grow older. Many of these men are remittance husbands; that is, they stay in Nairobi for long periods and send money home to feed, clothe and educate their families. This puts their wives in difficulties and may lead to more indulgence in casual sex by the women in the rural areas--although this is certainly more difficult for them than for the husbands in Nairobi. So the infection rate may be affected by the women in the rural areas in contact with local people who may be traveling back and forth to Uganda and by the men who stay in Nairobi without their wives and contact commercial sex workers. These men would then go home and infect wives or receive infection from wives and then bring it back and infect more people in Nairobi.

### **The Marriage Contract**

The marriage contract is made between two patriarchal corporate lineages, not between two individuals. In exchange for a consideration in wealth, the woman is given by one group of males to another group of males. She becomes an important link between the two lineages, though her person is apparently considered consumable or expendable.

For women, the marriage setup is such that refusal to play sex is breaking a contract that can endanger the entire family. No woman wants to be responsible for chiraa to befall the family, so she will go along with whatever the husband wants/does in order to uphold her side of the contract and not be the one who brings spiritual problems to her clan or his.

Women do not have control over their sexual and reproductive facilities. This control is transferred to the husband's clan or lineage as part of the marriage contract. Even the husband, who has immediate power over the wife, cannot refuse if the elders of his lineage or clan insist that the wife produce more children. So even couples in which the husband is committed to limiting births, for example, may come under threat of supernatural sanction if they refuse to honor the elders' wishes.

### **Customs Regarding Discussion and Questioning**

Kenyans nearly always approach any subject obliquely, never directly as Americans do--especially if the topic is sensitive in any way. This approach reaches extremes quite often when, for example, a meeting is called to discuss a certain topic and the meeting begins and ends without the topic at hand ever being brought up. Nevertheless, everybody goes away satisfied that the matter has been dealt with or surprised that they now have nothing to do in spite of the meeting having been held. The obverse of this phenomenon is that if a question is put directly, the answer often will be about some

other topic. There is no set formula for what topic to bring up in order to get information on the topic you want or what question to ask in order to get the answer to the question you want to ask.

The right to ask a question and the obligation to give an answer are intimately linked to generational, gender and occupational stratification. Thus, it is more difficult for a female to ask a question of a male or a younger person to ask an older person. A person of less authority or power is not expected to ask questions of those of greater authority or power and, when asked a question by a person of greater authority or power, the respondent of lower authority or power is expected to give the "correct"--but not necessarily the real--answer.

Kenyans are accustomed to and seem to thrive on a great deal of formality in public and official situations. Unfortunately, this formality interferes with the content of interaction. Lengthy introductions and grand public speeches are the order of the day for public officials. Even at a very local level, such as at family gatherings and private social events like weddings, there is a great deal of speechmaking and formal introduction of guests but little content.

### **Risk Management**

All of the peoples of Kenya have a long history of living in ecologically marginal environments. They all share a pre-occupation with cattle and integration of cattle into their social systems, regardless of their subsistence mode. Subsistence through animal husbandry and farming require strategies for risk management that may be unfamiliar to people from non-subsistence economies and rich food-producing environments. A striking example of outsiders' failure to understand risk-management strategies of economically/ecologically marginal peoples is the continued negative attitude taken by development experts toward the large numbers of cattle held by East African pastoralists. For many decades there has been a complete failure to grasp the need for large herds in good years in order to perpetuate genetic diversity and push living herds through periods of drought and epizootic. Human behavior in other aspects of life reflects risk management as a consideration of high importance in spite of the apparent non-sensibility of individual actions. An example in the current study is client non-compliance with treatment discussed below.

### **Postpartum Sex Taboo**

African couples recognize the need to protect the health and life of the mother and child during the first two years of life. The only certain method of protecting the mother from a new pregnancy that would endanger her, the baby and the fetus, is abstinence from sex. Abstinence in African cultures takes the form of the two-year postpartum sex taboo, meaning that the husband and wife may not have sexual intercourse until the newborn reaches somewhere around the age of two years. This is often defined as the lactation period, and weaning is seen as the point when couples may resume sexual activity.

If the husband is in the home, if the wife looks too attractive, or if love flourishes between them, then they may be tempted to have intercourse and thus break the taboo and risk a new pregnancy. A variety of strategies have been developed to prevent this from happening. Some of these strategies are consciously known and stated, while others have taken on a life of their own and have become entrenched independently of the need to protect mother and child. Among the Maasai, for example, both mother and child grow dreadlocks which make them very ugly. The mother stops wearing her ornaments and in general tries to avoid arousing her husband's interest. When the child has been weaned and named, the mother shaves her head and begins to dress nicely again, signaling that she is ready to resume relations with her husband. Other ethnic groups use similar strategies.

During the period of abstinence, the husband experiences frustration unless he has other wives. If he is monogamous, he must seek gratification outside the home. If he stays around the home, he may be tempted so he goes out of the home. To where? In the urban areas there are few alternatives for men whose wives are nursing. They may go to bars, in which case they are under pressure to buy alcohol and consume it. They are additionally under pressure to patronize prostitutes, though this pressure is not as severe. But the combination of sexual deprivation and alcohol place the man in a weakened position.

This is not to say that all men who seek sex outside their marriages are victims of cruel circumstance, but this is a major factor in the development of male behavior patterns that take them outside the home for sex. In some ethnic groups and for many individuals, activities outside the home have become a way of life and a mark of true manhood. Spending a great deal of time in bars, denying emotional attachment to wife and children, denying paternity of the wife's child, and generally negating ties to the family he has created--all help a man to reinforce himself in the uncomfortable situation he faces. This has reached extremes as young married men with no children and also men whose wives are neither pregnant nor lactating take an active part in the urban bar culture as if there were a reason for them to get away from their marital homes.

It is in the setting where men are more or less forced out of their homes and pressured by physical need and social and economic circumstances to seek sex outside the home, that they become vulnerable to infection and reinfection with STDs. They become both victims and carriers in a disease-transmission marathon fueled by alcohol. Ironically, a root cause of the man's apparent misbehavior is the need to protect the health of his wife and child. In the process, needed financial resources are used up, wives are abandoned, and infants are deprived of the attention of one of their parents. What has become a habit continues after the child is weaned and normal sexual relations can resume between husband and wife. Now both spouses are at risk of infection and reinfection, which is particularly ill-timed if the wife becomes pregnant again before discovering that she has been infected.

### **Individual vs. Collective**

The dynamic relationship between the individual and the collective is very different among East African peoples and Western peoples. This difference tends to create a gap in understanding on the part of those from outside who try to plan programs for Africa.

Whereas in the Western countries the individual is the primary unit and service provision is generally client- or individual-centered, East African peoples do not recognize a clear-cut boundary between individual and collective responsibility and action. This means that the individual's concerns are subordinated to the welfare and concerns of the collective, the collective being the extended family, lineage, clan or tribe. The collective at each level includes the living, the dead and the potentially living. Individual misfortune can be the result of collective misbehavior. Likewise, misfortune that repeats itself within a family or clan can be the result of individual or collective misbehavior or failure to comply with social rules.

### **Good Fortune/Bad Fortune**

There is a limited amount of good fortune in the universe. So if one person has some of it, then it must have been taken away from someone else or must have been acquired at someone else's expense. Misfortune can be caused by direct action of the living against others. This is witchcraft. A woman who is pregnant can be the target of one who is unable to conceive. A couple whose

marriage is stable and happy is subject to attack through witchcraft. A person who gets a promotion or has a nice house or gets good grades in school, is in danger of attack through witchcraft. The result of this belief in witchcraft and in direct open attack by people on those who do well is extreme secretiveness in personal and family affairs and avoidance of dangerous situations in which someone else's jealousy can be aroused to the point of spellcasting or undermining. This belief is a factor in late clinic attendance, as it is risky to let non-pregnant women know that one is expecting. It is also a factor in male partner non-attendance at the same clinic where his female partner has been diagnosed.

### **Supernatural Punishment**

Often the misfortune of the living is a form of punishment by the dead--the ancestors--who are watching and who can easily take umbrage at the living's failure to uphold what has been passed on to them by those who have already come and gone. This punishment is often meted out through the potentially living and, in addition to the immediate pain it inflicts, it also threatens the living with loss of continuity and loss of a place among the ancestors. For example, a registered nurse married a man from another tribe against her father's wishes. Her first child had Downs Syndrome and died at five months of age. This was seen as ancestral punishment for disobedience of the parent's wishes.

Each ethnic group has its own terms and rules which fall under the rubric of supernatural punishment for individual and/or group misbehavior. Among the Luo it is chiraa; the Kikuyu call it thahu. Negative pregnancy outcome, especially if repeated for an individual or common in a family, is often attributed to chiraa or thahu. The living then search their memories for a cause, such as bride price being paid incorrectly or marriage outside the proper boundaries. Once the cause is discovered, then cleansing or removal of supernatural displeasure or sanction can be effected. It is not uncommon for people, especially women who believe that their personal actions have had a negative effect on their families, to commit suicide. The process of identifying the cause of the curse is reflexive and tends to bring blame to the individual or group for misfortune that has no internal cause, at least not as seen by peoples of other belief systems. So, a syphilitic child or a series of stillbirths may have a medical explanation, but the real cause may be ancestral displeasure at some breach of custom by one or more members of the clan.

The famous Otieno case in which a Kikuyu widow of a Luo husband tried to bury the deceased on their farm near Nairobi in violation of Luo tradition brought out a strenuous defense of ethnic group custom by the leaders of the Umira Kager clan, who feared that their descendants would be eternally cursed if S.M. Otieno were not buried in his ancestral home in Laoland. They won the case.

### **Morality, Sexuality, Gender**

Kenyan indigenous ethnic groups are among the most prudish in the world. Even before embracing the Judaeo-Christian tradition, even without Islam's controls on every aspect of sexuality, East African peoples have their own strict regulatory devices, such as elaborate practices regarding incest taboos, structural limitations on partner availability, codes of honor and respect, and, of course, the ever-misunderstood genital mutilation of females. Sexual matters are seldom discussed, even among peers, and never among men or women of immediate ascending or descending age grades or generations.

### **Changing Society**

Kenyans, like 20th century people everywhere, have experienced enormous and rapid social, cultural and economic change in a fairly short time. Taking the year 1900 as a starting point, it would be

difficult to decide who has changed more, Kenyans or Americans. Generational conflicts that arise in Kenyan families and society in general are not unfamiliar to Americans. The only differences lie in some of the content or subject matter of conflicts that arise as each generation redefines society in its own way. Yet, there are strands of continuity which remain intact, either by conscious decision or because their validity is beyond question or because they are so deep as not to be able to be articulated for debate.

The global cash economy, induction into the community of nation states, class formation and changes in religion and schooling have been major factors in the creation of a "modern" or "mainstream" Kenyan. Three generations of literate Kenyans have struggled through a school system in which their survival depended in large part on their denial, negation and abandonment of their own culture. Education has been the most important factor in sorting out which families and individuals aggregated into which socio-economic classes in the first 25 years after independence. One result is that the Kenyans who the world hears from, because they are the well-educated ones, are also those who have had the greatest vested interest in denial of certain aspects of Kenyan culture.

Setting that consideration aside, however, the cash economy and reorganization of patterns of labor and benefit from labor, of geographical movement and changes in the patterns of family structure, have caused all Kenyans to encounter material impingements on their lives that have necessitated practical changes in previous ways of doing things. Family planning and birth limitation are a case in point. No matter what the ideological base or the tradition or the cultural requirement, people living now cannot support families as large as their grandparents could--and Kenyans know it. They have embraced the introduced technologies for family planning wholeheartedly and have added them to the technologies they already had.

As elsewhere, there is a strong tendency in Kenya to take on the new but not to give up the old entirely, especially if it has always worked. Equally, Kenyans have their own new ideas about how things should work. In this context, they make up their own practices and pass these on to their children, just like people everywhere else.

**APPENDIX B**  
**VOCABULARY**

**English**

moving around  
play sex  
meet the husband/wife - to have intercourse  
witchcraft

**Swahili**

magonjwa ya zinaa - std's - zinaa from zini, Arabic for adultery or licentiousness  
zinisha - indulge in debauchery  
mimba ya skati - a pregnancy that is not yet showing so that the woman can still wear a skirt  
kaswende - syphilis  
kisonono - gonorrhoea  
sekeneko - syphilis (but not in common use) - possibly Zanzibari  
kuchmekka - to catch syphilis -to be burned, stabbed, pricked  
kuungua - to catch syphilis - to be scorched, pulled apart, cut in two  
kuuguwa - to catch a disease  
uchawi - witchcraft  
urogi - spellcasting  
kutega - to trap  
tego - a trap or a spell cast to catch an adulterous spouse  
utamu - in sexual matters the feeling of pleasure  
rangi mbili - two colors - refers to antibiotic capsules (see Uniform ya KANU for red and black capsules under Sheng below)  
kuonana kimwili - "to see each other bodywise" - to have sexual intercourse  
mama watoto - "mother of children" - wife  
kujikunakuna - to scratch - itching  
ishara - sign, symptom  
vipele - rashes  
vidonda - sores  
kulalana - to lie together  
mtulivu - a reserved person  
matanga - mourning period  
kuwa na kasoro - to have a defect or blemish  
kujikinga - to protect oneself  
rika - age set

**Tanzanian Swahili and Tanzanian Sheng**

Gono - gonorrhoea - sheng?  
Kisonono - gonorrhoea  
Kaswende - syphilis  
Kugonga - to hit, knock, bang, fuck  
Kugongana - collide or play sex

Kugonga mwamba - to hit a rock or ridgepole  
 Kujikwaa - to stub toe, to trip oneself up, to stumble  
 Kunasa - to catch in a trap, to get stuck  
 Kukwama - to get stuck - gripped, squeezed, deadlocked  
 Kuumia kazini - to be injured at work (work=coitus)  
 Vidonda - sores  
 Kunoku injini - to have engine knock - Sheng  
 Kuumwa tumbo - to have a stomach ache  
 Kuvamia Mkenge - to pounce, jump on, flop on, grab the Albizzia tree  
 Kidonda chini - a sore below  
 Kuingia gari bovu - to get into a rotten car - Sheng  
 Kugonga gari - to bang a car - sheng  
 Pangusa - wipe  
 Kuwashwa - to be lit up  
 Fungas - fungus  
 Kichocho - stimulus or bilharzia - kisonono cha damu  
 TV - trichomonas vaginitis  
 Mtoki - painful swelling usually in the groin caused by a septic sore  
 GV - gentian violet  
 Herpes - herpes  
 Vipele - little pustules, breakout on the skin, scabies  
 Usaha - pus, discharge  
 Candidiasis - candidiasis  
 Hawasemi - they don't say - unmentionable  
 UTI - urinary tract infection  
 Kuharibikiwa - to be utterly ruined, robbed of everything  
 GC - gonorrhoea  
 Mafua - chest complaint  
 mkojo unaouma - painful urination  
 engine imegonga - engine knocked - Sheng

### **Kenyan Sheng**

mustandi - short time  
 injin kalaz - - engine has quit - refers to penile non-function  
 injin imeded - engine has died - refers to penile nonfunction  
 inatoa colgate - it is oozing - pus? foam?  
 kapimple - a small pimple-like bump  
 deki - dick - penis  
 kumove move - to have relations - to date - to go out with - to run around on the sly  
 kuchomeka - to be burned - to get syphilis  
 viruka njia - women with whom to use a condom  
 duke - condom  
 cocoon - condom  
 made to fit - condom  
 gloves - condom  
 soksi - condom  
 gumboots - condom  
 Durex - condom  
 goal keeper - condom

nylon - thread emanating from the penis during urination and pulling back in afterwards - if it is cut, you die

## Luo

nyach - STDs, some skin diseases

chiraa - calamity due to spiritual pollution, violation of social rules, curse, etc.

jathith - witchcraft?

Nyatut/nyatutu - gonorrhoea

tutu - pus

Nyaedha - rashes

nyakuodi - swollen lymph glands in groin

nylon - as described above under Kenyan Sheng

## Kikuyu

gatego - syphilis

gicununu - gonorrhoea (Kikuyu c = English sh)

thahu - curse

gweko - approved premarital interfemoral sex without penetration

muthuru - the girls leather apron on which the boy rubs his penis to orgasm

munyongoro - age set

riika - age set ?

mutiiri - circumcision sponsor

ngaita - a traditional cure for syphilis

## Other

Itakanyi - syphilis - Luluhya? Kiwanga? From Butere

Burista - Sabaot word for syphilis (blister?)

Olbae - Maa - syphilis

Induasi - Luluhya - syphilis or STDs or a skin disease - unclear - from Busia

Induali - Luluhya from Kakamega - skin rash, big wounds, stomach pain

Egesonono - gonorrhoea - Kisii

Egechwene - Syphilis - Kisii

oborogi - spellcasting or witchcraft - Kisii

mulochi - Luhya ?spellcasting

uoi - Kikamba? spellcasting

abuba - syphilis - language unknown

shisununu - Luluhya - reported as syphilis

chisununu - Luluhya - another dialect

nyo gwen - other people's word for syphilis reported by a Luo speaker

uwau wa mitambo - gonorrhoea - Kikamba

osupatei or osepatei - syphilis - Maa

olodwar - (olotua) cure for syphilis in Maa

lubusi - Luluhya - see nylon under Kenyan Sheng - you have to push the wall to get it out - worse than chisusunu but treatable nowadays

## Verbatims

Sijui - I don't know

Ni kama karatasi imefungwa juu ya mzigo - it is like a paper has been put over a load  
- (like something has been wrapped in paper) - referring to condoms

Condoms ni kitu chafu - kama gloves - condoms are a dirty thing - like gloves

Ukichota utabeba - Lit., if you draw water you will carry it - fig., if you dig down in your pocket  
to pay a prostitute, you will carry a disease away with you

condoms ni utoto - condoms are childish

condoms ni too refu or too fupi - condoms are too long or too short

utanigei - Sheng - you will give me - said by guys with red syringes on dance floor - and in  
matatus

condoms huzuia utamu - condoms prevent the pleasure

hutasikia ile raha - you won't feel that pleasure

mali yako yote itabaki pale - all your stuff will remain there

## APPENDIX C

### CHARACTERISTICS OF THE CLINIC-BASED SAMPLE

Between September and November 1992, starting from the time when each clinic received syphilis RPR training until the last day of November, the total number of antenatal first visits that appear in the RPR test record books for Baba Dogo, Dandora, Kangemi, Kariobangi, Langata, Ngara, Ngong Road and Riruta combined is 1,749. Of these, there were 119 RPR positives or 6.8% overall. The percentages varied by clinic, however. Using the names that appear in the book as our guides for discerning ethnic affiliation, we found that of the 1,749 antenatals there were:

- 33 Kalenjins (1.9%)
- 215 Kambas (12.2%)
- 421 Kikuyus (24%)
- 101 Kisiis (5.7%)
- 245 Luhyas (14%)
- 646 Luos (36.9%)
- 15 Merus (.08%)
- 15 Tesos (.08%)
- 5 Swahili or Mijikenda (.02%)
- 1 Ugandan (.002%)
- 2 Zairean (.005%)
- 1 Kuria (.002%)
- 12 whose names were not identifiable as to ethnic group (.07%)
- 37 with Muslim names who could belong to any of many ethnic groups (2%)

Of the 119 RPR positives:

- 11 were Kamba (9.2%)
- 23 were Kikuyu (19.3%)
- 3 were Kisii (2.5%)
- 17 were Luhya (13.4%)
- 56 were Luo (47%)
- 2 were Meru (1.7%)
- 2 were Muslim (1.7%)
- 1 was Ugandan (1.2%)
- 5 were of unclear origin (4.2%)

There were no Kalenjin or Teso among the RPR positives.

Luos were the most frequent users of the antenatal clinic (37%), followed by Kikuyu (24%), Luhyas (14.2%) and Kisiis (5.6%). But whereas Luos represented slightly over one-third of clinic users, they made up nearly half of RPR positives (47%).

Though the overall infection rate was 6.8%, we found that the Luo RPR positives made up 9% of total Luo antenatal clinic users. Among the Kamba, the percentage of RPR positives was 9.2%, while Kikuyu had only 6% RPR positives. The percentage of Luhya RPR positives was 7% and of Muslims 5.4%. These figures may be of only limited significance because of the sample size in each category.

Considering the major language groups, we find that Nilotic speakers comprise 694 (39.6%) of the 1,749 including those definitely known to be Luo, Kalenjin or Teso. Among the 37 Muslims we may assume that at least one-half are Nubian, who are Sudanic speakers and Somali, Cushitic speakers. We can guess there are about 25% Nilotic speakers among the Muslims. Also among the 9 antenatals whose ethnic affiliation is not clear, we may assume that some are Nilotes (perhaps 3).

This gives us an additional 12 Nilotes, bringing the total of Nilotes to 706 (40.3%). With the addition of an estimated 18 Sudanic and Cushitic speakers from among the Muslims and 3 from among those of unclear ethnic affiliation, the total non-Bantu speakers in the sample comes to 727 (41.5%).

Looking at the sample from yet another angle, we note that without including any of the Muslims and unidentifiables, 1,009 individuals (57.6%) were from Western Kenya ethnic groups (Luo, Kisii, Luhya, Teso, Kuria, Ugandan). If we add the Kalenjin to the Western groups, the percentage is 59.5 (1,042 individuals). Of the 119 RPR positives, 78 (65.5%) came from western groups, not including Zaireans.

Of all clinic users, excluding the Muslims and unidentifiables, 1,004 (57.4%) were Bantu speakers. Western Kenya Bantu speakers accounted for 348 or 34.6% of Bantu-speaking clinic users. Fifty six (47%) of the RPR positives were Bantu speakers. Of these, 20 (16.8%) of total RPR positives were from Western Kenya. This number represents 35.7% of Bantu-speaking RPR positives, again not including the Muslims and unidentifiables--some of whom are no doubt Bantu speakers as well.

## APPENDIX D

### CLINIC-BASED CASE STUDIES

The following narratives depict a typical situation of those men and women at risk of contracting syphilis. These narratives are based on actual interviews.

1. In Kangemi, a Kamba barmaid and a Maasai partner who acknowledges paternity of her current pregnancy, have been working together for several years and are very caring toward each other. It is unknown how she contracted syphilis. However, many women in Kenya who work as barmaids also earn money by providing sexual services to bar customers. It is known that both members of this couple have several other partners. The man, a bartender, goes home periodically to his compound near Loitokitok, where he has at least one wife. The interviewer is now trying to trace as much of the network as possible. Another regular partner of the woman is a Luhya married man who stays in Nairobi. He has expressed willingness to come to the clinic and also to make sure that his wife is treated, though as of this writing no follow-up has been made. The Maasai partner has not yet given any report on efforts to have his wife in Loitokitok, and any other partners he may have, diagnosed and treated.

2. A Luo couple who are active members of Legio Maria, a very important and large African church in Luoland, are very forthcoming and willing to talk with the interviewer and staff. Both the husband and wife are professional prayers. This means that they are consulted by people who have problems and then they go into a trance and speak with messages from the Holy Spirit or angels, saints or prophets and explain what should be done about the problem. She specializes in praying for infertile women who then conceive after her prayers. He specializes in praying for people who have family problems.

The client stated that she married at the age of 13 so as to avoid problems like getting STDs through premarital sex. Last June she had an exceptionally heavy period so they went to a private hospital, where the client and her husband were treated with three injections each. She has had painful intercourse and genital pain since that time.

This is their fourth pregnancy and the woman is in her seventh month. The second of their three children was born prematurely and is "small," meaning that he has not grown normally. The couples believe that the child's abnormal growth is due to nyach (Luo word for STDs and some skin diseases). The wife never attended antenatal clinic, preferring to give birth in their church attended by a church-based traditional birth attendant (TBA). She would not have attended an antenatal clinic this time either had it not been for dreams she and her son had one night telling them that she had something bad in her blood and that she should go to the clinic. She went to the clinic the following morning and was diagnosed, treated and then interviewed.

Both the client and her husband were very cooperative about his treatment. They reckon that the infection came about when the devil tempted the husband with a beautiful woman when he went to pray for some people in Tanzania several months ago. He felt that it was his father who was annoyed at him who activated a curse through the devil. However, they may have had syphilis for several years. The wife was resistant to condoms during her interview, saying that only God would be able to tell her the right thing to do. The interviewer convinced her that she should use the condoms until the Holy Spirit gives her the necessary guidance. The team is following up to have the small child

tested and to discuss further communications from the Holy Spirit with the couple. They are an important contact with a large and influential religious group.

3. A partner who found out he was HIV positive in 1989, was also interviewed. He and his antenatal wife are both HIV and syphilis RPR positive. Unfortunately, the wife was not available to be interviewed. He claims to be a counselor for HIV positive people through Know Aids, but a check at their office revealed that he is actually a watchman.

He explained that when he found out that he was HIV positive, he decided to sleep with several women and marry the first one who conceived so that he would not die a "child," that is, a man unmarried and without offspring. He had relations with six or seven women and married his wife, who is very young. She was diagnosed syphilis RPR positive at the antenatal clinic. According to the clinic staff, the wife is also HIV positive, but it is not clear how they know.

The interviewer went to the man's house accompanied by a neighbor and convinced him to come to the clinic where his blood was tested and found to be syphilis RPR positive. He accepted treatment but made excuses for not having come to the clinic when his wife informed him, right after her first antenatal visit. He finally admitted that he was afraid of being told the truth, so he had avoided coming. He then told the interviewer that he had known that he had syphilis on and off since 1989. On the tape, however, he says that he noticed that his skin was spoiled and that was why he decided to come to be examined.

## APPENDIX E

### COMMUNITY-BASED CASE HISTORIES

The following case histories are presented in narrative form and portray a typical situation of those who are at risk or have contracted syphilis. While based on the responses of specific individuals, they include details that are a composite of many responses and experiences in the areas where the study was conducted.

#### Mary

Mary suspected she was pregnant when her monthly period did not appear but she kept quiet and waited another month. When it did not appear again she reckoned that she must be pregnant because at about that time she noticed that her skin was getting lighter and her waist thicker. Soon she started to vomit in the mornings, and her husband also noticed that she had changed.

After a few weeks the vomiting stopped and Mary felt better but took a dislike to Joe, her husband, and became very quarrelsome. Joe knew that this is normal among pregnant women, and even Mary's bad temper could not dampen his happiness and anticipation that he would soon have a child. He was determined to make sure that his wife got good care during her pregnancy, so he asked friends what to do. They advised him to indulge her food whims, but to make sure that she ate lots of carrots and fruits plus meat and fish. Mary hated carrots, but she also knew, having been told by the neighbors, that carrots were a must for pregnant women.

Soon she felt fine and relaxed as her tummy got bigger and bigger. Her ankles were swollen and she sometimes had a headache, but otherwise she felt fine. The woman who always tried to give people contraceptives came to her one-room home one day and told Mary that she should go to the City Council Clinic to be examined and immunized for tetanus, but Mary did not see the need since she wasn't having any problems. Mary consulted the older women in her compound, and they laughed and said that there was plenty of time but that she should start thinking about where she would deliver.

Deliver? Mary had always thought that women delivered at home, but the neighbors and Joe's sister thought she should be prepared so they told her to go to the clinic to get the card and then there would be nothing to worry about since Mama Tito could be called to deliver her when the time came.

By this time, Mary was six months along and getting a bit big. Her first trip to the clinic was a disaster. She left home at 5:30 AM for the long walk to the clinic, but when she reached the river it was still dark and she slipped in the mud and ended up ankle deep in the water, embarrassed and fearful of what or whom might be hanging around the riverbank at that hour. Arriving at the clinic, she found the night watchman swathed in blankets, turning women away. Ten women sat huddled on the veranda clutching the precious cards they had just bought from the old man. They would now wait until 9 AM to be seen by the clinic staff.

Mary traipsed back home angry and frustrated and also feeling a bit disgusted with the idea of going to the clinic. So she went to see Mama Tito thinking that would be much easier. Mama Tito, a distant cousin of her father's closest agemate, had heard that she was in Nairobi and was happy to see a young expectant mother from home. She examined Mary and realized that even with her training, she needed to know more about Mary's blood pressure, so she sent Mary back to the clinic. The

next time, Mary got over the river in the dark before 5:30 and arrived at the clinic just in time to get the last card for that day.

When the clinic staff showed up at 8:30, the women waiting were sitting in the sun to try to get warm when they were called inside to sit on the hard benches of the waiting room. By 9:30, the nurses and clinical officer started the routine examinations. When it was Mary's turn, the nurse took her blood pressure and a blood sample, weighed Mary, and then told her to strip and get up on the examining table. The male clinical officer then came in and examined Mary in detail with eyes and hands. She was mortified and thanked God that her parents did not know this was happening to her.

In the end, the nurse gave her an injection and when she asked what it was for she was told not to ask questions. The nurse told Mary that there was something wrong with her blood, and that she would have to give birth at Pumwani. All the way home in the hot sun, Mary wondered what might be wrong. When she told Joe he also began to worry and wonder how he would get Mary to Pumwani on the other side of town and how he would pay for all the expenses. He sent her back to Mama Tito, who looked at her clinic card and explained that because her blood pressure was high she would have to give birth where highly qualified people could attend her.

Mama Tito calmed Mary's and Joe's fears, and advised them to talk to Luca the man with the taxi in the compound next to the shops to make arrangements for transport when the time came. Meanwhile, Mama Tito would give her some herb tea to drink to help bring her blood pressure down. Mary felt reassured, and determined that she would never go back to that awful clinic again now that she knew she was in good hands.

### Alice

Alice's mother had died trying to give birth to a baby in transverse position. Everyone at home knew this, and James' family had refused to start paying brideprice until she gave birth to at least two children, unless the first was a boy. They did not want to invest in a high risk who might die in childbirth.

After missing her period for the second time, her mother gave her the bus fare to go and join James in Nairobi, where she could get better care than in the rural area and maybe even deliver in a hospital. Her brother wrote a note for James and told her that if she got lost, she could get the Kariobangi matatu and ask for Michael's shop at the last stop. Michael could then direct her to James' place.

Arrival in the city was frightening and confusing, but Alice finally arrived at James' 10' x 12' room, in a compound with twenty other rooms filled with small children and young women like herself. She found one who could speak her language, and sat down to wait for James to return from work.

James had not planned on the extra financial burden of Alice living in the city, nor had he thought about what it might cost to look after her pregnancy and the baby. However, he was delighted at the prospect of becoming a father, even though the job he had now would last only another two weeks.

They both knew that Alice would need special care considering her history. So they went to Al Haj, the Swahili "mwalimu" (teacher) who had a reputation for many magical triumphs. He had been trained first by a Kamba magico-medical practitioner, and then had gone for further training with a renowned practitioner in Yemen.

Al Haj asked Alice her name and her mother's name and then opened his holy book and read the page. He said that there was a secret enemy at home using the spirit of the child her mother had failed to deliver to haunt her and interfere with her pregnancy. He would give her special medicine to rub all over her body and an amulet to wear hidden under her clothes to protect her from these evil forces. This protection and repeated spiritual monitoring would cost two white goats or the equivalent. The cost was more than James earned in a month but he got his clansmen to contribute and the medicines were prepared and administered.

Alice would be OK now if it were not for the awful taste of the food in Nairobi and the constant dizziness and vomiting. Sarah, the neighbor, took Alice, now weakened by dehydration but confident that things would be alright, to the clinic to be examined and treated. The nurse at the prenatal waiting area stopped them and demanded to know what they wanted. When told, she laughed at poor Alice and asked what she thought a pregnancy was, a flat stomach? The nurse told her to get out with her "skirt" pregnancy and come back when she had a real one. Did Alice think she was the only woman who ever vomited?

Sarah tried to reassure Alice on their way home and to cover up in their own language what the nurse had said in Swahili. Mercifully, Alice had not understood the abuse but only knew that she had been sent away. A woman in the market saw Alice's condition and took her to a man who prepared herbal remedies. The herbalist was very kind and sold Alice a special mixture of roots and barks to boil in water and drink each morning. After hearing that her mother had problems with pregnancy, he added another special root to the mixture.

After Alice left, the herbalist contacted a CBHW who went to Alice's compound looking for her. The CBHW informed the Sister in Charge at the clinic and accompanied Alice to the clinic the following week, where she received the usual routine examination and was given an appointment to come back in a month's time. Alice felt better about her pregnancy. She now had Al Haj's special medicine, her herbal tea which had made her stop vomiting, and the doctor who gave her an injection in the clinic.

### **Prisca**

This was Prisca's fourth pregnancy, and she was very frightened. Her first baby was born dead, covered with sores and skin that looked like boiling water had been poured over him. Her second baby, a girl, died five days after birth. The third was just like the first. She felt cursed. Her husband wanted to divorce her and left the room they had shared since she became pregnant again. Her aunt, who had a job, was helping to keep her alive.

No one had been able or willing to tell her what was wrong with her and why her babies died in such an awful way. After missing her second period, she went directly to the clinic, where her friend Elizabeth knew one of the nurses. The friend briefed the nurse and the nurse agreed to read her card after her examination and tell her whatever she could find out. Prisca would have to give the nurse something but it would be worth it if the information helped her to solve her problem.

At the clinic during her routine examination, she was bled and told to wait for the test results. A very nice young man called her into a room apart from the others and told her that she had a disease called syphilis in her blood. He gave her two injections and told her not to worry anymore, but to be sure to bring her husband or boyfriend right away as he also had to be treated. Prisca was wild with fear. She did not know where her husband was or why he also needed treatment if she was sick.

She knew of AIDS and feared the worst. But the friendly nurse caught up with her outside the clinic and told her the illness was not AIDS. It was worth the 20 shillings just to know that.

But then she started to think back, and remembered that six years ago, just before she got pregnant for the first time, she had a rash all over her body that lasted several weeks. She could remember it clearly because it appeared just two months after she first met her husband and they both laughed about it because he had had a similar rash before they met. John's workmates gave him the message that he was wanted at the clinic and he showed up the next day willing to take any humiliation if it would help him become a father at long last.

The same young man who treated Prisca gave him two injections, and told them both not to play sex for a week and to use condoms in the future in order to be sure that their baby will not die. He calmed their fears about AIDS, and John was feeling so relaxed that he did not think to ask about the dark purple lump that had appeared on his groin the previous week.

Knowing that they were both OK and that this baby would probably survive, John decided to move back and stay with Prisca to prepare for the baby's arrival.

### Jane

Jane has two children. The first was born when Jane was in her third year of high school.

At first she did not believe she could be pregnant so she put on loose clothing and avoided being seen as much as possible. She kept thinking that somehow it might go away if she wished hard enough. When labor started, she held her legs tightly together, trying to prevent the inevitable from happening. She held together for several hours in excruciating pain but finally rushed to the latrine where the baby emerged, its head distorted from squeezing.

Other students called the teacher, and Jane and her baby were taken to the local dispensary. The little girl, now five years old, was brain damaged and is very slow now. Jane's little boy is bright and bouncy at age three and Jane has been taking pills to make sure that she does not get pregnant again.

Her maid, a cousin from her home area takes care of the kids while Jane works as a clerk to keep them going. She picks up extra money from customers in a local by meeting them after drinks. This is a sad circumstance but necessary. The maid is 13 and secretly has a boyfriend. She knows that Jane's pills help her not to get pregnant so she takes one now and then just before or after playing sex with her boyfriend in the bushes behind the petrol station.

Jane, now sophisticated and city wise, notices the first signs of pregnancy and is incredulous. She has struggled and worked hard to support herself and the kids, and now this has to happen in spite of her best efforts! She wants to get rid of the pregnancy, but she knows that God will punish her because her religion teaches that abortion is murder. She also knows that she can not pay for a safe abortion on her meager earnings, so she must go through with the pregnancy. She will do it right this time and go to the clinic to make sure the baby is OK and that she can deliver in a good but cheap place.

When she reaches the clinic for her first visit, she is seen by the same medical man who monitored her last pregnancy. He looks at Jane and becomes enraged, screaming at her that she keeps on spreading her legs and getting pregnant irresponsibly, and that she is a dirty whore. He beats her in

the examining room and chases her away from the clinic. Jane will never go back, she does not believe in herbalists or magicians. She will stay at home and damn the government delivery facilities. Her neighbors can help when the time comes.

### Josephine

Josephine came to Nairobi thirty years ago with her husband, who was then working as a carpenter. They set up housekeeping in an area where many of their co-ethnics lived. None of them could afford big houses and they could not find the right kind of trees and soil to make proper houses, like at home. Neither could they afford the rent in the few areas where it was available, so they made do with materials they found in the city, like cardboard and plastic and old tin cans. There was a river nearby, which soon became foul as more poor migrants moved into the neighborhood.

While Festo worked and brought home some money, Josephine looked after their growing family and occasionally used her one skill, learned from her mother: delivering babies. Mostly she did this as a favor for the neighbors, and they would occasionally give her something as a gift of thanks. Over the years, she became known in the area as a very good birth attendant as she learned more and more about the care of pregnant and delivering women from other women of the many different ethnic groups now pouring into their burgeoning slum community.

She accumulated knowledge of herbal preparations from places she had never been to, and was taught massage techniques unknown to her own group. She learned the beliefs, fears and apprehensions of 20 or so different tribes and used this knowledge in caring for young women who she couldn't even talk to.

She could see what poverty and strange surroundings did to women who knew how to grow food but had no land, who knew how to cook but had no fuel, and who understood everything in their home areas but not the strange new life of the city.

Eventually, the demand for Josephine's humble, personal services became too great to work from home, so she decided to open a small clinic where the women could come to see her. Then the chief, who knew her, recommended her for training by a foreign donor. In spite of her inability to read and write, Josephine completed the training course and was certified as a Traditional Birth Attendant. Now in even greater demand, she holds regular clinic hours, gives multifaceted, spiritual, medical, herbal care combined with massage and counselling, directs difficult cases to biomedical care and makes her living through her prenatal care practice.

## APPENDIX F

### SAMPLE INTERVIEW TRANSCRIPT: CLINIC-BASED

#### Translation to English from Dholuo

- LAN; 13
- A.A; When did you last see your monthly period?
- L.13; On the 15.7.92. It stopped because I went to private doctor, who only felt my temperature, then gave us three injections.
- A.A; Were you sick?
- L.13; Yes, very. I felt I was going to die so I asked my ndugu what I should do. Then that's when he decided to take me to the doctor, because he is someone who prays for people so I don't know if maybe the devil stole him because in the month of may he prayed for some wazungu now I don't know if he was defeat by the powers of the devil. During this time I was bleeding twice or thrice. The doctor asked how long I have been sick, we told him that for one week, then he asked what I use, we told him that we only pray. Since then I have no problem except in my lower abdomen which always pains when ever I'm pregnant. This is my fifth month. After the three injections given to me.
- A.A; You and him?
- L.13; Yes, even him.
- A.A; When did you start coming to the clinic?
- L.13; Today is my first day
- A.A; So today is when you are going to be treated for the first time. Otherwise you have only been having problem with your lower abdomen.
- L.13; Yes, even now I have stayed for some time without meeting with him, because sometimes when I meet with him I have a lot of pain in my uterus. So when asks me, I tell him that he has misbehaved so he better leave me alone. Because when I meet him I feel as if my uterus is coming out.
- A.A; Do you eat well?
- L.13; YES, I just eat except if I eat I feel so full that I can't eat something again, like now I ate rice last night and up to now I just feel that I'm full.
- A.A; Did you eat some thing in the morning?
- L.13; No.
- A.A; What is your husband doing?
- L.13; My husband is not employed, he only prays for people, different people.
- A.A; Is he a luu?
- L.13; Yes, he is a luu.
- A.A; Do you think you tell him ?
- L.13; Yes, I will tell him, he can't refuse as it is the doctor who has said.
- A.A; What do you do?
- L.13; I am just a house wife, although I also pray for women who don't gave birth, those who have miscarriage and after that they conceive.
- A.A; God has given you that power?
- L.13; YES.
- A.A; What is your educational level?
- L.13; I didn't go to school much, I only reached class three, because my father was not working.
- A.A; Are you a luu?
- L.13; Yes I am a luu.

A.A; How many languages do you speak?  
L.13; Only dholuo.  
A.A; Where were you born?  
L.13; In kisumu, Manyata.  
A.A; How long have you stayed in Nairobi?  
L.13; This is my eighth year.  
A.A; You are in Legio Maria denomination.  
L.13; Yes.  
A.A; Where do you stay?  
L.13; I stay in kebera, in a place called FOFOFO.  
A.A; Is it a shanty?  
L.13; Yes, it is.  
A.A; Is it for rental or you own it?  
L.13; It is for rental.  
A.A; How does the floor look like?  
L.13; It is cement, but it is worn off.  
A.A; How do you get water?  
L.13; We buy from a tap not far from the house.  
A.A; How about the toilet?  
L.13; It is a latrine.  
A.A; Do you read bible sometimes?  
L.13; Not often, except when I am (checking) someone.  
A.A; Do you listen to the radio sometimes?  
L.13; Yes, I sometimes listen.  
A.A; How about T.V.?  
L.13; I only watch T.V. when I go to visit someone who has one.  
A.A; Is your mother still alive or dead?  
L.13; My mother and father are dead.  
A.A; Are you the only wife of your husband or he has others?  
L.13; I am the only one.  
A.A; Do you have female friends?  
L.13; No, the only friends that I have are only ones who come for prayers.  
A.A; Are those the only one that you have?  
L.13; Yes.  
A.A; When you have a problem, who do you talk to?  
L.13; There's one lady, who I even talked to about the movements of my husband with some young ladies although he denied. But me in my heart I felt afraid.  
A.A; When you have a problem do you prefer to discuss it with a female or a male friend?  
L.13; I don't like to talk unless a relative who I know his or her heart so well that is when I can say my problem.  
A.A; A very close relative?  
L.13; Yes.  
A.A; So today you came to the clinic with what problem?  
L.13; I just came to the antenatal clinic, because some times I feel so uncomfortable that I don't know what to do.  
A.A; Why did you wait for such a long time?  
L.13; Now if I don't know, what do I do.  
A.A; Which pregnancy is this?  
L.13; This is my fourth pregnancy.  
A.A; How early did you attend antenatal clinic in your other pregnancies?

- L.13; I never attended any clinic, because after my first born I did not meet a man as I was working for the Lord, for ten years. When I came here in Langata and they asked me so many questions that I felt were unnecessary so I decided not to come again, because there was no card because I gave birth in the church, so I decided just to be going to the church.
- A.A; So the others also you delivered in the church?
- L.13; Yes.
- A.A; Is there a midwife in the church?
- L.13; Yes.
- A.A; Are you planing to give birth in the clinic or church?
- L.13; I don't know because I am just a human being, it's God who knows because I'm a human being. Even now that it so happened that I have this disease the angel had already showed me or told me that this kind of disease was in my body, and when I told my husband he didn't believe me a that such a thing is in me.
- A.A; You mean the angel had informed you?
- L.13; Yes, there is a prayer that I had said, during this time I was very thin and I had stomach ache, after this prayer I said and after the injection is when I felt better, now again when I told him I that he was reluctant, so I forgot about it.

## APPENDIX G

### RESEARCH INSTRUMENTS: CLINIC-BASED

#### INTERVIEWER'S GUIDE--CLIENT

First, introduce yourself to the client and explain that you are from the University of Nairobi and are part of a study of pregnant women who have syphilis. The aim of the study is to help develop better services for pregnant women with syphilis. Explain that she has been tested for syphilis and found to be positive but that she has not been tested for AIDS and, therefore, you have no information on her HIV status. If she wants to be referred for an HIV test, you will give her the referral at the end of this interview. If she questions this, explain that some clients come thinking that they have been tested for AIDS and that you want to avoid that confusion. Do not withhold the referral information if she refuses to be interviewed.

#### I. IDENTIFICATION DATA

If the client does not want to give her name and address, don't push her.

Be sure to get her clinic card or the information about parity, gestational age, etc., from Sister. Also note any complications that may appear on her card or ask Sister for this information.

#### II. RECENTLY DELIVERED

Skip this whole section if the client is still pregnant. Its objective is to help the client relax and to help you find out if there has been an adverse outcome of the pregnancy, such as a still birth or a sick infant.

#### III. THIRD TRIMESTER

Use this section for women who are beyond 26 weeks of pregnancy.

#### IV. BASIC DATA - PARTNER TREATMENT

We are asking about the partner's responsible for this pregnancy. If he is her regular partner, his occupation tells us something about his economic means, and his ethnic affiliation tells us something about their relationship if it is cross-cultural. The most important data here is his notification and treatment status.

#### V. BASIC DATA - CLIENT

These questions are intended to find out if there is a link between any particular ethnic, occupational or religious group and syphilis. The client's migrational status and the kind of facilities available where she lives may also have a bearing on her health and health practices.

The questions about education, literacy use and language are aimed at finding out how best to approach the population we will be trying to serve.

The questions about her mother and close relatives, etc., are intended to find out what kind of social network she has in Nairobi and who she can turn to in times of trouble. Use this section to try to establish a friendly and sympathetic rapport with the client, especially if she has no close friends nearby. If you get the impression that she is VERY isolated, please make a note of it.

#### **VI. CLINIC/ANTENATAL CARE**

There seems to be a pattern in which pregnancy is downplayed until the tummy shows it clearly. We need to find out about this and why women do not go to the clinic immediately when they feel they may be pregnant.

Also, in this section we need to probe for client satisfaction with the clinic environment without printing out all the questions. Please probe for experiences and feelings about the clinic surroundings and delivery of services.

#### **VII. SYPHILIS**

There are no right or wrong answers in this section. If your client speaks purest porojo, record every word. That is what we are looking for!

#### **VIII. PARTNER TREATMENT**

We want to find out how the client approached her partner with the news that he is infected and needs treatment, how he reacted, and what she had to do to get him to accept the idea. The situation is very sticky and full of problems for the woman. Her partner's reaction and willingness to go for treatment or his covering up about treatment may have serious effects on her life. Probe and try to get as much detail and verbatims as possible but be sensitive.

#### **IX. RELATIONSHIP**

Now we are digging into some intimate information about the client's history. So far, clients have been forthcoming. Probe, but not if you see that you will lose the client for the rest of the interview.

#### **X. SEX EDUCATION**

The purpose here is to find out the best channel for getting information about safe sex to young people. So we need to know where they are learning what they know.

#### **XI. CONDOMS**

Make this a friendly--even joking--discussion. You catch more flies with honey than with vinegar. Agree with anything the client says.

#### **XII. WIND-UP**

Try to keep the client interested and feeling that she is important to us. Calm any fears about confidentiality. Let her see your notes or listen to the tape if she asks, but do not volunteer.

## CLIENT

Code:

Date of Interview

Time Begin Interview

Time End Interview

Reviewed by \_\_\_\_\_ date \_\_\_\_\_

Interview Taped

Language Used

### I. IDENTIFICATION DATA

1. Name (optional)

2. P. O. Box

Location

3. Phone

4. Age

(From Sister or clinic card) Parity

5. Gestational age at time of interview, or date of last MP or baby's DOB and age in weeks

6. Date of first attendance for antenatal care/gestational age at first antenatal attendance

If early why, and if late, why?

(Early - before 20 weeks, Late - after 20 weeks)

7. Date RPR diagnosis made

8. Date treated

### II. IF RECENTLY DELIVERED

Congratulate the new mother, then ask:

9. Where was your baby born?

10. How was the birth, any problems? How is the baby now, healthy?

### III. IF IN THIRD TRIMESTER OF PREGNANCY

If in third trimester (28 weeks on) of pregnancy, ask:

11. How have you been feeling?

12. Where do you plan to deliver?

13. Any problems during this pregnancy?

### IV. BASIC DATA - PARTNER

Now I would like to ask you some questions about your partner/partners.

14. Partner's occupation, ethnic affiliation.

15. Is he a regular partner? Casual?

16. Did you notify your partner? If not, why?

17. Partner treated? Date. Where?
18. Spontaneous compliance, assisted compliance
19. Not treated
20. If you had more than one partner, were they all notified?
21. If we give you more notification cards for your partners, do you think they will pass them on to their other partners?

## V. CLIENT

And now we need some information about you.

22. Occupation
23. Education
24. Ethnic background
25. Languages spoken
26. Place of birth
27. How long in Nairobi
28. Religious affiliation
29. General appearance
30. Lives in a:

House	Y/N
Flat	Y/N
Room	Y/N
Shanty	Y/N
Other	Y/N

31. Rents Y/N
- Owns Y/N
- Self built Y/N
- Share Y/N

(if needed, ask what materials the floor, roof and windows are made of)

Floor  
Roof  
Windows

32. Water source:

How far away?

Choo access:	Private	Y/N
	Share	Y/N
	Public	Y/N
	Flush	Y/N
	Latrine	Y/N
	Bushes	Y/N
	Other	Y/N

33. Literacy use:

Newspaper	Y/N
Religious materials	Y/N
Books	Y/N
Casual: Posters	Y/N

34. Media - TV: Do you watch TV? Where? How often?

Radio: Where? How Often?

Cinema: Where? How Often?

35. Client's mother: Where is she?

36. Co-wives: Number Location

How do you get on with your co-wives?

37. Other female relatives or close friends nearby?

38. Who do you talk to when you have a problem?

39. Have you told this person that you have syphilis? If not, why not?

40. Have you told anybody else?

41. Do you prefer to talk to person of the same sex or opposite sex?

42. Where should a woman be when she prepares to give birth?

When she delivers?

When she is recovering?

## VI. CLINIC/ANTENATAL CARE

Now I would like to ask for your ideas about coming to the clinic.

43. How did you decide when to start coming to the antenatal clinic?

44. How long did you wait between the time you first felt you were pregnant and your first visit to the clinic? Why?

45. If she responds that she waited until she was showing, ask why do most women wait until they are showing?

46. Why did you come to the clinic?

47. Why this clinic?

48. What other choices are available?

- Private doctor
- Private hospital
- Traditional Birth Attendant
- Home delivery

(Factors involved - money, trust, past experience, location, ethnic or social connection, language, marital supervision, other)

49. How do you get to the clinic? Walk, bus, matatu, taxi, car?

50. How long is the travel time?

51. Travel cost?

52. How long does your clinic visit usually take?

53. What other clinics have you used? Comparison: Best, Worst

54. How do you find the treatment you received at this clinic?

55. Should all pregnant women go to the antenatal clinic? Why? Why not? When?

56. Which types of pregnant women should go to the antenatal clinic?
57. Why do some women come for their first antenatal visit late in their pregnancies?
58. How can pregnant women be encouraged to start coming earlier in their pregnancies?

## VII. SYPHILIS

59. How did you find out that you had syphilis? Where?
60. How long ago was that?
61. What type of treatment did you receive?
62. What is syphilis?
63. What is it called in your mother tongue? What do other people call it?
64. How do people get syphilis?
65. When you were diagnosed, was it your first antenatal visit for that pregnancy?
66. Did you suspect that you may have had such an illness, or did you notice any signs or symptoms?
67. Have you ever had syphilis before?
68. What happened the other times?
69. Was it the first time you had any STD?
70. Did you ever think you would get syphilis?
71. How did you feel when you first found out?
72. What were the first thoughts that went through your mind? (Probe: blame, stigma, fear)
73. What exactly happened after you were told that you had syphilis?
74. If you have to be told that you have syphilis, who would be the best person to tell you?
75. Should your partner be informed?
76. Who is the best person to inform you partner?
77. Did someone explain to you about the disease, or what you needed to do to get cured?
78. Who, what did they tell you?
79. How did they behave toward you?
80. How did you feel about the treatment/information/education you received? (Satisfaction)
81. Do you think you might get syphilis again?
82. How can you prevent it?
83. If you get syphilis again, what will you do?
84. What causes syphilis, how do people get it?
85. What are the symptoms?
86. What are the effects on your pregnancy, yourself, the baby?
87. Did you know any of these things before you found out that you had syphilis?
88. If yes, where/how did you find out this information?
89. Do you know anyone else who has had syphilis?
90. What were supposed to do after you left the clinic on the day that they told you that you had syphilis? Did you do it? Why? Why not?
91. What can you do to be sure you do not get syphilis again? Why? Why not? What things?
92. What would be the best way to learn about avoiding syphilis? (Health talk, radio, posters, etc. - probe)
93. Is there any connection between syphilis and AIDS?
94. If you knew your friend had syphilis, how would you persuade him/her to get treated?

## VIII. PARTNER TREATMENT

Now let's talk about how you got syphilis.

95. Do you think you know who infected you with syphilis?
96. Do you think you got syphilis from a regular partner or a casual partner or from several partners?
- |         |     |
|---------|-----|
| Regular | Y/N |
| Casual  | Y/N |
| Several | Y/N |
97. How long ago do you think that was?  
(Explore as thoroughly as possible her relationship with partner(s), especially determine if monogamous, if has outside partner(s). \*Be extremely sensitive and non-judgmental; assure confidentiality.)
98. Does your partner have other women, either wives or regular girlfriends?
99. Does he play sex with many others or only a few?
100. Were you willing to notify partner(s) about the syphilis, and the need for them to be treated? Why? Why not?
101. Were you able to locate partner(s)? Why? Why not?
102. What were some of the feelings you had when thinking about notifying your partner?
103. How did you inform him?
- |                   |     |
|-------------------|-----|
| Notification card | Y/N |
| Verbally          | Y/N |
| Phone             | Y/N |
| Third person      | Y/N |
| Other             | Y/N |
104. What actually happened when you told him/them?
105. How did he react when you told him that you were RPR positive, and that he needed to be treated? (Get verbatims)
106. What were some of the things you talked about?
107. Do you remember the actual words you used?
108. Where were you when you told him?
109. At what time of day and in what setting did you tell him?
110. Why did you choose that location, time, setting?  
(\* This set of questions is critical for development of the partner handouts. GET VERBATIMS IF AT ALL POSSIBLE, get actual words, focus on his response)
111. Did you tell anyone else? Who? Why? Why not?
112. What can we plan that would make it easier for you and other women to tell your partner that you had syphilis and that he also needed treatment?
113. (If her partner refused treatment:) What can women tell their partners to convince them to go for treatment?
114. We would also like to talk to your partner(s) about their feelings and experiences with the disease? Would you mind if we talked to them? Why? Why not?
115. Do you know how we can contact him/ will you help us locate them? Do you think they will talk with us?
116. Name/contact for partner.

117. (If her partner complied spontaneously:) Why was your partner willing to come to the clinic as soon as he found out he had syphilis?
118. After you told him, how long did he wait before going for treatment?
119. Why was he unwilling to?
120. After your partner has been treated for syphilis, can he get it again? How?  
If not, why not?
121. Why do some men decide not to get treated for syphilis? (Shy, fearful, arrogant, ashamed, disbelieving, proud)
122. What kind of men refuse treatment?

## **IX. RELATIONSHIP**

Now I am going to ask about your personal background and your relationship with your partner. This will be kept strictly confidential.

123. How many partners have you had in your life?
124. How many regular partners do you have?
125. How many casual partners do you usually have in a month?
126. Do you use precautions to prevent  
Pregnancy?  
Disease?
127. What precautions do you normally use?
128. Do you use them with regular partners?  
With casual partners?  
Only on certain occasions?
129. Do you ever discuss sexual matters with your partners?
130. How is it best to bring up these matters to a man?
131. Do you discuss the pregnancy with your partner?
132. How does your partner feel about the pregnancy?

(Ask the next three questions only if you got no response earlier.)

133. What happened when you told your partner (male) that you and he have syphilis?
134. What did you and your partner do after you found out you had syphilis?
135. Were there any things you or your partner did/avoided/used after you found out you had syphilis? What?
136. Did you and your partner continue to play sex after you were told you had syphilis?  
Why? Why not?
137. Who decides when, if you play sex?
138. Can you refuse to play sex with your partner?
139. How is the best way to refuse if you want to?
140. If you cannot refuse, why not?
141. Between you and your regular partner, who first brings the idea to play sex?
142. Can a woman bring the idea to a man or must the man bring it?

## **X. INITIATION/SEX EDUCATION**

Now we would like to discuss how you received your education in sexual matters. This will help us to plan better ways of getting information about syphilis to people who need it:

143. How did you learn about sex matters?
144. Who usually instructs young women/men about sexual matters?  
In the rural area:  
In the city:
145. How does the instruction take place?  
Rural:  
City:
146. In what kind of setting?  
Rural  
City
147. Did you go through an initiation ceremony?
148. Are you circumcised? Where were you circumcised?
149. Did you go through ceremonies before and after your circumcision?
150. Who sponsored you for initiation?
151. If you were circumcised in hospital, did you receive the same teaching that occurs in traditional circumcision?
152. What were you taught about sex matters during these ceremonies/training?
153. Were you taught about relationships between men and women?
154. Who was instructing you?
155. What were you told?
156. How long did this instruction take?
157. Were all the initiates in your area instructed by the same people?
158. What is safe sex?
159. Did you receive any instruction about safe sex during this time?
160. Were you told anything about AIDS during this time?
161. Were you told anything about AIDS by other people who told you about sex matters?
162. What suggestions can you make about the best ways to teach young people about safe sex, STDs and AIDS?
163. If you don't have any suggestions now, will you think about it and let us know?

## **XI. CONDOMS**

Now let's discuss condoms and the ways people can use them. This will help us plan educational programs about condoms.

164. What is a condom?
165. Have you ever seen a condom?
166. Show a condom and ask - By what name or names is it called?
167. Where did you first hear about condoms?
168. Have you ever talked to somebody about condoms? To whom?

169. What did you discuss?
170. What are condoms used for?
171. Where can you get them?
172. How much do they cost?
173. Have you ever bought condoms yourself?
174. Were you told anything about condoms when you found out you had syphilis? What?
175. Were you given condoms, told where to get them?
176. How to use them, why it was necessary to use them?
177. How to talk with your partner about the need to use them, when and how to use them?
178. Do you discuss such matters as condoms with your friends?
179. How do your friends feel about condoms?
180. What do your friends think about people who use condoms? With their regular partners or with casual partners? Probe for image of the condom user.
181. Who would you feel comfortable discussing condom use with?
182. In what setting?
183. Who is the best person to discuss condom use with and who is the worst?
184. Is playing sex different when you use a condom?
185. How do you feel about using condoms?
186. What have you heard about people having used them?
187. What can you say for or against the use of condoms?
188. Who decides to use/not use condoms?
189. If you want your partner to use condoms, how can you tell him?
190. Do women ever refuse a partner who uses condoms?
191. If your regular partner refuses to use a condom, can you refuse to play sex?
192. If a casual partner refuses to use a condom, can you refuse to play sex?
193. What would happen if you refused?
  - Regular:
  - Casual:
194. Is it important to use condoms after you find out you have syphilis? Why? Why not?
195. If you and your partner continued to play sex after being told you had syphilis, did you use condoms? Why? Why not?
196. How did you bring up the subject of condom use?
197. What did you actually say when you told your partner about the need to use condoms to prevent reinfection?
198. What was his reaction?
199. What can we plan that might make it easier for you and other women to talk with their partners about the need to use condoms after treatment for syphilis?
200. Had you ever talked with him about using condoms before? Why? Why not?
198. Did you ever use condoms before you were told that you should use them to prevent reinfection with syphilis? Why? Why not?
199. Do you know if your partner has ever used them?
200. How do you dispose of used condoms?
201. Is there any specific thing which you think you/we could tell your partner that would motivate him to use condoms?
202. How do you think condoms can be made more acceptable to men? Why?
203. What is the best way to persuade a man to use a condom?

Thanks so much for helping us explore with women and their partners what it is like to use condoms.

## **XII. WIND-UP**

204. Any other things you would like to tell me about what happened after you found out you had syphilis?
205. Any problems you had that we have not already discussed?
206. Would you like to talk to a medical person about the effects of syphilis on yourself, your baby, your partner?
207. Would you be willing to talk to us again about matters related to syphilis?
208. What is the best way to contact you when we are ready?

Thank you for talking with me about your illness. It will help us to improve services for other women who have syphilis when they are pregnant.

Give the HIV test referral if she wants it.

Give the client the envelope containing 100/- and the Project card. Encourage her to contact you through the office if she has anything to add or if she thinks of any ideas.

## **INTERVIEWER'S GUIDE--PARTNER**

First introduce yourself to the partner and explain that you are from the University of Nairobi and are part of a study of pregnant women and their partners who have syphilis. The aim of the study is to help develop better services for pregnant women and their partners with syphilis.

Explain that his partner has been tested for syphilis and found to be positive but that she has not been tested for AIDS and, therefore, you have no information on her HIV status. If he wants to be referred for an HIV test, give him the referral at the end of this interview. If he questions this, explain that some clients come thinking that they have been tested for AIDS and that you want to avoid that confusion. Do not withhold the referral information if he refuses to be interviewed.

### **I. IDENTIFICATION DATA**

If the partner does not want to give his name and address, don't insist. The most important data here is his notification and treatment status.

We are assuming that the partner being interviewed is responsible for the pregnancy. Some women may be bringing men who are not the real partner just to comply with requirements. If there is any hint that the man you are speaking with is not the father, probe and get as much information as possible on who he is and why she brought him.

### **II. MALE PARTNER**

These questions are intended to find out if there is a link between any particular ethnic, occupational or religious group and syphilis. The couple's migrational status and the kind of facilities available to them may also have a bearing on their health and health practices.

The questions about education, literacy use and language are aimed at finding out how best to approach the population we will be trying to serve.

### **III. SYPHILIS**

There are no right or wrong answers in this section. If your respondent speaks purest porojo, record every word. That is what we are looking for! Use as many tapes as needed.

### **IV. RELATIONSHIP**

In this section, try to establish a man-to-man rapport and get as much detail as possible on his relational patterns. We would like to know how extensive and active his network is. We want to find out how the client approached her partner with the news that he is infected and needs treatment, how he reacted, and what she had to do to get him to accept the idea. We are also concerned with how he feels about being called to report at a clinic and being treated without testing.

Remember that if he is tested and shows negative, it may be putting the client into a life-threatening situation. So don't urge him to be tested. But we need to find out why men tend to refuse that they are infected or refuse to come to the clinic or insist on blaming the whole thing on the pregnant partner. Probe and try to get as much detail and verbatims as possible but be sensitive.

## **V. SEX EDUCATION**

The purpose here is to find out the best channel for getting information about safe sex to young people. So we need to know where they are learning what they know and from whom.

## **VI. CONDOMS**

Make this a friendly--even joking--discussion. You catch more flies with honey than with vinegar. Agree with anything the client says. Verbatims are especially important so get all the porojo you can!

## **VII. PERSONAL CONCERNS**

Men may not be very forthcoming about this. Do the best you can as a fellow man. If you are a woman interviewing a man, be serious and sympathetic and see if that works.

## **VIII. NEED FOR ANC**

There seems to be a pattern in which pregnancy is downplayed until the tummy shows it clearly. We need to find out about this and why women do not go to the clinic as soon as they feel they may be pregnant.

Also, we are trying to find out how much involvement the partner has in administering this and other pregnancies. Is it something men leave entirely to women or what?

## **XI. WIND-UP**

Try to keep the partner interested and feeling that he is important to us. Calm any fears about confidentiality. Let him see your notes or listen to the tape if he asks, but do not volunteer. Be sure to try to get continuity and good contacts.

## CLIENT'S PARTNER

Date of Interview  
Time Begin Interview  
Time End Interview  
Reviewed by \_\_\_\_\_ date \_\_\_\_\_  
Interview Taped  
Language Used  
Complied with Treatment

Welcome the partner and thank him for coming. Explain that he was asked to come for treatment because his pregnant partner was tested and found to have syphilis. Explain that the partner had not been tested for AIDS and that this interview is not about AIDS. Offer to give him a referral if he wants to be tested for AIDS.

### I. IDENTIFICATION DATA

1. Name of RPR positive pregnant partner (optional)
2. Name of man interviewed (optional)
3. Location P.O Box
4. Phone contact Age
5. Clinic where RPR positive diagnosis of pregnant partner was made
6. Date diagnosis made
7. This interviewee treated?
8. Date of treatment
9. Where Treated?
10. Confirmation of treatment (if treated outside the clinic)
11. Spontaneous compliance? Assisted compliance?
12. Non-compliant

### II. MALE PARTNER BASIC DATA

13. Occupation
14. Education
15. Ethnic background
16. Languages spoken
17. Place of birth
18. How long in Nairobi
19. Religious affiliation
20. General appearance
21. Lives in a House \_\_\_ Flat \_\_\_ Room \_\_\_ Shanty \_\_\_ others \_\_\_
22. Rents \_\_\_ Owns \_\_\_ Self built \_\_\_ Share \_\_\_  
(if needed, ask what materials the floor, roof and windows are made of)

23. Water source: How far away?

Choo access:	private	Y/N
	Share	Y/N
	Public	Y/N
	Flush	Y/N
	Latrine	Y/N
	Bushes	Y/N
	Other	Y/N

24. Literacy use:

Newspaper	Y/N
Relig. materials	Y/N
Books	Y/N
Casual: posters, packages	Y/N

25. Media:

TV: Do you watch TV? Where? How often?  
Radio: Where? How Often?  
Cinema: Where? How often?

26. When you have a problem, who do you talk to?

### III. SYPHILIS

27. How did you find out that you had syphilis? Where?
28. How long ago was that?
29. What is syphilis?
30. What is it called in your mother tongue?
31. What do other people call it?
32. Who told you? When? Where?
33. What exactly did she/they say?
34. How long ago was that?
35. Was it the first time that you had syphilis?
36. Was it the first time you had any STD?
37. What happened the other times?
38. Did you notice any symptoms of syphilis?
39. Did you ever think you would get syphilis?
40. How did you feel when you first found out?
41. What were the first thoughts that went through your mind? (Probe: blame, stigma, fear)
42. What exactly happened after you were told that had syphilis?
43. If you have to be told that you have syphilis, who would be the best person to tell you?
44. Should your partner be informed?
45. Who is the best person to inform your partner?
46. After you were informed, what did you do first?
47. Were you told that you should go to the clinic for treatment?
48. When you came to the clinic, were you examined? Was your blood tested?

49. Were you treated at the clinic or referred somewhere else?
50. Would you have preferred to be tested for syphilis RPR when you went to the clinic or just to receive the injection?
51. Why were you willing to come to the clinic for treatment as soon as you found out you had syphilis?
52. Did you have to get your employer's permission to go to the clinic?
53. If you had to take time off from work to go to the clinic, what was your employer's reaction?
54. What kind of document do you need in order to get permission?
55. What kind of document would be the best?
56. If you noticed any syphilis, which one?
57. If your partner has syphilis, does that mean that you also have syphilis?
58. If you did not go to the clinic, why were you unwilling to?
59. Where did you go for treatment?  
How did you find out about that place or person?
60. Did you receive treatment?
61. What type of treatment?

If treated, ask:

62. Between being told you had syphilis and going for treatment, how much time elapsed?
63. When you went for treatment did someone explain to you about the disease, or what you needed to do to get cured?
64. Who, what did they tell you?
65. How did they behave toward you?
  
66. Did you ever think you would get syphilis?
67. How did you feel about the treatment/information/education you received? (Satisfaction)
68. Do you think you might get syphilis again?
69. How can you prevent it?
70. If you get syphilis again, what will you do?
71. What causes syphilis, how do people get it?
72. What are the symptoms?
73. What are the effects on pregnant women, yourself, the baby?
74. How can it be prevented?
75. Did you know any of these things before you found out that you had syphilis?
76. If yes, where/how did you find out this information?
77. Do you know anyone else who has had syphilis? Who?
78. What were you supposed to do after you left the clinic on the day that they told you that you had syphilis? Did you do it? Why? Why not?
79. What should you do to be sure you do not get syphilis again?  
Why, why not? What things?
80. What would be the best way to learn about avoiding syphilis? (Health talk, radio, posters, etc. - probe)
81. Why do some men decide not to get treated for syphilis? (Shy, fearful, arrogant, ashamed, disbelieving, proud)

82. What kind of men refuse treatment?
83. Do you think syphilis is a serious disease? Why? Why not?
84. Do you think it is important for someone who has syphilis to get treated?
85. Is it important that you personally get treatment if you have syphilis? Why? Why not?
86. What would have made it easier for you to get treatment when you were told your partner had syphilis? What?
87. What would be the best way for you to have received that information/knowledge?
88. If you knew your friend had syphilis, how would you persuade him/her to get treated?

#### IV. RELATIONSHIP

89. Do you know who infected you with syphilis?  
Was she a regular partner or a casual partner?
90. When do you think that was?
91. Do you have a regular sexual partner?
92. How many regular partners do you have?
93. How many casual partners do you usually have in a month?
94. Do you use precautions to prevent.  
Pregnancy?  
Disease?
95. What precautions do you normally use?
96. Do you use them with regular partners?  
With casual partners?  
Only on certain occasions?
97. Explore relationship with partner(s).
98. PROBE: Nature, frequency of outside contacts, attitude toward sex outside of primary union, etc.
99. Have you had sex with any outside women since your regular partner became infected this time?

If yes, ask:

100. Is it important to notify your other partners that you have syphilis? Why? Why not?
101. Were you/are you willing to notify any other sexual partner(s) you have about the syphilis, and the need for them to be treated? Why? Why not?
102. Were you/will you be able to locate partner(s)? Why? Why not?
103. What were some of the feelings you had when thinking about notifying your other sexual partner(s)?
104. Did you tell her/them? What actually happened when told her/them?
105. What were some of the things you talked about?
106. How did she react? (Get verbatims.)
107. Was your other partner(s) treated? Why? Why not? Where?
108. Did you tell anyone else? Who? Why? Why not?
109. If we give you more notification cards for your partners, do you think they will pass them on to their other partners?
110. How is it best to bring up these matters to a man?

111. Do you normally discuss sexual matters with your partners?
112. How can we plan a way to make it easier for men to tell their other partner(s) that they have syphilis, and that she also needs treatment?
113. What would have made it easier for you?
114. Did you and your pregnant partner continue to play sex after you were told you had syphilis? Why? Why not? What about with your other partners?
115. Who decides when, if you play sex?
116. What did you or your partner do/avoid/use after you found out you had syphilis?
117. Did you and your partner continue to play sex after you were told you had syphilis? Why? Why not?
118. Who decides when, if, you play sex?
119. Can a woman refuse to play sex with her partner?
120. How is the best way for her to refuse if she wants to?
121. If she cannot refuse, why not?
122. Between you and your regular partner, who first brings the idea to play sex?
123. How can a woman bring the idea to a man or must the man bring it?

## **V. INITIATION/SEX EDUCATION**

124. How did you learn about sex matters?  
How old were you at the time?
125. Who usually instructs young women/men about sexual matters:  
In the rural area?  
In the city?
126. How does the instruction take place?  
Rural:  
City:
127. In what kind of setting?  
Rural:  
City:
128. Are you circumcised? Where were you circumcised?
129. If not circumcised, did you go through an initiation ceremony?
130. Did you go through ceremonies before and after your circumcision?
131. Who sponsored you for initiation?
132. If you were circumcised in hospital, did you receive the same teaching that occurs in traditional circumcision?
133. Were you taught about sex matters during these ceremonies?
134. Were you taught about relationships between men and women?
135. Who was instructing you?
136. What were you told?
137. How long did this instruction take?
138. Were all the initiates in your area instructed by the same people?
139. What is safe sex?
140. Did you receive any instruction about safe sex during this time?
141. Were you told anything about AIDS during this time?
143. Were you told anything about AIDS by others who told you about sex matters?

144. What is the name of your age set (riika)?

## VI. CONDOMS

145. Do you know what a condom is?
146. Have you ever seen a condom?
147. Show a condom and ask: "By what name is this called?"
148. Where did you first hear about condoms?
149. Have you ever talked to somebody about condoms? To whom?
150. What did you discuss?
151. What are condoms used for?
152. Where can you get them?
153. How much do they cost?
154. Have you ever bought condoms yourself?
155. Were you told anything about condoms when you found out you had syphilis? What?
156. Were you given condoms, told where to get them?
157. Told how to use them? Why it was necessary to use them?
158. How to talk with your partner about the need to use them?  
When and how to use them?
159. How do you feel about using condoms?
160. What can you say for or against the use of condoms?
161. How do your friends feel about condoms?
162. Do you discuss such matters with them?
163. Who would you feel comfortable discussing condom use with?
164. In what setting?
165. Who is the best person to discuss condom use with and who is the worst?
166. Do you think playing sex is different when you use a condom?
167. What do your friends think about using a condom with their regular partners or with casual partners? (Probe for image of the condom user.)
168. What have you heard about people having used condoms?
169. If you want to use condoms, how can you tell your partner?
170. Do women ever refuse a partner who uses condoms?
171. Is it important for you to use condoms after finding out that your partner has syphilis?
172. Is there anything that would have made it easier for you to use condoms after being treated for syphilis?
173. Who decides to use/not use condoms?
174. Did you ever use condoms before you found out that you had syphilis? Why not?
175. Does anyone else you know use condoms? Why? Why not?
176. What do you think would increase the acceptability of condoms to yourself or other men you know? (Get verbatims)
177. Do you know where it is possible to get condoms?
178. Have you ever gotten them from that place?
179. What would you say to a friend to get him to use condoms?
180. Do you think that using condoms can protect you from getting any other STDs? AIDS?  
Why? Why not?

181. Were there any other things you or your partner did/avoided/used after you found out you had syphilis? What?
182. Did you change anything else after you found out you had syphilis? What? Why? Why not?
183. Are there any things you might do to be sure you do not get syphilis again? Why? Why not? What things?
184. If you want to use condoms with a partner, can she refuse?
185. Do women ever refuse a partner who uses condoms?
186. How do you feel if a woman asks you to use a condom?
187. Has your regular partner ever refused to have sex with you without a condom?
188. With what kind of woman would you use a condom?
189. Do you ever decide to use a condom? Under what circumstances?
190. How do you think condoms can be made more acceptable to men? Why?
191. Would you ever try to convince a friend to use a condom?
192. How would you persuade him?
193. How do you dispose of condoms?
194. What is the best way to persuade a man to use a condom?

## **VII. PERSONAL CONCERNS**

195. To whom do you talk when you have a problem?
196. Do you prefer to talk to a person of the same sex or opposite sex?
197. Did your partner ever refuse to play sex with you?  
How do you feel when she refuses to play sex?
198. Between you and your regular partner, who first brings up the idea to play sex?
199. Can a woman bring the idea to a man or must the man bring it?
200. After your partner has been treated for syphilis, can she or he get it again? How?
201. Is there any connection between syphilis and AIDS?
202. If you knew your friend had syphilis, how would you persuade him to get treated?

## **VIII. NEED FOR ANC**

203. Did you learn that you had syphilis because your partner went to the antenatal clinic for routine care?
204. When did you find out she was pregnant?
205. How do you feel about the pregnancy?
206. Do you think it is important for pregnant women to go to the antenatal clinic?
207. Do you know how far along in pregnancy your partner was when she first went to the clinic for antenatal care?
208. Do you have any idea why pregnant women often do not attend antenatal clinic until late in the pregnancy?
209. What might motivate pregnant women to attend earlier?  
How can a man insure that his partner goes to the clinic?

## **IX. WINDUP**

210. Any other things you would like to tell me about what happened after you found out you had syphilis?
211. Any problems you had that we have not already discussed?
212. Would you like to talk to a medical person about the effects of syphilis on yourself, your baby, your partner?
213. Would you be willing to talk to us again about matters related to syphilis?
214. What is the best way to contact you when we are ready?

Thank you for talking with me about your illness. It will help us to improve services for other men who have syphilis.

Give the client the envelope containing 100/= and the Project card.

## CLINIC STAFF

Date of Interview  
Time Begin Interview  
Time End Interview  
Location of Interview  
Interview Conducted by \_\_\_\_\_  
Reviewed by \_\_\_\_\_ date \_\_\_\_\_  
CIDA/STD-trained  
MotherCare/Syphilis-trained  
No Previous STD Training

### I. IDENTIFICATION DATA

1. Name (optional)
2. Age      Type of Health Worker
3. Clinic
4. Has person being interviewed or other staff at this clinic received:
  - previous CIDA project STD training?
  - when?
  - initial training for the MotherCare syphilis project? When?
  - any other STD training, type, date

### II. INTRODUCTION

As you may know, we are working with the University of Nairobi on a project to reduce the incidence of congenital syphilis. We are talking with health care providers at some of the clinics where pregnant women with syphilis might first seek care to get health worker's views about syphilis and about the current system for syphilis screening for pregnant women.

6. Have you or any of the other workers at this clinic received training about syphilis or other STDs?
7. If yes, when, what type of training, by whom? Did you find the training useful?
8. Are there any other things about STD/syphilis screening, treatment and education that you would like to know about that were not covered in the training you received? What?
9. Do you personally think that syphilis is an important problem in Kenya in general? Among pregnant women? Why, why not?
10. About what percent of pregnant women would you think have syphilis in the Nairobi area today?
11. Do you often see pregnant women with syphilis in your own clinic practice? How often? About how many?
12. Do you currently screen all pregnant patients for syphilis? (\* especially important at non-project clinics. At project clinics, all pregnant patients should be screened according to project protocol.) Why? Why not?

13. Ask project clinic staff: Did you screen all pregnant patients for syphilis before becoming associated with this project? Why? Why not?
14. Speaking as a clinician, are there any particular types of people who get syphilis? What types of people?
15. Are there certain practices or behaviors that people with syphilis are involved in?
16. Which practices?
17. In your opinion, what should be the major components (activities) in a comprehensive program to detect and treat syphilis in pregnant women?
18. Which components of care for patients with syphilis are particularly important? Why?
19. Which components of care are unnecessary? Why?
20. Which of these components of care are currently part of your clinics activities? For each: Why? Why not?
21. What is your own role in the activities above?
22. Do you have a personal responsibility for any particular components of care mentioned above? Why? Why not?
23. Are any of these components of care difficult to achieve in your clinical setting? Which? Why?
24. What are some of the specific barriers you face in providing effective syphilis/STD treatment?
25. Could you suggest some ways of improving the current system at your clinic for treatment of pregnant patients with syphilis and their partners?
26. Compared with the other components of care for pregnant patients with syphilis, how important do you think post-diagnosis counseling is?
27. Do you think the time available to counsel patients, especially pregnant women with syphilis, is sufficient to allow for discussion of all of the information they need to have? Why? Why not?
28. About how much time do you spend now counseling pregnant women who are RPR positive? Where does the counseling currently take place (\*privacy)?
29. What specific things do you talk with them about? (GET verbatims)
30. How do you tell the RPR positive women that they must inform their partners? What do they say?

After asking the open-ended question above, ask:

31. Before we finish talking, let me review some of the possible counseling points about things you should do after being treated for syphilis. Listen carefully, and then tell me if you tell RPR positive patients and/or their partners these things or how it is different from what you do tell patients:

NOTE: Pause after reading each individual point to get response.

o In order for couples with syphilis to avoid reinfection, the partner should be treated right away.

o You both should not play sex for at least two weeks after treatment (\*this is a standard recommendation in the US--please check with project staff to determine appropriate time period for post treatment abstinence).

o If for some reason you do play sex before two weeks, you and your partner should use condoms, even if he is your steady partner and/or your only partner. This prevents the infection from passing back and forth between you until the treatment has had time to cure you both.

o If your partner has other outside partners, he should use condoms with them as well; this includes him using condoms with outside partners during the two-week waiting period, for the rest of the time you are pregnant, and even after the baby is born.

o Any/all of his additional sexual partners should be informed of the need to be tested/treated.

o If you trust each other and you believe he does not have any other outside sexual partners, or that he will always use condoms with any/all outside partners he may have, the two of you do not need to continue using condoms when you play sex together after the two-week post-treatment period.

### **III. PARTNER TREATMENT**

32. About how many partners (what percent) come for treatment? Why do you think men do/do not come for partner treatment?
33. What do the male partners tell you when they come to clinic? What are the most common things they ask you, the most common feelings they express during post-diagnosis counseling?
34. How do you respond?
35. When partners of RPR positive women report to the clinic for treatment, do they get any counseling? Why? Why not? Where do you currently do the male-partner counseling?
36. What do you usually discuss with partners of RPR positive women?
37. What do you think should happen, if anything, to track partners of RPR positive women who do not voluntarily report to the clinic for treatment?
38. Is this what happens now? Why? Why not?
39. We talked briefly before about the types of people you feel are most likely to get syphilis. Do you think that there are any problems or barriers which pregnant patients and their partners with syphilis have:
  - o finding out that they have the disease?
  - o getting treatment once the diagnosis is made?
  - o getting good counseling, including the importance of partner treatment?
  - o telling their partner about their diagnosis?
  - o the partner coming to the clinic to be treated?

o preventing reinfection through condom use or other changes in the couple's sexual practice?

40. Which of the areas mentioned above do you think might be most problematic for women? Why?
41. What or who do you think is responsible for some of the problems and barriers listed above?
42. Are there some ways that these barriers or problems that pregnant patients with syphilis have could be addressed? How?
43. If the health worker you are interviewing was very motivated and gave many thoughtful responses, you could also explain that we are planning to develop some case histories for use in future training, and ask:
44. Can you think of any particularly interesting or challenging cases of treatment/management of pregnant patients with syphilis and their partner(s)? Why was it interesting/challenging?
45. What strategies did you use or would you suggest for patients'/partners who are particularly difficult to trace and treat?

Thank you for taking the time to talk with me about syphilis and for sharing your feelings and ideas about how to improve syphilis screening in pregnancy. We will also be talking with health workers at other NCC clinics; at the refresher training planned for February, we plan to discuss the results of these discussions with the group.

Distribute the questions on the next page to health workers after they have completed the interview. You can ask them to record their responses directly onto the paper, or you can ask the questions and record the answers yourself.

These are technical knowledge questions about syphilis which will help us to develop the technical aspects of the upcoming training.

1. What are some of the signs of infection with syphilis? When do these symptoms occur during the course of the disease? Are the symptoms and signs different in men and women?
2. Do you think babies or children have syphilis? Why? Why not? If yes, what might some of the signs and symptoms be?
3. What are some of the possible effects (consequences, sequelae) of syphilis which is not treated or improperly treated in pregnant women? babies or children? men?
4. Can you tell the difference between the physical signs of syphilis and other STDs? How?
5. What might the laboratory findings be in a patient with syphilis?
6. Are there any problems that you are aware of in making a definite laboratory diagnosis of syphilis?
7. How would you make a definitive diagnosis of syphilis? Are there certain physical signs and laboratory findings that you feel are conclusive? Which?
8. Do you routinely look for these findings among pregnant women or other patients that you see? Why? Why not?
9. Ideally, how often would you perform laboratory tests for syphilis on pregnant women? Which type of tests? Why?
10. Once you are sure of a diagnosis of syphilis in a pregnant patient, what do you think is the most effective treatment? Why? Is this how you usually treat patients you diagnose as having syphilis? Why? Why not?
11. Are you aware of any difference between the different types of injectable penicillins? If yes, what is the difference? Could any type of injectable penicillin be used effectively in patients with syphilis?
12. Are there any other types of effective syphilis treatment? Which?
13. Do you know of any commonly employed syphilis treatment which you personally feel is ineffective? Where does this usually occur? Why?
14. Would the pregnancy itself or the health of the pregnant woman or her newborn be any different depending on what point in the pregnancy syphilis is being treated? Please explain.
15. Is it possible that pregnant women treated for syphilis could become reinfected? How? What do you think could prevent this from occurring? Is this normally done? Why? Why not?
16. Do you think patients with syphilis are more likely to have other STDs at the same time? Why, which other STDs? Do you screen for other STDs in your patients with syphilis or recommend that they get further testing? Why? Why not?
17. Do you think patients with syphilis are at increased risk of contracting HIV? Why? Why not?

## APPENDIX H

### RESEARCH INSTRUMENTS: COMMUNITY-BASED

#### TOPIC GUIDE FOR PRIMIPAROUS WOMEN

Interviewers: Before beginning make a note of the stratum by language and clinic use.

#### INTRODUCTION

Thank you for coming. You are most welcome. My name is \_\_\_\_\_. Also with me today is \_\_\_\_\_ who will be recording. We want to discuss prenatal care and gather your ideas and opinions in order to help us develop effective and appropriate materials for pregnant women.

Your participation is important. I am interested in your ideas, comments and suggestions. There are no right or wrong answers. All comments are welcomed. Please feel free to disagree with each other, as we are interested in all points of view.

\_\_\_\_\_, who you have already met, will be taking notes. Everything said here is confidential. These notes are for our study only. The tape recorder is only to give us a record of the discussion. The tape will not be played or aired anywhere but among us.

I want this to be a group discussion, so I will call on all of you to assist us in gathering information. So that we don't take too much time, I may change subjects or move ahead, but you can stop me if you want to add something.

Let us begin by introducing ourselves before we turn on the tape. Each person should give her name, what you do and anything else you would like to share about yourself, such as your age, where you come from, etc.

#### I. WARM UP

How does everyone feel about being pregnant for the first time?

What kind of special attention does a woman need when she is pregnant?

Scope: Look for any apprehensions, fears, things they are looking forward to.

#### II. KAP

Let us discuss how women feel about getting care when they are pregnant and about to deliver.

Scope: Look for understanding of prenatal care, need for prenatal care, approaches to prenatal care. Drawbacks of prenatal care.

Probe for: timing, frequency of visits, concepts of early care, time between knowing they are pregnant and going for care.

When your labor starts, what will you do?

### **III. RANGE AND QUALITY OF PRENATAL CARE**

Now let us talk about where women go for prenatal care and why.

Scope: Look for the range of sources of care the women recognize, which ones they choose and why, where they plan to give birth and why.

Probe for: economic factors, staff service delivery, surroundings of care venue, friendship network factors, positive and negative aspects of each care source.

### **IV. BARRIERS/MOTIVATORS**

Let us talk about why some women decide not to go for prenatal care or go very few times.

Scope: Look for factors that prevent or discourage women from going for prenatal care in general and to NCC clinics in particular, such as cost, time involved, distance, availability of drugs, syringes, etc.

Look for the factors that make clinic appealing -- reassurance, blood tests, clinic card, etc.

Probe for ways to make clinic attendance more attractive as an option for prenatal care.

### **V. NCC CLINICS**

What about Nairobi City Council Clinics as an prenatal care source?

Scope: Look for the general reputation of NCC health care services, specific pros and cons of NCC prenatal care, effects of cost-sharing, how the group sees NCC clinics in relation to themselves and other people.

### **VI. WINDUP**

This has been an interesting discussion. Does anyone have anything to add? I have learned a lot from all of you. We will now be able to use your ideas in planning better services for pregnant women. Thank you all very much.

## TOPIC GUIDE FOR MULTIPAROUS WOMEN

Interviewers: Before beginning, be sure to note the stratum by language and clinic use.

*Add mention in the introduction that as experienced mothers, their opinions are especially valuable. They should mention how many children they have before the tape is turned on: if this is not OK then they may be able to say whether they have two or more or if they are old or young, meaning many or few children.*

### I. WARM UP

How does everyone feel about this pregnancy?

What kind of attention does a woman need when she is pregnant?

Scope: Look for any apprehensions, fears, things they are looking forward to.

### II. KAP

Let us discuss how women feel about getting care when they are pregnant and about to deliver.

Scope: Look for understanding of prenatal care, need for prenatal care, approaches to prenatal care, drawbacks of prenatal care. *Variations in their attitudes during different pregnancies.*

Probe for: timing, frequency of visits, concepts of early care, time between knowing they are pregnant and going for care.

When your labor starts, what will you do?

### III. RANGE AND QUALITY OF PRENATAL CARE

Now let us talk about where women go for prenatal care and why.

Scope: Look for the range of sources of care the women recognize, which ones they choose and why, where they plan to give birth and why. *Their experiences with different care sources for different pregnancies.*

Probe for: economic factors, staff service delivery, surroundings of care venue, friendship network factors, positive and negative aspects of each care source, *reasons for changing care source.*

### IV. BARRIERS/MOTIVATORS

Let us talk about why some women decide not to go for prenatal care or go very few times.

Scope: Look for factors that prevent or discourage women from going for prenatal care in general and to NCC clinics in particular, such as cost, time involved, distance, availability of drugs, syringes, etc.

Look for the factors that make clinic appealing -- reassurance, blood tests, clinic card, etc.

Probe for ways to make clinic attendance more attractive as an option for prenatal care.

## **V. NCC CLINICS**

What about Nairobi City Council Clinics as an prenatal care source?

Scope: Look for the general reputation of NCC health care services, specific pros and cons of NCC prenatal care, effects of cost-sharing, how the group sees NCC clinics in relation to themselves and other people.

*Probe for any changes in the quality of NCC clinic care during their various pregnancies.*

## **VI. WINDUP**

This has been an interesting discussion. Does anyone have anything to add? I have learned a lot from all of you. We will now be able to use your ideas in planning better services for pregnant women. Thank you all very much.

## TOPIC GUIDE FOR PARTNERS

### INTRODUCTION

Thank you for coming. You are most welcome. My name is \_\_\_\_\_. Also with me today is \_\_\_\_\_, who will be recording. We want to discuss prenatal care and gather your ideas and opinions in order to help us develop effective and appropriate materials for pregnant women and their partners.

As expectant fathers, your participation is important. I am interested in your ideas, comments, and suggestions. There are no right or wrong answers. All comments are welcomed. Please feel free to disagree with each other as we are interested in all points of view.

\_\_\_\_\_, who you have already met, will be taking notes. Everything said here is confidential. These notes are for our study only. The tape recorder is only to give us a record of the discussion. The tape will not be played or aired anywhere but among us.

I want this to be a group discussion, so I will call on all of you to assist us in gathering information. So that we don't take too much time, I may change subjects or move ahead, but you can stop me if you want to add something.

Let us begin by introducing ourselves before we turn on the tape. Each person should give his name, what you do, and anything else you would like to share about yourself, such as your age, where you come from, etc.

### I. WARM UP

How does everyone feel about his partner's pregnancy?

Scope: Look for any apprehensions, fears, things they are looking forward to, *their involvement in or distance from the pregnancy.*

### II. KAP

Let us discuss how men feel about their partners getting care when they are pregnant.

Scope: Look for understanding of prenatal care, need for prenatal care, approaches to prenatal care, drawbacks of prenatal care. *Their views on how the female partner sees prenatal care.*

Probe for: timing, frequency of visits, concepts of early care, time between knowing they are pregnant and going for care, *how closely the male partners monitor or notice the female partner's care-seeking behavior.*

### III. RANGE AND QUALITY OF PRENATAL CARE

Now let us talk about where women go for prenatal care and why.

Scope: Look for the range of sources of care the *men* recognize. *The men's involvement or distance from the women's choice-making process and, if involved, how much they direct or just go along with the choice.*

Probe for: economic factors, staff service delivery, surroundings of care venue, friendship network factors, positive and negative aspects of each care source.

#### **IV. BARRIERS/MOTIVATORS**

Let us talk about why some women decide not to go for prenatal care or go very few times.

Scope: *Look for men's involvement in or distance from the process and how they see the women doing what they do.* Look for factors that *men believe* prevent or discourage women from going for prenatal care in general and to NCC clinics in particular, such as cost, time involved, distance, availability of drugs, syringes, etc.

Probe for: ways to make clinic attendance more attractive as an option for prenatal care. *Probe for ways in which male partners can participate or encourage their female partners to attend clinic.*

#### **V. NCC CLINICS**

What about Nairobi City Council Clinics as an prenatal care source?

Scope: Look for the general reputation of NCC health care services, specific pros and cons of NCC prenatal care, effects of cost-sharing, how the group sees NCC clinics in relation to themselves, their female partners, and other people.

#### **VI. WINDUP**

This has been an interesting discussion. Does anyone have anything to add? I have learned a lot from all of you. We will now be able to use your ideas in planning better services for pregnant women. Thank you all very much.

## IN-DEPTH INTERVIEW GUIDE FOR PRIMIPAROUS WOMEN

Introduce yourself and explain that the purpose of the interview is to learn more about how pregnant women get prenatal care.

1. Name: (optional)
2. Contact: (optional)
3. Occupation:
4. Mother tongue:
5. First pregnancy + or -
6. Participation in FGD + or -
7. Clinic use + or -

### I. WARM UP

1. How do you feel about this pregnancy?
2. How does your partner feel about the pregnancy?

### II. KAP

3. What kind of prenatal care are you receiving?
4. Why did you choose that kind?
5. How far along in pregnancy were you when you first went for prenatal care?
6. Why did you decide to start then?
7. Why not earlier/later?
8. How many times do you expect to go for prenatal care during this pregnancy?
9. How do women know that they are pregnant?
10. How did you know?
11. After finding out that you were pregnant, how long did you wait before seeking prenatal care?
12. Why?
13. Why should pregnant women need prenatal care?
14. Have you had any problems with this pregnancy?
15. What kinds of women need prenatal care? Why?
16. After giving birth, is it important to come back to the clinic with the baby?
17. Why?
18. When?

### III. RANGE AND QUALITY OF PRENATAL CARE

19. Where else could you have gone for prenatal care?
20. Why did you not choose any of the other sources of care?
21. During your first visit for prenatal care, what happened?
22. How did you feel about the service you received?
23. How was the facility? Did you feel comfortable there?
24. How did the staff behave toward you?
25. If you could change anything about your care source, what would you change?
26. When you begin labor, what will you do?
27. Where do you plan to give birth?

28. Why have you chosen that place?
29. Where else could you go to give birth?

#### **IV. BARRIERS/MOTIVATORS**

30. Do you like going for regular prenatal care? y / n
31. Reasons?
32. How do you get to the place where you go for care?
33. How long does that take?
34. How long does your visit usually take?
35. What do you think about that length of time?
36. How often are you supposed to go for prenatal care?
37. What do you think about going that often?
38. Each time you visit the clinic, how much money does it cost you?
39. How do you feel about spending that amount?
40. Some women decide not to get prenatal care, what kinds of women?
41. Why do they decide not to?
42. What prevents women from starting prenatal care early in their pregnancies?
43. How can women be convinced that they should start prenatal care early?
44. What else would help women to get prenatal care?

#### **V. NCC CLINICS**

45. How do you feel about Nairobi City Council clinics?
46. Which clinic is nearest where you live in Nairobi?
47. Have you ever used that clinic?
  - a. for prenatal care? Y / N
  - b. for anything else? Y / N
  - c. What else?
48. How was the service there?
49. How does cost sharing effect you?
50. How does it affect other people?

#### **VI. WINDUP**

51. Is there anything else you would like to add about prenatal care and City Council Clinics?

Thank you for your help. This information will help us to plan better services for pregnant women in Nairobi.

## IN-DEPTH INTERVIEW GUIDE FOR MULTIPAROUS WOMEN

Introduce yourself and explain that the purpose of the interview is to learn more about how pregnant women get prenatal care.

1. Name: (optional)
2. Contact: (optional)
3. Occupation:
4. Mother tongue:
5. First pregnancy + or -  
Parity or how many live births
6. Participation in FGD + or -
7. Clinic use + or -

### I. WARM UP

1. How do you feel about this pregnancy?
2. How does your partner feel about the pregnancy?

### II. KAP

3. What kind of prenatal care are you receiving?
4. Why did you choose that kind?
5. How far along in pregnancy were you when you first went for prenatal care?
6. Why did you decide to start then?
7. Why not earlier/later?
8. How many times do you expect to go for prenatal care during this pregnancy?
9. How do women know that they are pregnant?
10. How did you know?
11. After finding out that you were pregnant, how long did you wait before seeking prenatal care?
12. Why?
13. Why should pregnant women need prenatal care?
14. Have you had any problems with this pregnancy?
15. What kinds of women need prenatal care? Why?
16. After giving birth, is it important to come back to the care source with the baby?
17. Why?
18. When?

### III. RANGE AND QUALITY OF PRENATAL CARE

19. Is your present source of prenatal care the same as for previous pregnancies? Y / N
20. If no, what other care sources have you used?
21. How would you compare them with your present care source?
22. Why did you decide on a different care source this time?
23. Where else could you have gone for prenatal care?
24. Why did you not choose any of the other sources of care?
25. During your first visit for prenatal care, what happened?
26. How did you feel about the service you received?
27. How was the facility?

28. Did you feel comfortable there?
29. How did the staff behave toward you?
30. If you could change anything about your care source, what would you change?
31. Where do you plan to give birth?
32. Why have you chosen that place?
33. Where else could you go to give birth?
34. In the past, when your labor began, what did you do?
35. What will you do this time?
36. Have you ever had any bad experiences in prenatal care or delivery?

#### **IV. BARRIERS/MOTIVATORS**

37. Do you like going for regular prenatal care? y / n
38. Reasons
39. How do you get to the place where you go for care?
40. How long does that take?
41. How long does your visit usually take?
42. What do you think about that length of time?
43. How often are you supposed to go for prenatal care?
44. What do you think about going that often?
45. Each time you visit the clinic, how much money does it cost you?
46. How do you feel about spending that amount?
47. Some women decide not to get prenatal care, what kinds of women?
48. Why do they decide not to?
49. What prevents women from starting prenatal care early in their pregnancies?
50. How can women be convinced that they should start prenatal care early?
51. What else would help women to get prenatal care?

#### **V. NCC CLINICS**

52. How do you feel about Nairobi City Council clinics?
53. Which clinic is nearest where you live in Nairobi?
54. Have you ever used that clinic?
  - a. for prenatal care? Y / N
  - b. for anything else? Y / N
  - c. What else?
55. How was the service there?
56. How does cost sharing effect you?
57. How does it affect other people?

#### **VI. WINDUP**

58. Is there anything else you would like to add about prenatal care and City Council Clinics?

Thank you for your help. This information will help us to plan better services for pregnant women in Nairobi.

## **IN-DEPTH INTERVIEW GUIDE FOR MALE PARTNERS**

Introduce yourself and explain that the purpose of the interview is to gather information on how partners of pregnant women view the process of getting prenatal care.

1. Name: (optional)
2. Contact: (optional)
3. Occupation:
4. Mother tongue:
5. Partner's mother tongue:
6. First pregnancy + or -
7. Partner's participation in FGD + or -
8. Partner's clinic use + or -

### **I. WARM UP**

1. How do you feel about your partner's pregnancy?
2. How does your partner feel about the pregnancy?
3. Do women need any special attention or care when they are pregnant?
4. If so, what?

### **II. KAP**

5. How did you find out that your partner was pregnant?
6. What is prenatal care?
7. What does it consist of?
8. How do you know this?
9. What kind of prenatal care is your partner receiving?
10. Why did she choose that kind?
11. Did you participate in making the decision?
12. How far along in pregnancy was she when she first went for prenatal care?
13. Why did she decide to start then?
14. How often does she go for prenatal care?
15. Is that the right number of times? frequency of visits?
16. Why should pregnant women get prenatal care?
17. Has your partner had any problems during this pregnancy?
18. After giving birth, is it important to come back to the clinic with the baby?
19. Why?
20. When?
21. How did you know that?

### **III. RANGE AND QUALITY OF PRENATAL CARE**

22. Where else could your partner have gone for prenatal care?
23. Why did she not choose any of the other sources of care?
24. Does she talk to you about her prenatal care and what happens when she goes for prenatal care?
25. What does she tell you?
26. How do you feel about the care she is receiving?
27. If you could change anything about her care source, what would you change?

28. Where does she plan to give birth?
29. What was your role in deciding on that place?
30. Where else could she go to give birth?
31. What preparations will you make for her delivery?
32. When she begins her labor, what will you do?

#### **IV. BARRIERS/MOTIVATORS**

33. Some women decide not to get prenatal care, what kinds of women?
34. Why do they decide not to?
35. How did you know that?
36. How can women be convinced that they should start prenatal care early?
37. What should the male partner's role be in all the matters having to do with the pregnancy?
38. How can male partners encourage or help pregnant women to get prenatal care?
39. Is there anyone else nearby who can help your pregnant partner?
40. What else would help women to get prenatal care?
41. How do you know this?

#### **V. NCC CLINICS**

42. How do you feel about Nairobi City Council clinics?
43. Which clinic is nearest where you live?
44. Have you ever used that clinic?
45. How was the service you received there?
46. How does cost sharing effect you?
47. How does it affect other people?
48. How do you know?

#### **VI. WINDUP**

Thank you very much for your help. The information you have given us will help in planning better services for pregnant women in Nairobi.

## IN-DEPTH INTERVIEW GUIDE FOR COMMUNITY-BASED HEALTH WORKERS

Introduce yourself and explain that the purpose of this interview is to gather information on prenatal care in Nairobi.

1. Name: (optional)
2. Contact: (optional)
3. Agency:
4. Area/Catchment:
5. Attachment:
6. Paid? y / n
7. Duties:
8. What are the main problems in the community where you work?
9. What is your role in prenatal care provision?
10. How do the women in your area generally get care when they are pregnant?
11. What sources of care are available?
12. What sources do most women seem to prefer?
13. Why?
14. What kinds of women do not get prenatal care?
15. Why?
16. What kinds of women in your area need prenatal care most?
17. Why?
18. Is the community where you work very mixed or does one ethnic group predominate?
19. If so, which one or ones?
20. How are the people of your work area the same or different from others?
21. How are the women of your area of work the same as other women in Nairobi?
22. How are they different in their care-seeking behavior?
23. Which NCC clinic is nearest your area?
24. In your opinion, how do the women in your area feel about the clinic?
25. About other NCC clinics?
26. In your opinion, what is the best source of prenatal care in your area?
27. Why?
28. When a woman is pregnant, when should she start prenatal care?
29. Are there any activities in your area aimed at encouraging women to start prenatal care early in their pregnancies?
30. What activities?
31. How can women in your area be encouraged to start prenatal care early?
32. Do male partners in your area encourage their female partners to get prenatal care?
33. How can they be encouraged to encourage their partners to get prenatal care?
34. How much do the men in your area involve themselves in their female partners' pregnancies?
35. Who else helps women who are pregnant?
36. What do you would (\*\*) improve the quality of prenatal care in your area?
37. How do the women in your area deliver?
38. Where do they normally go for delivery?
39. How do they get there?
40. Do you help women make arrangements for delivery?
41. Do you deliver babies or assist in delivery?
42. What would be the best channels for communicating with the women in your area about prenatal care and delivery?

43. As a health worker, what are the major problems you face in your work?
44. Is there anything else you would like to add regarding prenatal care in your area of work?

#### **WINDUP**

Thank you very much for your help. The information you have given us will help in planning improved prenatal care for women in Nairobi.

## IN-DEPTH INTERVIEW GUIDE FOR TRADITIONAL BIRTH ATTENDANTS

Introduce yourself and explain that the purpose of this interview is to gather information on prenatal care in Nairobi.

1. Name: (optional)
2. Contact: (optional)
3. Agency (maybe private):
4. Area/Catchment:
5. Attachment:
6. Paid? y / n
7. Duties:
8. How did you learn to be a TBA?
9. What are the main problems in the community where you work?
10. What is your role in prenatal care provision?
11. How do the women in your area generally get care when they are pregnant?
12. What sources of care are available?
13. What sources do most women seem to prefer?
14. Why?
15. What kinds of women do not get prenatal care?
16. Why?
17. What kinds of women in your area need prenatal care most?
18. Why?
19. Is the community where you work very mixed or does one ethnic group predominate?
20. If so, which one or ones?
21. How are the people of your work area the same or different from others?
22. How are the women of your area of work the same as other women in Nairobi?
23. How are they different in their care-seeking behavior?
24. Which NCC clinic is nearest your area?
25. In your opinion, how do the women in your area feel about the clinic?
26. About other NCC clinics?
27. In your opinion, what is the best source of prenatal care in your area?
28. Why?
29. When a woman is pregnant, when should she start prenatal care?
30. Are there any activities in your area aimed at encouraging women to start prenatal care early in their pregnancies?
31. What activities?
32. How can women in your area be encouraged to start prenatal care early?
33. Do male partners in your area encourage their female partners to get prenatal care?
34. How can they be encouraged to encourage their partners to get prenatal care?
35. How much do the men in your area involve themselves in their female partners' pregnancies?
36. Who else helps women who are pregnant?
37. What do you would (\*\*) improve the quality of prenatal care in your area?
38. Do you provide prenatal care?
39. How do the women in your area usually deliver?
40. Where do they normally go for delivery?
41. How do they get there?
42. How do the women in your area make arrangements for delivery?
43. How many times before delivery do you normally see your clients?

44. About how many deliveries do you perform per week or month?
45. Have you noticed a change in the number of deliveries you perform recently?
46. What is the reason for the change?
47. What is it about your service that your clients prefer?
48. How much do you charge for a delivery?
49. Where do you usually perform deliveries?
50. What are the best channels for communicating with women in your area about prenatal care and delivery?
51. As a TBA, what are the major problems you face in your work?
52. How could prenatal care and delivery services in your area be improved?
53. Is there anything else you would like to add about prenatal care and delivery in your area of work?

## **WINDUP**

Thank you very much for your help. The information you have given us will help in planning improved prenatal care for women in Nairobi.

## IN-DEPTH INTERVIEW GUIDE FOR PRACTITIONERS

1. Name: (optional)
2. Contact: (optional)
3. Agency (maybe private):
4. Area/Catchment:
5. Type of practice:
  - a. single private
  - b. private clinic
  - c. Church clinic
  - d. NGO clinic
  - e. Other
6. What type of medicine do you practice?
7. What are the main problems in the community where you work?
8. What is your role in prenatal care provision?
9. How do the women in your area generally get care when they are pregnant?
10. What sources of care are available?
11. What sources do most women seem to prefer?
12. Why?
13. What kinds of women do not get prenatal care?
14. Why?
15. What kinds of women in your area need prenatal care most?
16. Why?
17. Is the community where you work very mixed or does one ethnic group predominate?
18. If so, which one or ones?
19. How are the people of your work area the same or different from others?
20. How are the women of your area of work the same as other women in Nairobi?
21. How are they different in their care-seeking behavior?
22. Which NCC clinic is nearest your area?
23. In your opinion, how do the women in your area feel about the clinic?
24. About other NCC clinics?
25. In your opinion, what is the best source of prenatal care in your area?
26. Why?
27. When a woman is pregnant, when should she start prenatal care?
28. Are there any activities in your area aimed at encouraging women to start prenatal care early in their pregnancies?
29. What activities?
30. How can women in your area be encouraged to start prenatal care early?
31. Do male partners in your area encourage their female partners to get prenatal care?
32. How can they be encouraged to encourage their partners to get prenatal care?
33. How much do the men in your area involve themselves in their female partners' pregnancies?
34. Who else helps women who are pregnant?
35. What do you would (\*\*\*) improve the quality of prenatal care in your area?
36. Do you provide prenatal care?
37. How do the women in your area usually deliver?
38. Where do they normally go for delivery?
39. How do they get there?
40. How do the women in your area make arrangements for delivery?
41. How many times before delivery do you normally see your clients?

42. About how many deliveries do you perform per week or month?
43. Have you noticed a change in the number of deliveries you perform recently?
44. What is the reason for the change?
45. What is it about your service that your clients prefer?
46. How much do you charge for a delivery?
47. Where do you usually perform deliveries?
48. What are the best channels for communicating with women in your area about prenatal care and delivery?
49. As a medical practitioner, what are the major problems you face in your work?
50. How could prenatal care and delivery services in your area be improved?
51. Is there anything else you would like to add about prenatal care and delivery in your area of work?

## **WINDUP**

Thank you very much for your help. The information you have given us will help in planning improved prenatal care for women in Nairobi.

## IN-DEPTH INTERVIEW GUIDE FOR RELIGIOUS LEADERS

1. Name: (optional)
2. Contact: (optional)
3. Title:
4. Church:
5. Area/Catchment:
6. What are the main problems in the community where you work?
7. What is your church's role in prenatal care provision?
8. How do the women in your area generally get care when they are pregnant?
9. What sources of care are available?
10. What sources do most women seem to prefer?
11. Why?
12. What kinds of women do not get prenatal care?
13. Why?
14. What kinds of women in your area need prenatal care most?
15. Why?
16. Is the community where you work very mixed or does one ethnic group predominate?
17. If so, which one or ones?
18. How are the people of your work area the same or different from others?
19. How are the women of your area of work the same as other women in Nairobi?
20. How are they different in their care-seeking behavior?
21. Which NCC clinic is nearest your area?
22. In your opinion, how do the women in your area feel about the clinic?
23. About other NCC clinics?
24. In your opinion, what is the best source of prenatal care in your area?
25. Why?
26. When a woman is pregnant, when should she start prenatal care?
27. Are there any activities in your area aimed at encouraging women to start prenatal care early in their pregnancies?
28. What activities?
29. How can women in your area be encouraged to start prenatal care early?
30. Do male partners in your area encourage their female partners to get prenatal care?
31. How can they be encouraged to encourage their partners to get prenatal care?
32. How much do the men in your area involve themselves in their female partners' pregnancies?
33. Who else helps women who are pregnant?
34. What do you would (\*\*) improve the quality of prenatal care in your area?
35. How do the women in your area usually deliver?
36. Where do they normally go for delivery?
37. How do they get there?
38. How do the women in your area make arrangements for delivery?
39. What are the best channels for communicating with women in your area about prenatal care and delivery?
40. How could prenatal care and delivery services in your area be improved?
41. As a religious leader, what are the major problems you face in your work?
42. Is there anything else you would like to add about prenatal care and delivery in your area of work?

## **WINDUP**

Thank you very much for your help. The information you have given us will help in planning improved prenatal care for women in Nairobi.