

Determinants Of Choice Of A Place For Delivery Among Women Aged 18-49 Years Attending Post-Natal Clinic At Nyahururu County Hospital Laikipia County, Kenya.

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Abstract: Choice of a place for delivery is important because this prevents maternal death, in support of Sustainable Development Goals (SDG). In Kenya, according to KDHS (2014) 62% of the women chose a health facility as a place, 38% chose to deliver at home, while in Laikipia County 48.8% were seen to choose to deliver at home. The specific objectives were assessing the demographic cultural and the facility determinants of choice of a place for delivery. A descriptive cross-sectional research design is what the study adopted. A systematic random sampling technique was done among a calculated sample of 265 clients who met the inclusion criterion. Statistical Program for Social Sciences (SPSS) version 20 software package was used for the analysis. Chi square test was used to establish the association. The major findings were that 60.0 % (n=160) of the respondents delivered in a government hospital, 25.7 % (n=68) in a private hospital while 14.0 % (n=37) had their delivery at home. The significant demographic determinants to this, were age, (p-value, $\chi^2 = 56.941$, df=6, p<0.001) and education (p-value, $\chi^2 = 77.177$, df=6, p<0.001). Marital status (p-value, $\chi^2 = 13.083$, df=8, p=0.109), and respondents occupation (p-value, $\chi^2 = 19.764$, df=10, p=0.032) were not. Cultural determinants of Ethnicity, had 69.81% (n=185) of the respondents coming from the kikuyu community, 7.92% (n=21) from Samburu community, 6.04% (n=16) from Turkana community 6.42% (n=17) Kalenjin. Husbands and elderly women influenced where respondents to choose for delivery. The health facility determinants, where 62.6% (n=166) of the respondents covered a distance < 5KM, 37.4% (n=99) covered >5km which 78% of those who delivered at home covered. This however, was not statistically, significant, (p-value, ($\chi^2 = 37.978$, df=2, p<0.001), although that the likelihood to choose to deliver at home increased with the likelihood of residing a distance of >5KM away from a health facility. Preference of company specifically spouse and mother (86%), was significant; (p-value, $\chi^2 = 24.886$, df=6, p<0.001). In conclusion, the null hypotheses were rejected. The study recommends accelerated health education on importance of hospital delivery using strategies responsive and sensitive to specific communities in the county, as well as encouraging education and economic empowerment of men and women. The hospital staffs may consider allowing preferred birth companions within the hospital setup, ensure short waiting time for clients and have strategies that would allow more interactions between health workers and clients before and during labor and delivery.

Key Words; demographic determinants, cultural determinants, health facility related determinants, choice of a place for delivery

INTRODUCTION

Choice of a place for delivery is a fundamental principle in midwifery in which clients and midwives engage in a collaborative decision-making process. Birth settings and experience creates an everlasting impression among women even in situations of a normal birth physiology (Budin, 2013). To accelerate the decline of maternal mortality rate (MMR), there must be access to and also ability to use quality care during pregnancy and childbirth (WHO, 2016).

In the United States, clients chose to give birth where majority of births occurs. Living in shelters, streets or the under housed clients in Ontario are social determinants affecting choice of a place to deliver (Midwives Association of Ontario, 2016). The reason that babies are first taken to a sterile steaming nursery and feeding is allowed on a four-hour schedule in the US, affects women's decision about choice of a place where to deliver. In addition, women chose to have their babies outside traditional hospital settings due to the almost normalized routine interventions observed in the hospitals (Budin, 2013).

In Africa, women in the community are available to support their pregnant counterparts during labour and delivery, with breast feeding and bonding is allowed immediately; as compared to United States where home births are about 2% (Budin, 2013). A study done in Zambia to explore the role of traditional birth attendants in home deliveries revealed that only those clients who were identified by nurses as at risk of or had developed complications of pregnancy during the antenatal care (ANC) in their previous deliveries were likely to choose to deliver under skilled attendance, the rest would choose unskilled attendance (Sialubanje, Massar & Ruiter, 2015).

In East Africa, Tanzania, a study done revealed how community level characteristics influenced women to utilize health facilities as their place to deliver. In this case, the strategies used were integrated person to person interactions of women in the community

as well as within family units so as to promote facility deliveries (Levira, 2014). In Kenya, where haemorrhage contributes to 34% of all maternal deaths (Ministry of Health, Kenya, 2016), 62% of births were attended by a skilled provider probably at the hospital, 48% were attended at home by unskilled attendants (KDHS, 2014), despite the fact that government maternity services are affordable and the assumption is that most clients would choose to deliver in the government public hospitals.

Choice of a place to deliver is important and should be planned earlier during antenatal period by the skilled health worker and the client. This is because pregnant women are at risk of developing obstetric complications during childbirth, some of which are fatal, and which are better managed in a health facility with skilled attendance; this prevents maternal deaths, a target of millennium sustainable goals.

The aim of this study is to assess the determinants of choice of a place for delivery among women age 18-49 years attending postnatal clinic at Nyahururu Hospital, one of the two Referral Hospitals in Laikipia County, the other being Nanyuki Hospital, especially in this era of free maternity services in the country.

Problem Statement

In Kenya, the Demographic Health Survey of 2014 reported 48% home births. The Rift Valley Region that hosts Laikipia County, the target area for this study had 48.8% births that happened at home (KDHS, 2014). This is a significantly high rate of home deliveries, which mostly happens under unskilled attendance. Choice of a home birth should be under a skilled provider and within a system that supports a rapid achievable transition to a hospital if necessary, as well as support and respect for families' rights to an informed choice of their birth setting (National Peri-natal Association, 2008). Laikipia County, an area with scarcity of resources since most of it is in the Arid and Semi-Arid Land (ASAL) zone is contributing to poor maternal health indicators in the Rift Valley Region, as the Demographic Health Survey of 2014 revealed. This is despite the fact that the area has providers of ANC services; health workers who are trained and qualified to provide maternity and delivery services. There is however a paradox when it comes to the documented uptake of both ANC and skilled delivery services among women in the area. Most (37.4%) deliveries which occurred at home were assisted by friends and relatives and a few (5.5%) were assisted by Traditional Birth Attendants (TBAs) (KDHS, 2014). Kenya being a diverse country it is important to have every region's unique cultural characteristics explored in depth, especially the effects of demographic, cultural and the health facilities determinants to choice of a place for delivery. This study proposes to achieve this goal.

Theoretical Framework

The framework for this study was one, Health belief model, which is a psychological model first developed in the 1950s by Hochbaum, Rosenstock and Kegell. These were psychologists working in the United States of America. This model explains and predicts health behaviour based on the value that a person raises on their particular goals. This is why some people will take specific care to achieve a safe delivery at the health facilities while others will not. The individual perception and beliefs about the dangers associated with delivery will influence their choice of a place of delivery among women aged 18-49 years. The clients who have safety as their value are likely to choose to deliver with skilled attendance. This can be a public health facility or a private health facility. The modifying factors considered here based on this model are the previous exposure and experiences at the health facility which will determine whether the mother would still choose that facility a second time. Adequate privacy, as the perceived benefit of being attended in a private health care compared to the County Hospital and lack of adequate privacy as the perceived barrier preventing the client from accessing skilled care are viewed as likely determinants of how women chose of a place of delivery.

Cultural Determinants of Choice

Culture is known to highly influence health and human service delivery programs. With cultural competency, the knowledge of individuals and groups of people is achieved and integrated to develop specific policies and practices which can then be applied into each cultural setting appropriately (Vista Nursing Continuing Education, 2017).

The findings of one of the studies done in India by Puthuchira on social demographic influences towards choosing a place to deliver among women of Tamil Nadu State of India, revealed that more than a half of those who did not deliver at the facility were restricted by their family members (Puthuchira, Kulasekalan & Taminaladu 2014).

In Accra, Ghana, a study done by Dako-Gyeke, Aikins, Aryeetey, Mccough, & Adongo (2014) found out that the local residents' interpretations about pregnancy-affected women's health seeking behaviour in that there were always associated high levels of anxieties rooted in cultural beliefs concerning pregnant women. This resulted in multiple choices of care among pregnant women which include the herbalists, TBAs and those giving spiritual care that interrupted the continued use of skilled care among pregnant women. Local understanding of disease aetiology therefore influenced decision making about place to deliver.

It is expected therefore that when a skilled attendant is culturally competent, they can effectively establish helping relationships, they can engage clients at individual level and this improves the quality of service that is provided to the mother during, labour and delivery. Core capacities of warmth, empathy and genuineness, which are fundamental expectations of every skilled attendant, are determinants to achieve cultural competence. Practitioners are seen to acquire behaviours that concur with cultural expectations and have expected skills and moral responsibility. They can then be seen to be exemplifying cultural competency, as well as affirming existing cultural differences among their clients Vista Continuing Education, (2002-2017). Ethnicity has been described to play a role of influence to women's choice of a place to deliver (Sakeahet *et al.*, 2014).

Health Facility Determinants

Skilled deliveries according to the WHO guidelines are given by skilled attendants who are trained doctors, midwives or nurses. These professionals are equipped with skills to manage pregnancies, childbirth, immediate postnatal period as well as managing emergencies and complications WHO, 2004.

In the UK, high technology in the hospital labour wards influence women's preference to the hospital delivery. The clients who avoided hospital births cite the risks posed by hospital to natural births such as the routine medical interventions. Furthermore, some clients cited lack of privacy at a vulnerable time as a reason for avoiding to birth in a hospital (Coxon K, 2014). A study carried out in Yemen revealed that majority of the women chose home as a place to deliver despite acknowledging the importance of their medical needs because of fear of bad experience of the institutional delivery. This included being forced to deliver lying on their back, attitude of superiority on the part of health providers, lack of authority during birth, inability to have questions answered and separation of baby and mother at the health facility (Abebe, Berhane, & Girma, 2012).

Developing countries; according to Karkee, Binns and Lee (2013) have lack of access and no availability of services as determinant of choice of a place to deliver. Quality care access is an explanation of the existing disparities concerning choice to use skilled attendance. This is better explained in terms of how best health personnel are equipped in terms of skills, facilities and functional referral systems (Karkee, Lee, & Khanal, 2014).

In a study carried out in Zambia by Sialubanje *et al.*, (2015), client's attitude towards the health provider and their previous experiences were found to be significant factors influencing client's choice of giving birth at home even with unskilled assistance. The researchers found out those clients' preferred unskilled but friendly and available relatives or friends to the unfriendly trained attendants. The clients were happy that their birth attendants did not abandon them and their babies even after delivery.

Kenya is committed to give mothers, girls and children acceptable, maternal and neonatal health services through a national health framework by addressing key bottlenecks in service delivery in order to enhance quality of care, and integrating existing services with innovative approaches. The county government has an obligation to ensure capacity building and equitable distribution of health workers, as well as efficiently using resources to ensure universal health coverage (Ministry of Health, 2016). Findings in a study done by Gitimuet *et al.* (2015) on what determines skilled attendance as a choice by women in Makueni County, Kenya, differed with Sakeahet *et al.*, (2014) findings, as a distance of more than six kilometres was found to have influenced the likelihood of choosing unskilled attendance. This is probably because of the terrain as the region is quite hilly. This distance barrier was even stronger when there was no transport such as ambulances to carry pregnant women in times of need (Gitimu, *et al.*, 2015).

METHODOLOGY

A descriptive cross-sectional research design is what the study adopted at the Nyahururu Hospital postnatal clinic where quantitative data collection was done. This enabled the researcher to examine how different variables stated in the study interrelated and informed the recommendations of this study (Mugenda & Mugenda, 2003).

Women within reproductive age, and who are aged 18-49 years who reside in Laikipia County were targeted. Purposive sampling was used to sample Nyahururu County Hospital Post-natal clinic. Assessment of sampled clients for their eligibility and obtaining an informed consent preceded the interview. The client who failed the inclusion test was dropped and the next one taken. The first client to arrive for the service who met the inclusion criteria was termed as the first respondent of the day during the period of interview.

The sampling size determination used Fishers formula.

$$n = Z^2 p (1-p) / d^2$$

Questionnaires were used to collect the data. Statistical Package for Social Science (SPSS) version 20 was used for analysing the data to generate descriptive statistics in form of frequencies, percentages and means. Presentations were done using percentage and frequency tables, bar graphs and pie charts. Chi square was used and the levels of association between variables (independent versus dependent) demonstrated.

RESEARCH FINDINGS

Demographic determinants

On age, the study found the modal class that is (62.6%, n=166) of women bearing children was between 21 and 30 years of age among those targeted. There was a significant association between age of women and choice of place of delivery. ($\chi^2 = 56.941$, $df=6$, $p<0.001$) This agrees findings from a study done in Makueni where also Most mothers aged between 25 and 34 years (81.5%) delivered in a hospital or health facility ($p<0.001$) (Nduku, 2015).

On education levels majority (94.3%, n=250) of expectant women had education meaning most women attending the Postnatal Clinic at Nyahururu Hospital are fairly educated and they preferred hospitals as a choice of a place to deliver unlike their uneducated counterparts who preferred home. The association found enough evidence to suggest a significant association between education and place of delivery. ($\chi^2 = 77.177$, $df=6$, $p<0.001$) This finding agree with a study done in Accra, Ghana, by Dako-Gyeke *et al.*, which found out that local understanding of disease aetiology influenced decision making about place to deliver. The findings also agree with Luthra (2015) whose study found that mothers with primary education are able to take better care of their children and are likely to seek medical care, when compared to those without schooling. In Kenya, husband's education is associated with increased skilled attendance (KDHS, 2014). This therefore means it is good for mothers that they have basic education.

The study revealed that majority (80.8%, n=214) of children bearing mothers have husbands. Since the value, ($\chi^2 = 13.083$, $df=8$, $p=0.109$) is greater than the chosen value of significance ($p=0.05$), there is not enough evidence to suggest a significant association between marital status and choice of place for delivery. In this study husbands have been shown to be very significant in decision making during labor and delivery. These findings agree with a descriptive survey on women's perception towards husbands' support at pregnancy, labor and delivery in selected hospitals in Ogun State in Nigeria which revealed that 96.5% of all the participants agreed that husbands are supportive during the phases that an expectant woman goes through and in which 86.5% said that their husbands support made pregnancy less stressful while 94.5% were of the opinion that husbands' provide emotional security (Mosunmola, Adekunbi, & Foluso, 2014). This suggests that most women in the study area could be getting support from their husbands that might be improving their experience during pregnancy.

The study showed majority, (80.7% n=214) of the women attending Postnatal had conceived between one and three times while among the rest (31%, n=83) had conceived once and 10.6%, n=28 had conceived more than 4 times. In addition, most (98.1%, n=260) of the respondents in the area of study had given birth to live children. The results indicate that the mean between the numbers of times of conceived, given birth and number of live births ranges between 2.32 and 2.45 which is narrow range. It suggests a low difference between number of times of conception and number of live births, which would suggest further that the women are able to conceive and carry a pregnancy to term. A review into past studies show nulliparous women (that is women having no previous births) are at higher risk for adverse birth outcomes than multiparous women (that is women having had at least one previous birth). The study concluded that differences in rates of adverse outcomes between nulliparous and multiparous women were partially linked to higher-risk women not having subsequent live birth. (Miranda, Edwards, & Myers, 2011). Collaborating with findings in this study implies that women giving birth first time had delivery done at a health facility. ($\chi^2 = 60.246$, $df=12$, $p<0.001$, hospital deliveries therefore were more common in women with fewer number of conceptions).

The study further revealed that the majority of expectant women never needed permission from their family members and relatives in order to have delivery done at a hospital. This implies that there is high freedom among the expectant mothers that would make a choice to deliver at the hospital be solely left to the women. This implies that a woman's choice of where to deliver could be influenced by the extent to which they depend on others. The community's belief on the person who influences choice of place of delivery was not significantly associated with choice of place for delivery ($\chi^2 = 7.104$, $df=8$, $p=0.525$).

Cultural determinants

The study revealed that majority (69.81%, n=185) of the respondents were from the kikuyu community. Other significantly represented communities included Samburu community (7.92%, n=21), Turkana (6.04%, n=16) and Kalenjin (6.42%, n=17).

The study did a cross tabulation between communities and choice of a place for delivery Majority (n=127) of respondents from Kikuyu community delivered at the hospital while majority (n=13) of respondents from Turkana community delivered at home. In addition, majority (n=14) respondents from Samburu Community delivered at home while an equal delivered either at a private hospital or at a public hospital. Among all (n=37) home deliveries from this study, majority, (73%), were from Samburu and Turkana communities, meaning that ethnicity in this study was a determinant to the choice of a place to deliver. Since p-value ($\chi^2 = 132.805$, $df=8$, $p<0.001$) is less than the chosen value of significance ($p=0.05$), there is enough evidence to suggest a significant association between respondents' ethnicity and choice of place of delivery. These findings agree with the one of a study done in Accra, Ghana, where researchers in their study had cited ethnicity to be playing a role of influence to women's choice of a place for delivery. (Sakeahet *et al.*, 2014).

The study further revealed that a large number of the respondents do not believe that birth complications and associated deaths are brought by bad spirits. In addition, the study further revealed that most women attending Postnatal Clinic are predominantly Christians with less of other religion including Muslims. Christianity is the most prevalent religion in the area and could thus be regarded as the most influential religion among the respondents. Since the associations found p-value ($\chi^2 = 14.322$, $df=4$, $p=0.516$) is greater than the chosen value of significance ($p=0.05$), there is not enough evidence to suggest a significant association between the religion of the respondents and choice of place for delivery.

These findings disagrees with findings of an inductive qualitative study done among post-partum women in Ghana and which focused on religious beliefs and practices in pregnancy and labor. The study found out that health care givers during delivery should support women to exercise their religious beliefs and practices (Aziato, Odai, & Omenyo, 2016). The findings of this study are closely related to a study done by (Song, *et al.*, 2016) that explores factors which may influence hospital delivery from multiple perspectives in the Butuo and Daofu counties of China, and which revealed that women in Butuo County that follow Animism religion refuse to visit hospitals for delivery. However, the main cultural determinant of choice of a place for delivery in the study quoted was the view that childbirth should not be watched by strangers, thus home delivery was safe and more acceptable, which is not agreeing with the findings of this study because only a few respondents and from particular communities chose home as a place for delivery.

The study revealed that birth positions at home were not more comfortable than those at the hospital. This implies that birth position may not be a determining factor for women who opt to deliver at home. The study findings disagrees another study that examined the labor experiences of women in relation to the birth position which revealed that the most important factor influencing choice of positions to be the woman's preference. However, being in a position to choose own birthing position is a contributor to a woman's sense of control during the delivery experience, and her perception about choice of a place for delivery (Virtual Medical Centre, 2011).

The study further revealed that majority disagreed that women with normal pregnancy do not need to go to hospital. This suggests that perception about whether a pregnancy is normal does not influence women to deliver at the hospital or not. In addition, majority of the respondents disagreed that mothers with normal pregnancy during ANC did not develop complications during labor. This suggests that the respondents were aware that mothers with normal pregnancy during ANC could develop

complications during labor. It further suggests that choice to deliver at the hospital could not be decided upon based on whether the pregnancy was normal or not. This however disagrees with a study in Malawi that showed that perceived health risk influenced the clients' choice of place to deliver (Roberts, et al., 2015).

Responses from this study finding revealed that husbands and elderly women were the main influencers of the decision of women's place for delivery in this community. The associations findings further suggest that since p-value ($\chi^2 = 24.886$, $df=6$, $p<0.001$) is less than the chosen value of significance ($p=0.05$), there is enough evidence to suggest a significant association between preference of company during labor and choice of place for delivery. Therefore, any intervention towards change of behavior as regarding where women delivers cannot ignore the husbands and the elderly women. Results from a cross tabulation shows that out of the 37 respondent who chose to deliver at home, majority (78%), had their husbands and elderly women influencing their decision to deliver at home. These findings agree with a descriptive survey on women's perception towards husbands' support at pregnancy, labor and delivery in selected hospitals in Ogun State in Nigeria which revealed that 96.5% of all the participants agreed that husbands are supportive. This shows a large number of expectant women would prefer their spouses and mothers be present during delivery.

Facilities Related Determinants

The study revealed that a huge number of women delivering at the hospital are from Nyahururu town and its environs. A cross tabulation from this study on the distance of $<$ or $>$ 5KM away from the hospital showed that the likelihood of choosing a hospital as the place for delivery decreased with the increase in the distance covered to the hospital. There is enough evidence to suggest a significant association between distance to the health facility of the respondents and choice of place of delivery, since p-value ($\chi^2 = 37.978$, $df=2$, $p<0.001$) is less than chosen value of significance ($p=0.05$). The above findings further collaborate Lwelamira and Safari (2012) who observed that likelihood for delivery at a hospital under skilled care decreased with living within a distance of more than 10 kilometers away from the health facility relative to those who lived 5 kilometers away.

Majority ($n=160$) of the respondents chose public hospitals for their delivery, while others, ($n=68$) chose private hospitals. The study showed that women were of the view that long waiting time at the public hospital is a factor that would determine whether a woman delivered at the hospital or not. This implies there is a concern over long queues at the hospital and which could discourage expectant women from choosing to deliver at the hospital. This suggests that queue management is important in improving the attendance of women at a public facility. A study in Ghana by Afrane and Appah (2014) premised on the fact that queuing is a major global challenge for healthcare services and more acute in the developing countries established that applying queuing theory and modelling to queuing and capacity challenges could enhance decision making with regards to what will provide optimal performance. According to Mathai (2011) waiting time is a crucial factor in government institution that take up more than 1 ½ hours in Government government institution in Kenya.

The study further revealed that a few respondents agreed that women avoid delivering at the public hospital because there is no privacy. Since p-value ($\chi^2 = 31.401$, $df=8$, $p<0.001$) is less than the chosen value of significance ($p=0.05$), there is enough evidence to suggest a significant association between lack of privacy in the public health facilities and choice of place of delivery. This shows almost half of women are conscious of the fact that there is not enough privacy at the general hospital and this could contribute to their choice of place of delivery. This could discourage expectant women from visiting public hospitals to deliver. It further implies that boosting privacy at Nyahururu hospital could enable more women to choose it for their delivery. These findings collaborate Coxon (2014) who reported that expectant mothers cited lack of privacy at a vulnerable time as a reason for avoiding to birth in a hospital.

The study further revealed that majority of women were not of the opinion that possibility of being abandoned by doctors and midwives during labor was a reason they chose to deliver at home. Since p-value $\chi^2 = 16.534$, $df=8$, $p=0.035$ This means the influence of possible abandonment was not a major determinant to choice. This contrasts an almost similar report by Abebe, Berhane and Girma (2012) that showed that an attitude of superiority by HCW, diminished authority during birth, failure to get responses to their questions and separation of baby and mother are factors that could lead to option of giving birth at home. This is further strengthened by the study findings that revealed that more than half of respondents thought that nurses and doctors at the public hospitals provide better care than their counterparts in the private hospitals. There is enough evidence to suggest a significant association between better care from the and choice of place of delivery ($\chi^2 = 88.415$, $df=8$, $p<0.001$). This collaborates Yanagisawa (2015), in a study that showed that a consistent and comfortable experiences with birth attendants during ANC expectant mothers was an influencer to choosing of skilled attendance during delivery. This implies that services offered by doctors and nurses could determine choice of a place to deliver. It further suggests that respondents are conscious of how 'friendly' the health care givers are. The study findings agrees with findings from a study in Zambia that showed that expectant mothers failed to go to hospital during delivery because HCW at the clinic had unkind language while attending to them. This made them preferred attendants at home who were friendly, available and did not abandon them and their babies even after delivery (Sialubanje, Massar, & Ruiters, 2015).

Conclusions

Most women bear children when they are between ages 21 and 30. The significant demographic determinants to this, were age, (p-value $\chi^2 = 56.941$, $df=6$, $p<0.001$) and education (p-value $\chi^2 = 77.177$, $df=6$, $p<0.001$). Marital status (p-value $\chi^2 = 13.083$, $df=8$, $p=0.109$), and respondents occupation (p-value $\chi^2 = 19.764$, $df=10$, $p=0.032$) were not. Most are fairly educated and are married and these were seen to be determinants of choice of a place for delivery. They are also engaged in income generating activities, together with their husbands who also support them during pregnancy and delivery. The study revealed that other determinants of choice included spouse, religion, and number of times one has conceived before, number of previous births as well as the successful live births. Based on these findings therefore, the first hypothesis was rejected.

Cultural determinants that influenced the women's choice of a place to deliver mainly included the perceived influence of husbands and elderly women on women decision to deliver at the hospital. The others were cultural consideration that women who deliver at the hospital are not brave, cultural perception that complications and deaths at birth are brought by bad spirits, perceptions that birth positions at home are more comfortable than birth positions in the hospital, perception that women with normal pregnancy do not need to deliver in the hospital, perception that only God prevents complication and not the health worker, among several others.

The study revealed that major determinants related to the health facility were preference of company during delivery where many respondents, (86%) preferred company of specifically spouse and mother. This was significant; (p-value, $\chi^2 = 24.886$, $df=6$, $p<0.001$). Which however, does not happen at the health facilities, but may be happening when women deliver at home. Other health facility related determinants included distance covered by clients where 62.6% (n=166) of the respondents covered a distance < 5KM, 37.4% (n=99) covered >5km which 78% of those who delivered at home covered. This however, was not statistically, significant, (p-value, ($\chi^2 = 37.978$, $df=2$, $p<0.001$), although that the likelihood to choose to deliver at home increased with the likelihood of residing a distance of >5KM away from a health facility.. Women also avoided delivering at the public hospital because there was no privacy. Choice by women to deliver at home was as a result of fear of being abandoned by doctors and mid-wives at the hospital during labor. Based on this the second hypothesis was therefore rejected.

Recommendation

To address the social demographic determinants, policy makers in the health sector should support and promote access to education for the girl child across the entire age groups, with great emphasis to the sexual health in all curriculums. Enhanced economic empowerment for women will be a determinant of choice of hospitals as their place for delivery.

To address the cultural concerns, Nyahururu Hospital management team may consider achieving change of behavior and attitude among individual clients. There should be targeted health education on importance of hospital delivery using strategies responsive to specific ethnic communities, considering their cultural and religious practices in order to encourage delivery at the hospital. This is because generalized health messages may not work in this area due to the diversity demonstrated.

To address health facilities' determinants that prevented some clients from visiting them during delivery, the facilities may consider allowing preferred birth companions within the hospital setup as well as strategies that could allow an environment which favors more interactions between clients and HCW's. Male involvement coupled with elderly women opinions may improve labour and delivery experiences as found in this study. In addition, hospitals may enhance women's privacy and dignity, as well as also maintaining que management in order to reduce waiting time for services.

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