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Stephen Okumu Ombere

BACKGROUND: Birthing choices play significant roles in maternal outcomes. This article describes the birthing choices made by some women on Mageta Island (hereafter called simply "the Island") of Western Kenya in relation to Universal Health Coverage (UHC) and free maternity services (FMS) policy ideals. Kenya has officially rolled out UHC and has also initiated universal coverage of maternal healthcare services to reduce maternal morbidities and mortalities. In 2016, the government of Kenya expanded FMS, called the *Linda Mama* (Taking Care of the Mother) initiative, which targets all pregnant women, newborns, and infants by offering free maternal healthcare services. Despite the existence of UHC and FMS in Kenya, women living on the Island have no access to such services. They therefore devise mechanisms for accessing maternal healthcare services.

DESIGN: This study is based on an ethnographic design. Data were collected for 5 months using informal conversations, participant observation, and note-taking with mothers at their homes. The study included interviews with six pregnant mothers who were living on the Island at the time of our interviews.

DISCUSSION: It emerged that women relied on their agency to find alternatives to biomedical maternal healthcare services, despite the existence of UHC. Such alternatives included having traditional midwives attend their births in their own homes, migrating to the mainland for proper care, and using kin relations as alternatives for birthing beyond the Island. This article highlights how the implementation of the UHC policy might be tailored to specific local contexts, which could help avert maternal mortalities in hard-to-reach areas such as the Island.

KEYWORDS: birthing; free maternity services; medical anthropology; traditional midwives; universal health coverage

INTRODUCTION

> One day my cousin Angi went into labor. She was full-term, but when she reached the health facility, complications arose that the nurse in charge could not handle. She urgently suggested that we take Angi to the mainland. I called my cousin Anesis, who was on another beach, to help out with getting a boat for hire to the mainland. I waited anxiously, so worried, and the boat finally arrived an hour later. By this time, a storm had arisen and the waves on the lake were large and difficult to navigate. However, we had no choice but to navigate through the lake to the mainland. Because the lake was so rough, it took us 1.5 hours to get to the mainland. We then had to find a taxi

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> to take Angi to the nearest hospital, another 30–45 minutes' drive. Meanwhile, Angi was in terrible pain and stress and was terrified that she might lose the baby. There were only four of us: Angi, my cousin Anesis, me, and the boat driver. None of us knew what to do to help Angi. We could only empathize with and encourage her that all shall be well. On the mainland, Angi's sister was at the shore waiting for us with a taxi to take Angie to the hospital. When we arrived at the hospital, Angi was rushed to the emergency ward where two doctors attended to her. This experience ignited my urge to research maternal health on the Island, focusing on women's birthing choices.

This article is based on the findings from a qualitative study I conducted in 2023 that explored women's perceptions and experiences of maternal health care on Mageta Island (hereafter called simply "the Island"), Western Kenya. I investigated the cultural beliefs, practices, and experiences associated with pregnancy, birth, and the postpartum period in relation to the utilization of maternal healthcare services among women on the Island. The purpose of this article is to describe the factors that influence pregnant women's choice of place of delivery, their alternative access to maternal healthcare services, and how birthing alternatives are embedded in the islanders' cultural practices.

The shortcomings of the free maternity services (FMS), which were later expanded to the *Linda Mama* (Taking Care of the Mother) initiative in the public sector in Kenya, have been widely documented (Ombere et al., 2023; Orangi et al., 2021; Owuor et al., 2019; Wamalwa et al., 2015). Despite the fact that Kenya rolled out Universal Health Coverage (UHC) in 2019 and included FMS as a key component, remote rural areas considered to be "hard-to-reach zones" (Ministry of Health, 2020) have received little attention. While UHC should mean that all people have access to the full range of quality healthcare services they need, when and where they need them, and without financial hardship, the reality on the ground does not reach this ideal. In order to explore what actually happens in the so-called "hard-to-reach" areas, I conducted ethnographic research on the Island that focused on pregnant women's birthing choices.

The Island is a remote rural area of Kenya, accessible only by boat and approximately 10 km from mainland Kenya. The Island has only one public health facility (*kakamongo*), which serves the islanders and residents from neighboring islands in Uganda. Adjacent Magare Island and the uninhabited Sirigombe Island form Mageta location, which has a population of approximately 10,000 persons. It is adjacent to the islands of Wayasi, Siamulala, Hama, Siro, and Lolwe in Uganda. Mageta location has six fish landing beaches (where fishermen dock to sell fish), namely, Kuoyo, Magare, Mahanga, Mitundu, Sika, and Wakawaka (Ombere, 2021b; Ombere et al., 2015, 2018; Ombere & Nyambedha, 2023).

Island fishing communities like those on the Island are considered hard-to-reach, resource-limited settings due to accessibility challenges and rural locations (Ssetaala et al., 2020). Decisions on where to give birth, existing alternatives, and navigating those alternatives to access maternal health care are at the core of determining maternal healthcare outcomes on the Island. Despite global campaigns addressing maternal mortality and the rollout of UHC in Kenya, poor women in remote areas such as the Island are the least likely to receive timely health care and thus carry the burdens of maternal and perinatal mortalities that can result from childbirth complications (Shikuku et al., 2020).

My colleagues and I (Ombere et al., 2021) have argued that sociocultural factors play significant roles in pregnant women's expectations and choices during pregnancy and childbirth, as well as in how they plan to raise their children. Therefore, while pregnancy and childbirth are biological/physiological events, the experiences surrounding them are heavily socially shaped by cultural perceptions and practices (Davis-Floyd & Cheyney, 2019; Jordan, 1993; Kaphle et al., 2013; Rice, 1997). In this article, I argue that the social and cultural powers on the Island are what create the potential for diversity in motherhood, birth, beliefs, practices, and experiences. Jordan (1993:1) and Liamputtong (2005) argued that "the social meaning of birth is shaped by the society in which the birthing women live." This argument gives the island community a culturally meaningful way to explain any pregnancy or birth misfortunes. This article is also grounded in DeVries et al.'s (2001) arguments on birth. These authors stated that they viewed birth as "a physiological process with certain universal characteristics, which is at the same time an individual experience totally unique to each woman who experiences it and a profoundly significant cultural event, as the future of a society (still) depends on women giving

birth to babies who will grow up to perpetuate that society" (DeVries et al., 2001).

Women's decisions about how to give birth reflect the fundamental principles and culture of a society, offering insights into how specific societies perceive the world and into the roles and positions of women in those societies (Davis-Floyd, 2003, 2018; Davis-Floyd & Cheyney, 2019; Jordan, 1993). During pregnancy and childbirth, women in different sociocultural settings are confronted with many difficult choices (Ombere, 2021b; Ombere et al., 2021). Choices that go awry and systemic disparities often result in unfavorable outcomes for expectant mothers and their babies, which are common in low-income countries (Emelumadu et al., 2014). Cultural practices and beliefs are commonly implicated in determining the care received by mothers during pregnancy and childbirth, which is an essential determinant of maternal mortality (Emelumadu et al., 2014). Therefore, understanding of local beliefs and practices regarding health issues such as pregnancy is imperative for ensuring high-quality care and positive health outcomes for both the client and the service provider (Ngomane & Mulaudzi, 2012).

Women in geographically isolated places such as the island fishing communities on Lake Victoria may be at increased risk of maternal death due to inadequate or no provision of care during antenatal care visits. However, despite the varying contexts and as previously mentioned, childbirth is significantly influenced by women's cultural perceptions, beliefs, expectations, fears, and cultural practices. Scholars such as Davis-Floyd (2003, 2022) and Jordan (1993) have long noted that the cultural context in which birth occurs provides norms that influence attitudes, values, and personal and interpersonal experiences. On the Island, just as in other hard-to-reach areas, the birthing process entails decision-making about where to give birth depending on the number of children born, diet, and other factors that can contribute to successful deliveries.

Maternal mortality has long been and remains a global public health challenge; current statistics indicate a lag in its improvement (World Health Organization [WHO], 2023). Although remarkable progress and improvements have been observed in maternal mortality reduction, the global maternal mortality ratio is still unacceptably high. In 2020, approximately 287,000 women died during and following pregnancy and childbirth. In that same year, almost 95% of all maternal deaths occurred in low- and low-to-middle-income countries and most could have been prevented (WHO, 2023). Maternal and newborn health is of paramount importance in the realm of attaining sustainable development goals (SDGs) that also focus on UHC (Chowdhury et al., 2022). The SDGs set ambitious targets to reduce maternal and neonatal mortalities to less than 70 per 100,000 live births (target 3.1) and to end the preventable deaths of neonates and of children under 5 years of age (target 3.2) by 2030 (Callister & Edwards, 2017; WHO, 2018).

In Kenya, there are inequalities in the uptake of maternal healthcare services, despite the June 2013 introduction of FMS, which boosted the number of hospital births, averted catastrophic healthcare expenses, and ensured rightful access to maternal healthcare services for all mothers, including those from vulnerable populations (Kenya National Bureau of Statistics (KNBS), Ministry of Health/Kenya, National AIDS Control Council/Kenya, Kenya Medical Research Institute, & National Council for Population and Development/Kenya, 2015). After the implementation of the FMS policy, there was an increase from 44% facility-based deliveries, in 2008, to 61% in 2015 and an increase in births attended by skilled biomedical practitioners (KNBS, Ministry of Health/Kenya, National AIDS Control Council/Kenya, Kenya Medical Research Institute, & National Council for Population and Development/Kenya, 2015). Despite this increase in facility deliveries and the high demand for FMS, studies have highlighted the need to reduce barriers to access and utilization of FMS to improve maternal health outcomes (Gitobu et al., 2018; Lang'at et al., 2019; Lee et al., 2016; McKinnon et al., 2015; Okungu et al., 2017; Pyone et al., 2017). However, these studies have not examined access to maternal healthcare services in hard-to-reach rural areas such as the Island. This article seeks to extend the literature on birth choices and the alternative utilizations of maternal healthcare services and access in hard-to-reach areas by focusing on alternatives to biomedical births on the Island in Western Kenya. This study is unique in several respects. To the best of my knowledge, this is the first anthropological study on birthing choices on the Island. For this study, I utilized primary anthropological qualitative data collection methods rather than cross-sectional data from population surveys.

METHODS

Study Setting and Study Design

As previously noted, this study was conducted on the Island, which is the largest island (at some 7 km^2) on Lake Victoria in Western Kenya. The Island is part of Mageta location, which includes the islands of Magare and uninhabited Sirigombe. As also previously noted, the location as a whole has a population of approximately 10,000 but Mageta's population fluctuates due to migration to and from the Island with people looking for economic opportunities (Ombere et al., 2015). Most people live in small villages, and fishing is the primary source of employment. There are six fish landing beaches, each linked to a village where my study participants lived: Kuoyo, Magare, Mahanga, Mitundu, Sika, and Wakawaka (Ombere, 2021b; Ombere et al., 2015, 2018). There are also small-scale trade and subsistence farming communities. The Island has no electricity, and the primary means of transport is motorbike.

The prevalence of HIV and AIDS in Mageta location is 24.8%, approximately five times the national rate of 4.9% (National AIDS Control Council, 2018). Maternal and infant mortalities on the Island exceed the national average by 42%, and half of these deaths occur postpartum (KNBS, Ministry of Health/Kenya, National AIDS Control Council/Kenya, Kenya Medical Research Institute, & National Council for Population and Development/Kenya, 2015). The Island has only one public health facility, which serves the islanders as well as residents from the nearby islands of Wayasi, Siamulala, Hama, Siro, and Lolwe in Uganda. There are no ambulances on the Island, and in case of any health emergencies, residents have to hire a motorboat to go to the mainland for timely treatment (Gwengi, 2016). While this may seem simple, it is in fact a precarious procedure, as the story of one of my study participants, Doli, illustrates.

Doli was 8 months pregnant when she developed complications and the health facility on the Island could not assist her. The nurse who was in charge of the health facility wrote a referral letter to the mainland hospital for Doli. Because the health facility did not have a water ambulance, she and her family members had to urgently get a means of transport to the mainland. Additionally, as the nurse told Doli, the health facility could not hire a boat to the mainland for her due to the inadequacy of its emergency funds. She told me how difficult it was to get a boat to instantly take her to the mainland. Though she did ultimately manage to get to the mainland, it was a horrific experience for her.

My Ethnographic Fieldwork. I was born on the mainland but spent most of my holidays with my grandparents on the Island. I still have many relatives there whom I visit regularly. Over the years, I noticed that, despite the fact that the government had rolled out UHC, women on the Island were still giving birth at home or, to give birth in a hospital, they had to migrate to the mainland well before their due dates and live with close relatives for many months—or they tried to give birth in the health facility, but as soon as any complications arose, they had to go to the nearest hospital on the mainland (as in the case of Angi, which was described in the introduction to this article). My deep connection to the Island placed me in the ideal position to conduct research there. Over the years, I have conducted several research projects on the Island, including studies regarding COVID-19 vaccine sensitization, fishermen and sexual behavior, children's vulnerability to sexual abuse, and the uptake of modern family planning methods. It was therefore not difficult for me to conceptualize this research project and to gain access to interlocutors. I began formal fieldwork in June 2023, and this first phase comprised four visits to participants' homes on the Island. Between November and December 2023, I conducted more participant observations on the Island. My entry point was the health facility, where the nurse in charge introduced me to Banjo, the chairperson of the community health volunteers on the Island. With Banjo's help, I identified six expectant mothers who were willing to talk freely about their pregnancies. All six agreed to become research participants. Two lived in Kasi village, two in Mahenga, and two in Tundu.

During my four visits to the Island, I got to know these women and established rapport with them through informal conversations. I also used ethnographic fieldwork methods, including participant observation and field notes, for example, while conducting my study, I assisted the participants with their agricultural tasks or lent a hand when fetching water from the lake. These informal conversations were important, as they not only enabled me to build rapport but also helped the women feel relaxed so they could easily express themselves. Our conversations at the participants' homes entailed stories about reproduction, maternal healthcare choices, and their access to healthcare facilities on the Island. It soon became evident that these women's experiences of utilizing

maternal healthcare services on the Island varied greatly, depending on their bargaining powers and socioeconomic circumstances. My conversations with these six women covered many other topics as well, including the alternatives available to them regarding where to give birth and the impacts of their relatives' perceptions and levels of support for the choices they made regarding healthcare services. All the interviews were conducted in the local language, *Dholuo*, and were translated into English for the purpose of this article. I used thematic analysis to draw out the main themes from the data, which are explored in the following sections.

This study was approved by the National Commission for Science, Technology, and Innovation. I obtained ethical clearance from the Faculty of Humanities, University of Pretoria Research Ethics Committee, and from the Maseno University Ethics Review Committee. I also obtained permission to conduct the research from the Department of Health at Siaya County and from the local authorities. I obtained voluntary informed consent from all participants. Pseudonyms have been used throughout to protect the participants' anonymity.

FINDINGS

Meanings of Motherhood on the Island

On the Island, motherhood is one of the most important attributes that defines a married woman. Among the islanders, a woman's worth is tied to her performance of culturally defined reproductive and productive roles. Bride wealth payments are made while being mindful of these expectations. Though men are the sole decision-makers, women are held responsible for ensuring live births, which are supposed to adhere to local cultural beliefs. To successfully give birth to live babies on the Island, women have to employ their agency and devise protective measures to ensure the baby's health and safety. On the Island, a pregnant woman is considered vulnerable, both physically and socially. Therefore, there are norms and practices that are intended to offer protection to both the woman and the unborn baby. The woman thus must adhere to specific cultural beliefs about following the "right path" during pregnancy, which I have illustrated below. Nevertheless, pregnant women are not expected to neglect their domestic and productive work. During my fieldwork, I observed that women who had recently given birth continued with domestic chores. Such chores included the following: farming, going to the lakeshore in the early morning to purchase fish for business, fetching water, cooking for the family, and all other responsibilities that women have when they are not pregnant or recently postpartum. Pregnancy and motherhood are considered to be normal events, and the mother is only thought to be vulnerable at a particular time. The cultural expectation is that she will be fine after giving birth, and the mothers I talked with affirmed that pregnancy is not to be treated as a disease. They believe motherhood should be a sign of joy, not a slavery to culture.

A good example was provided by Adoyo, 33 years old and a mother of three children living in Mahenga beach. During our conversation at her home, she mentioned that being a mother adds to a woman's value in a family and legitimizes her marriage. However, she also mentioned that occasionally, she deviated from the societal expectations of food restrictions. She did not have any complications during birth. Adoyo stated the following:

> It is an obvious thing that when I give birth, my value is cemented in this family. The number of children and even the gender of the child gives me respect. My husband can listen to me. That is why I say that motherhood is not just what people see outside here. It includes so many things; some are expectations by the family members, and some are our expectations as mothers.

Doli, the previously mentioned 40-year-old pregnant mother, added that pregnancy has been treated as a sickness not only on the Island but also on the mainland. Pregnant women are not supposed to eat certain types of food. While we were walking together from the lake, she explained that, if the woman is not careful, pregnancy can make her sick and can even cause her to fail to do normal household chores. Doli elaborated the following:

> Sometimes I wonder what happens here. The moment you are pregnant, then you have some restrictions. Like now, there are foods I am not supposed to eat, I am not supposed to attend funerals, but even if I go, I am not supposed to go near the dead body. Here we have those practices, and they are meant to protect the

> mother and the unborn child. But the two children I have now, I did not follow what they told me. If you follow everything, then you can be a slave to your own pregnancy.

Adoyo and Doli's narratives depict cultural expectations about how women should deal with their pregnancies. Additionally, despite the still high home-birth rate on the Island, many births have become biomedicalized—a process by which human experiences or conditions come to be treated as illnesses or diseases on the Island and elsewhere. However, such medicalizations are embedded in the islanders' culture and are there to ensure that mothers understand what motherhood is because, as previously noted, it comes with specific cultural expectations.

Traditional Midwives as Birthing Options

On the Island, there are no maternity waiting homes. Locally, mothers consult traditional birth attendants (TBAs), also known as traditional midwives. I talked with a 45-year-old woman named Bonita, who was in her third trimester. She had previously given birth on the Island and was assisted by a TBA. Bonita mentioned to me that TBAs are officially not allowed to attend births; instead, they are supposed to refer pregnant women to the health facility. Nevertheless, according to Bonita, the TBAs on the Island do play critical roles during births. Bonita was able to mention the names of several women who had given birth at home with the help of a TBA. During my conversations with Bonita, I learned that the TBAs provide their services throughout the antenatal, birth, and postnatal periods. Their services are integrated in nature, ranging from what are believed to be magical abilities in aiding conception, to changing the baby's position in the womb, and to practical aspects of delivery, care, and management of postdelivery complications in culturally appropriate ways. Just as in other similar cultural contexts, pregnant women regularly visit the TBAs on the Island for belly massages and the administration of herbs. For instance, Bonita narrated to me the following:

> He paid my bride wealth after giving birth to our firstborn. It took me 10 years to give him a child. It was God's time. But I thank the traditional birth attendant, locally referred to as *Nyamrerua*, who has made me a mother. In hospitals on the mainland, they said I did not have a problem, but the TBA gave me herbal medicine for 5 consecutive months, and I conceived. You see how these TBAs are important to us. They play a big role in this motherhood thing. However, the community health volunteers discourage us from visiting TBAs. Anyway, it is a personal choice, and it was highly recommended by my mother-in-law.

At the time of the interviews, Nyomino, a 44-year-old mother with eight children, was expecting her ninth child. She had given birth to all her children on the Island. During our informal conversations, she mentioned that most women on the Island are acquainted with both the biomedical and the traditional healthcare systems. Nyomino told me that she preferred antenatal clinics and delivery services in the health facility. However, the Island's health facility had inadequate delivery beds, with only one nurse on duty at night. Nyomino said that she resorts to other options and that one of the best options for her and her friends was giving birth at home. She mentioned that the facility could not assist them when they had complications such as an obstructed labor. Although I did not talk with the healthcare providers, Nyomino mentioned that sometimes in the health facility, the matron calls for assistance from the TBAs in cases of obstructed labor. She narrated that

> I was assisted by a TBA. I had difficulties in giving birth. She was called by the matron to the health facility. She came in and touched my belly. I felt the baby moving in my stomach. The matron was there trying to tell the TBA what to do. The TBA was more experienced than the doctors of today. It did not take 20 minutes, the baby came, and I delivered. Were it not for her, then I tell you I could have died.

Nyomino added the following:

> I am not worried because I have been giving birth even without going to that hospital for assistance. Okay, that free maternity thing is only applicable in the mainland maybe. Here it is different. If they are unable to assist with complications, you have to hire a boat to

> the mainland. Yes, there is a tuk-tuk [a three-wheeled bicycle with an overhead roof] that takes pregnant mothers to deliver in the health facility. But when things become hard, then it is me and my family. If I cannot hire a boat to the mainland, I give birth at home, and my mother-in-law is an experienced traditional midwife.

These narrative excerpts mean that the informal engagements of the TBAs reflect how their expertise and knowledge of the birthing process are appreciated both by the mothers and by the healthcare providers. As previously noted, on the Island, the TBAs still provide comprehensive and consistent care during pregnancy, birth, and the postnatal period. They are trusted by the community and provide options for deliveries. They also cherish and facilitate the cultural practices that are related to birth and the birthing process. Nyomino explained that the advice given by healthcare providers in the hospital during delivery is often subject to a TBA's approval.

Relationships and Birthing Beyond the Island. Within and beyond the Island, there are relationships that go beyond blood ties and family networks. These relationships play important roles in supporting the mothers. Three mothers I spoke with reiterated that their relationships and their social networks went beyond the Island borders. Therefore, in some instances, pregnant mothers migrate to the mainland to stay with a close family friend or a relative until they give birth as a way of seeking care during birth beyond the Island's borders. Women reported valuing the additional social support provided by other members of the family and by the wider community during delivery. Mothers, mothers-in-law, other female relatives, neighbors, and occasionally spouses also provide advice and sometimes assistance during labor and birth.

Additionally, migrating husbands provide support to their pregnant wives. They call to find out how they are faring and send money for family use. However, Paulina, age 40, and Nancy, age 45, explained that when they moved to the mainland to give birth, their family members on the Island never bothered to find out what was going on and that this lack of contact was stressful for them. However, the relatives they stayed with on the mainland were very helpful. They delivered successfully and then returned to the Island. For example, Paulina told me "My husband is a fisherman, and they move from one beach to another. But am happy because he did send me money to buy cotton, baby clothes, and also food when I went to give birth at Usenge. It meant a lot to me."

DISCUSSION

This qualitative study has demonstrated that pregnant women on the Island utilized their agency to choose better options for giving birth. Thus, birthing choices among the pregnant women on the Island varied. According to Cheyney and Davis-Floyd (2022: 480), "Pregnancy is never an unmarked category; in every society, it is the occasion for special attention and specialized treatment in forms that vary widely" (see also Ivry, 2010). My ethnographic study has also demonstrated that the islanders' understandings of motherhood entailed a central agency that triggered choices that mothers resorted to so they could give birth on the Island instead of going to the mainland. Motherhood is a social reality that has existed since time immemorial. It is associated with women's reproductivity and with their sociocultural lives. As many anthropological studies, including this one, have shown, it determines the woman's status and her identity in her family and in the outer world. Cultural competence is a vital component of quality healthcare delivery. The islanders' ways of life are reflected in their knowledge of what ought to be done during, before, and after birth. This study has shown how the islanders depict "authoritative knowledge," which is rooted in the cultural beliefs that eventually motivate decisions and actions (Davis-Floyd, 2018; Jordan, 1993, 1997).

As the study findings show, maternal health outcomes reflect decisions about maternal health and well-being made at all levels within a nation (Anderson & Roberts, 2023). These decisions may result in both positive and negative outcomes. Additionally, such decisions are grounded in the moral foundations, history, traditions, and cultural values of a nation. In Africa, as elsewhere, how birth is experienced by a woman reflects the values of the society in which that birth occurs, as well as the value placed on the woman's individual beliefs (Esposito, 1999). Pregnancy and birth are biological phenomena that carry heavy cultural overlays, and pregnant and birthing women need care and attention during both ordinary and extraordinary times (Ali et al., 2021). My findings concur with those of other social scientists, especially anthropologists,

who have paid significant attention to this cultural marking and shaping of birth (Ali & Davis-Floyd, 2020; Davis-Floyd, 2018, 2022; Davis-Floyd & Cheyney, 2019; Davis-Floyd & Sargent, 1997; Ombere et al., 2021).

Despite the Kenyan government's provision of FMS in all public health facilities, pregnant women who do not wish to deliver their babies in underresourced health facilities like the one on the Island have to find alternatives for giving birth. Such alternative plans for access to successful deliveries are negotiated at different layers. For instance and as also previously explained, when pregnant women develop complications that the health facility cannot manage successfully, the alternatives on the Island are either to hire a boat to the mainland or to deliver at home with the assistance of a traditional midwife. In navigating and negotiating these alternatives, either the pregnant mother gives birth successfully or maternal mortality occurs. The birth outcomes depend on the alternatives chosen by different families. However, on most occasions and during such crises, traditional midwives/TBAs play critical roles in ensuring continuous access to culturally appropriate maternal healthcare services. Similarly, studies in Africa and in other contexts have shown that TBAs play critical roles in curbing maternal mortalities (Davis-Floyd & Sargent, 1997; Kassie et al., 2022; Ombere, 2021a; Ombere et al., 2021). Even though the efforts of TBAs are evident in their communities, as previously noted, they are not officially allowed to attend births. This fact is well documented in Kenya's healthcare policies (Byrne et al., 2016; Gitobu et al., 2018; Ombere, 2021b). Far too often, this devaluation of traditional midwives has resulted in the loss of their own self-confidence and of the former confidence of many of those who used to value and utilize their services (Ali et al., 2021; Ombere, 2021b, 2022). This study also established the relevance of kinship and of relationships in caring for mothers within and beyond the Island borders. Kinship fulfills many functions; caregiving is one of these. The flexibility and fluidity of relationships and of kinship networks as adaptive responses by families to disruptions have been well documented (Manderson & Block, 2016; Nyambedha et al., 2003). For this study, I use the definition of kinship: "[the] whole edifice of socially significant biological, genealogical, and conjugal ties, which every society constructs to order daily life, in the patterning of economic interdependence and patterns of coresidence." My study's findings on the relevance of kinship networks to care provision concur with those of Wallace et al. (2022) and Manderson and Block (2016). These researchers have argued that the willingness to care flows, in part, from the quality of affective relationships, which are essential in most kinship networks, whether affinal, consanguineal, or fictive. During the care that is provided by these kinship networks, the sociocultural customs and traditions surrounding birth are adhered to. Moreover, according to my interlocutors, their husbands still played critical roles in the provision of support, even when they were not with the mother at home or at the relative's residence. Studies have shown that husbands can play crucial roles during pregnancy and childbirth in decision-making about seeking appropriate healthcare services, especially in the patriarchal societies of many low-income countries (Othman et al., 2011; Wai et al., 2015). This study also showed that mothers whose husbands were present and helping, or away and helping, experienced less pressure while negotiating access to maternal healthcare services.

Strengths and Weaknesses

The main strength of this study is that it is the first anthropological study conducted on birth and birthing processes among expectant women on the Island, Western Kenya. It makes an important contribution to the research on this topic and provides first-hand accounts of what it means to give birth in hard-to-reach areas such as the islands in Western Kenya. Such accounts from mothers can feed into the Kenyan government's safe motherhood initiative. The participants might have exaggerated their responses; however, I countered this potential weakness through repeated interviews, participant observation, and informal conversations. Moreover, the findings cannot be generalized to Kenya as a whole; however, they might be applied to other similar islander communities in Western Kenya.

CONCLUSION

In this article, I have described the birthing choices made by some women who live on the Island. Through ethnographic fieldwork, I have demonstrated that, as elsewhere, women's experiences of childbirth on the Island are shaped by the wider sociocultural context in which they live. Throughout, my concern has been to bring my interlocutors' voices to the fore—to let these women's voices be heard. Thus, this study also explored the somatic aspects of birth as experienced and described by my study participants, showing that,

since a majority of mothers could not access biomedical birth services in the health facility, they used their agency to choose alternatives for birthing, such as TBAs, relationships extending beyond family or blood ties, and also migrating to the mainland to have access to better healthcare services. I found that, although the women whom I interviewed were aware of the availability of FMS, they needed to have alternatives for birthing because often, the Island health facility could not handle complicated pregnancies as effectively as the traditional midwives could. Some women's choice was to move to the mainland to stay with kin until they gave birth in a biomedical hospital where such complications could also be safely managed, although not in the culturally appropriate ways that the traditional midwives used.

In conclusion, the findings clearly demonstrate that the promotion of good maternal healthcare outcomes and the push for UHC on the Island require an understanding of the context in which the UHC policy is implemented. Moreover, the formal engagements of TBAs in healthcare systems in hard-to-reach areas, such as the Island, should be considered. If the high rates of maternal mortality on the Island are to be addressed, it is essential to have collaborative efforts from local institutions and groups, including the traditional midwives, and the support of spouses, family, and relatives. These women's experiences provide valuable insights into the flaws in the rollout of UHC in Kenya, which can be used to improve this national healthcare policy.

REFERENCES

Ali, I., & Davis-Floyd, R. (2020). The interplay of words and politics during COVID-19: Contextualizing the universal pandemic vocabulary. *Practicing Anthropology*, *42*(4), 20–24. https://doi.org/10.17730/0888-4552.42.4.20

Ali, I., Sadique, S., Ali, S., & Davis-Floyd, R. (2021). Birthing between the "traditional" and the "modern": *Dāī* Practices and childbearing women's choices during COVID-19 in Pakistan. *Frontiers in Sociology*, *6*, 622223. https://doi.org/10.3389/fsoc.2021.622223

Anderson, B. A., & Roberts, L. R. (2023). Global maternal and child health: Medical, anthropological, and public health perspectives. *Springer Nature*. https://doi.org/10.1007/978-3-031-23969-4

Byrne, A., Caulfield, T., Onyo, P., Nyagero, J., Morgan, A., Nduba, J., & Kermode, M. (2016). Community and provider perceptions of traditional and skilled birth attendants providing maternal health care for pastoralist communities in Kenya: A qualitative study. *BMC Pregnancy and Childbirth*, *16*(1), 43. https://doi.org/10.1186/s12884-016-0828-9

Callister, L. C., & Edwards, J. E. (2017). Sustainable development goals and the ongoing process of reducing maternal mortality. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *46*(3), e56–e64. https://doi.org/10.1016/j.jogn.2016.10.009

Cheyney, M., & Davis-Floyd, R. (2022). Rituals and rites of childbirth. In S. Han& C. Tomori (Eds.), *The routledge handbook of anthropology and reproduction* (pp. 480–493). Routledge. https://doi.org/10.4324/9781003216452-38

Chowdhury, M. A. K., Karim, F., Hasan, M. M., Ali, N. B., Khan, A. N. S., Siraj, M. S., Ahasan, S. M. M., & Hoque, D. M. E. (2022). Bottleneck analysis of maternal and newborn health services in hard-to-reach areas of Bangladesh using "TANAHASHI" framework': An explanatory mixed-method study. *PloS One*, *17*(5), e0268029. https://doi.org/10.1371/journal.pone.0268029

Davis-Floyd, R. (2003). Home-birth emergencies in the US and Mexico: The trouble with transport. *Social Science & Medicine*, *56*(9), 1911–1931. https://doi.org/10.1016/s0277-9536(02)00213-7

Davis-Floyd, R., & Cheyney, M. (Eds.). (2019). *Birth in eight cultures*. Waveland Press.

Davis-Floyd, R. (2003). Home-birth emergencies in the US and Mexico: The trouble with transport. *Social Science & Medicine (1982)*, *56*(9), 1911–1931. https://doi.org/10.1016/s0277-9536(02)00213-7

Davis-Floyd, R. (2022). *Birth as an American rite of passage* (3rd edn.). Routledge.

Davis-Floyd, R. E., & Sargent, C. F. (Eds.). (1997). Childbirth and authoritative knowledge: Cross-cultural perspectives. University of California Press. https://doi.org/10.1525/9780520918733

Davis-Floyd, R. (2018). Birthing practices. *The International Encyclopedia of Anthropology*, 1–7. https://doi.org/10.1002/9781118924396

DeVries, R., Wrede, S., Teijlingen, E. van, & Benoit, C. (Eds.). (2001). *Birth by design: Pregnany maternity care, and midwifery in north america and europe*. Routledge. https://doi.org/10.4324/9780203902400

Emelumadu, O., Ukegbu, A., Ezeama, N., Kanu, O., Ifeadike, C., & Onyeonoro, U. (2014). Socio-demographic determinants of maternal health-care service utilization among rural women in anambra state, South East Nigeria. *Annals of Medical and*

Health Sciences Research, *4*(3), 374–382. https://doi.org/10.4103/2141-9248.133463

Esposito, N. W. (1999). Marginalized women's comparisons of their hospital and freestanding birth center experiences: A contrast of inner-city birthing systems. *Health Care for Women International*, *20*(2), 111–126. https://doi.org/10.1080/073993399245827

Gitobu, C. M., Gichangi, P. B., & Mwanda, W. O. (2018). The effect of Kenya's free maternal health care policy on the utilization of health facility delivery services and maternal and neonatal mortality in public health facilities. *BMC Pregnancy and Childbirth*, *18*(1), 77. https://doi.org/10.1186/s12884-018-1708-2

Gwengi, I. (2016). No shortage of human activity on Mageta Island, the island that time forgot. https://www.standardmedia.co.ke/counties/article/2000194183/no-shortage-of-human-activity-on-mageta-island-the-island-that-time-forgot

Ivry, T. (2010). *Embodying culture: Pregnancy in Japan and Israel*. Rutgers University Press. https://doi.org/10.1111/j.1467-9566.2010.01253_5.x

Jordan, B. (1993). R. Davis-Floyd (Ed.), *Birth in four cultures: A cross-cultural investigation of childbirth in yucatan, holland, sweden and the united states* (4th ed.). Waveland Press.

Jordan, B. (1997). Authoritative knowledge and its construction [Eds. Davis-Floyd, R, E., Sargent, CF]. In *In childbirth and authoritative knowledge: cross-cultural perspectives* (pp. 55–79). University of California Press. https://doi.org/10.1525/9780520918733-003

Kaphle, S., Hancock, H., & Newman, L. A. (2013). Childbirth traditions and cultural perceptions of safety in Nepal: Critical spaces to ensure the survival of mothers and newborns in remote mountain villages. *Midwifery*, *29*(10), 1173–1181. https://doi.org/10.1016/j.midw.2013.06.002

Kassie, A., Wale, A., Girma, D., Amsalu, H., & Yechale, M. (2022). The role of traditional birth attendants and problem of integration with health facilities in remote rural community of West Omo Zone 2021: Exploratory qualitative study. *BMC Pregnancy and Childbirth*, *22*(1), 425. https://doi.org/10.1186/s12884-022-04753-5

Kenya National Bureau of Statistics (KNBS), Ministry of Health/Kenya, National AIDS Control Council/Kenya, Kenya Medical Research Institute, & National Council for Population and Development/Kenya. (2015). Kenya Demographic and Health Survey 2014.

Lang'at, E., Mwanri, L., & Temmerman, M. (2019). Effects of implementing free maternity service policy in Kenya: an interrupted time series analysis. *BMC Health Services Research*, *19*(1), 645. https://doi.org/10.1186/s12913-019-4462-x

Lee, E., Madhavan, S., & Bauhoff, S. (2016). Levels and variations in the quality of facility-based antenatal care in Kenya: evidence from the 2010 service provision assessment. *Health Policy and Planning*, *31*(6), 777–784. https://doi.org/10.1093/heapol/czv132

Liamputtong, P. (2005). Birth and social class: Northern thai women's lived experiences of caesarean and vaginal birth. *Sociology of Health & Illness*, *27*(2), 243–270. https://doi.org/10.1111/j.1467-9566.2005.00441.x

Manderson, L., & Block, E. (2016). Relatedness and care in Southern Africa and beyond. *Social Dynamics*, *42*(2), 205–217. https://doi.org/10.1080/02533952.2016.1218139

McKinnon, B., Harper, S., & Kaufman, J. S. (2015). Who benefits from removing user fees for facility-based delivery services? Evidence on socioeconomic differences from Ghana, Senegal and Sierra Leone. *Social Science & Medicine (1982)*, *135*, 117–123. https://doi.org/10.1016/j.socscimed.2015.05.003

Ministry of Health. (2020). Kenya community health policy 2020 - 2030 [Nairobi: Ministry of Health, Kenya].

National AIDS Control Council. (2018). Kenya HIV estimates report 2018. *Kenya HIV Estimates*, 1–28. https://doi.org/10.1111/j.1365-2664.2007.0

Ngomane, S., & Mulaudzi, F. M. (2012). Indigenous beliefs and practices that influence the delayed attendance of antenatal clinics by women in the Bohlabelo district in Limpopo, South Africa. *Midwifery*, *28*(1), 30–38. https://doi.org/10.1016/j.midw.2010.11.002

Nyambedha, E. O., Wandibba, S., & Aagaard-Hansen, J. (2003). Changing patterns of orphan care due to the HIV epidemic in western Kenya. *Social Science & Medicine (1982)*, *57*(2), 301–311. https://doi.org/10.1016/s0277-9536(02)00359-3

Okungu, V., Chuma, J., & McIntyre, D. (2017). The cost of free health care for all Kenyans: Assessing the financial sustainability of contributory and non-contributory financing mechanisms. *International Journal for Equity in Health*, *16*(1), 39. https://doi.org/10.1186/s12939-017-0535-9

Ombere, S. O. (2021a). Access to maternal health services during the COVID-19 pandemic: Experiences of indigent mothers and health care providers in Kilifi County, Kenya. *Frontiers in Sociology*, *6*, 613042. https://doi.org/10.3389/fsoc.2021.613042

Ombere, S. O. (2021b). Men's emic perspectives on factors contributing to child sexual abuse vulnerability on the Islands of Western Kenya. *African Studies*, *80*(1), 95–

110. https://doi.org/10.1080/00020184.2021.1892476

Ombere, S. (2022). Negotiating access to maternal health services during COVID-19 pandemic in Kilifi County, Kenya: Rapid qualitative study. In S. Roy & D. Nandy (Eds.), *Understanding post-COVID-19 social and cultural realities: global context* (1st ed., pp. 123–136). Springer Nature. https://doi.org/10.1007/978-981-19-0809-5_7

Ombere, S., Haller, T., & Nyambedha, E. (2021). Cultural practices during pregnancy and birth among the giriama community in coastal Kenya: A qualitative study. *International Journal of Childbirth*, *11*(4), 154–165. https://doi.org/10.1891/IJC-2021-0008

Ombere, S. O., & Nyambedha, E. O. (2023). Non-adherence to antiretroviral treatment among migrating fishermen in western Kenya's islands: A rapid qualitative study. *African Journal of AIDS Research*, *22*(3), 237–243. https://doi.org/10.2989/16085906.2023.2276375

Ombere, S. O., Nyambedha, E. O., & Bukachi, S. A. (2015). Wimbo: Implications for risk of HIV infection among circumcised fishermen in Western Kenya. *Culture, Health & Sexuality*, *17*(9), 1147–1154. https://doi.org/10.1080/13691058.2015.1018949

Ombere, S. O., Nyambedha, E. O., Haller, T., & Merten, S. (2023). Local perspectives on policy implementation of free maternity health services in Kenya: Implications for universal health coverage. *African Journal of Reproductive Health*, *27*(5s), 71–81. https://doi.org/10.29063/ajrh2023/v27i5s.9

Ombere, S. O., Nyambedha, E. O., & Bukachi, S. A. (2018). Sex in the green lodging: The voices of medically circumcised fishermen on the shores of lake victoria, Western Kenya. *AIDS Clinical Research and STDs*, *5*(1), 1–6. https://doi.org/10.24966/ACRS-7370/100018

Orangi, S., Kairu, A., Ondera, J., Mbuthia, B., Koduah, A., Oyugi, B., Ravishankar, N., & Barasa, E. (2021). Examining the implementation of the Linda Mama free maternity program in Kenya. *The International Journal of Health Planning and Management*, *36*(6), 2277–2296. https://doi.org/10.1002/hpm.3298

Othman, K., Kaye, D. K., & Osinde, M. O. (2011). Male involvement in birth preparedness and complication readiness for emergency obstetric referrals in rural Uganda. *Reproductive Health*, *8*(1), 1–7. https://doi.org/10.1186/1742-4755-8-12

Owuor, H. O., Asito, S. A., & Adoka, S. O. (2019). The differential effect of the free maternity services policy in Kenya. *African Journal of Primary Health Care & Family Medicine*, *11*(1), e1–e6. https://doi.org/10.4102/phcfm.v11i1.1887

Pyone, T., Smith, H., & van den Broek, N. (2017). Implementation of the free maternity services policy and its implications for health system governance in Kenya. *BMJ Global Health*, *2*(4), e000249. https://doi.org/10.1136/bmjgh-2016-000249

Rice, P. L. (1997). Giving birth in a new home: Childbirth traditions and the experience of motherhood among Hmong women from Laos. *Asian Studies Review*, *20*(3), 133–148. https://doi.org/10.1080/03147539708713131

Shikuku, D. N., Tanui, G., Wabomba, M., Wanjala, D., Friday, J., Peru, T., Atamba, E., & Sisimwo, K. (2020). The effect of the community midwifery model on maternal and newborn health service utilization and outcomes in Busia County of Kenya: A quasi-experimental study. *BMC Pregnancy and Childbirth*, *20*(1), 708. https://doi.org/10.1186/s12884-020-03405-w

Ssetaala, A., Nabawanuka, J., Matovu, G., Nakiragga, N., Namugga, J., Nalubega, P., Kaluuma, H. L., Chinyenze, K., Perehudoff, K., Michielsen, K., Bagaya, B., Price, M., Kiwanuka, N., & Degomme, O. (2020). Components of antenatal care received by women in fishing communities on Lake Victoria, Uganda; A cross sectional survey. *BMC Health Services Research*, *20*(1), 901. https://doi.org/10.1186/s12913-020-05739-9

Wai, K. M., Shibanuma, A., Oo, N. N., Fillman, T. J., Saw, Y. M., & Jimba, M. (2015). Are husbands involving in their spouses' utilization of maternal care services?: A cross-sectional study in Yangon, Myanmar. *PloS ONE*, *10*(12), e0144135. https://doi.org/10.1371/journal.pone.0144135

Wallace, L., Macdonald, M., & Storeng, K. (Eds.). (2022). Global maternal and child health: Medical, anthropological, and public health perspectives. *Springer*. https://doi.org/10.1007/978-3-030-84514-8

Wamalwa, E., Osuga, B., & Adoyo, M. (2015). Implementation of free maternity services policy in Kenya: Health workers' attitude and involvement. *The Pan African Medical Journal*, 5986240–5986251. https://doi.org/10.11604/pamj.2015.22.375.6708

World Health Organization (WHO). (2018). Sustainable Development Goals (SDGs). https://www.who.int/health-topics/sustainable-development-goals#tab=tab_2

World Health Organization (WHO). 2023. "Maternal mortality." https://www.who.int/news-room/fact-sheets/detail/maternal-mortality

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