

# Caring After Birth: Exploring The Realities of Post-Natal Care for Mothers and Infants in Nyakach, Kisumu County

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Submitted: 08 January 2026 Accepted: 19 January 2026 Published: 26 January 2026

**Citation:** Otieno, B., Oloo, F., Doyle, S., & Oguttu, M. (2026). Caring After Birth: Exploring The Realities of Post-Natal Care for Mothers and Infants in Nyakach, Kisumu County. *J of Clini Epi & Public Health*, 4(1), 01-08.

## Abstract

Postnatal care (PNC) is a critical but often neglected component of maternal and newborn health services, especially in low-resource settings like Nyakach sub-county in Kisumu County, Kenya. Despite evidence that many maternal and neonatal deaths occur within 42 days after birth – and notably within the first week—PNC coverage and quality remain inadequate. This qualitative study aimed to explore the realities of PNC utilization in Nyakach subcounty, highlighting community level factors associated with uptake and document strategies to improve practice. Data was collected through follow-up surveys with 95 postnatal women, and 23 focus group discussions involving 460 postnatal women across 15 community units. Thematic analysis revealed low utilization of PNC services and disparities in service content despite high (98 pc) facility-based deliveries. Only 77pc of women received PNC information before discharge. Information was often provided in technical language that limited comprehension. Cultural practices, including postpartum seclusion, reliance on traditional birth attendants, coupled with socio-economic constraints such as financial barriers, poor transport infrastructure, and gender power dynamics, significantly impeded timely PNC uptake. Negative experiences with healthcare workers and fragmented service delivery further discouraged follow-up visits. Mental health support and danger sign awareness were notably deficient. The role of community health providers emerged as vital in bridging access gaps, providing home-based education, counseling, and follow-up. Nonetheless, systemic challenges such as understaffed facilities, inadequate training, poor integration of services, and weak referral systems persist. The study underscores the need for comprehensive strategies to improve both supply and demand aspects of PNC by strengthening health facility capacity, enhancing community health worker skills, improving communication of health information tailored to local contexts, and addressing socio-cultural barriers. Targeted interventions should particularly focus on younger mothers and remote areas to advance equitable access. Strengthening community engagement and leveraging social networks can promote culturally sensitive PNC practices, ultimately contributing toward improved maternal and neonatal health outcomes and progress toward Sustainable Development Goal 3 in Kisumu County and similar settings.

**Keywords:** Post Natal Care, Community Post Natal Care, Rural healthcare, Postpartum Care.

## Introduction

Care after birth is a crucial part of health services for mothers and their newborns, however, it is often overlooked or least prioritized in the pregnancy continuum of care [1, 2]. According to World Health Organization (WHO), most postnatal maternal and neonatal deaths occur during the first 42 days after childbirth, with a significant number taking place within the first week [3]. Specifically, around 48.9% of postpartum maternal deaths hap-

pen on the first day, 24.5% between days 2 and 7, and 24.9% between days 8 and 42. Nearly half of postnatal maternal deaths occur within the first 24 hours, and 66% occur during the first week. For neonates, 75% of all neonatal deaths happen during the first week of life, with about 1 million newborns dying within the first 24 hours [4, 5]. Yet globally only about 3 in 10 women and babies receive any form of post-natal checkup in the critical first days after birth [6]. Uptake of services in low- and

middle-income countries remains highly inequitable and varies markedly with socioeconomic status, weak health systems, cultural barriers, and a lack of awareness [7].

Numerous studies emphasize the critical importance of effective postnatal care (PNC) in improving health outcomes for both mothers and their infants. Studies by Titalay and Bhutta highlight that early and regular postnatal visits, particularly when delivered by skilled healthcare providers and reinforced through community-based interventions substantially reduce health risks during the postpartum period [8-10]. Proper postnatal support facilitates the adoption of beneficial health practices, including adequate nutrition, routine health assessments, and emotional support, which collectively enhance child well-being [11, 12]. These findings underscore the potential impact of PNC in providing infants with a strong foundation for healthy development. Nonetheless, in contexts such as Kenya, the postpartum period remains inadequately addressed, constituting the most neglected phase in neonatal care [13, 14]. While significant improvements have been made, the Kenya Demographic and Health Surveys (KDHS) have shown that postnatal care (PNC) access remains inconsistent. The 2022 survey indicates 53% of women received a check-up within 48 hours with key barriers to utilization being those commonly reported in previous studies from sub-Saharan Africa: late first postnatal check-ups around six weeks, non-comprehensive services especially for newborn, financial constraints, logistical challenges such as distance and transport issues inadequate staffing and infrastructure in health facility early discharge without adequate education, and socio-economic factors like unemployment and low income further compound the problem [15-21].

Similarly, PNC in Kisumu County remains a critical component of maternal and neonatal health services. Despite significant strides in reducing maternal mortality by approximately 30% over recent years postnatal care services are still characterized by low utilization, service fragmentation and remain suboptimal with many women not receiving timely and adequate postpartum follow-up [22]. Historically, postnatal care has been neglected in Kisumu. A 2014 survey reported that more

postnatal maternal deaths occurred in Kisumu than in all but six of Kenya's forty-seven counties. Both maternal mortality– 343 per 100,000 live births – and child mortality– 39 per 1,000 live births – remain high today, with about a third of maternal deaths occurring postnatally [23]. Factors such as low skilled birth attendance, disjointed service delivery, rough terrain, long distances to health facilities, entrenched cultural practices and climatic shocks (floods and extreme heat) that discourage early postnatal movement contribute to the gap.

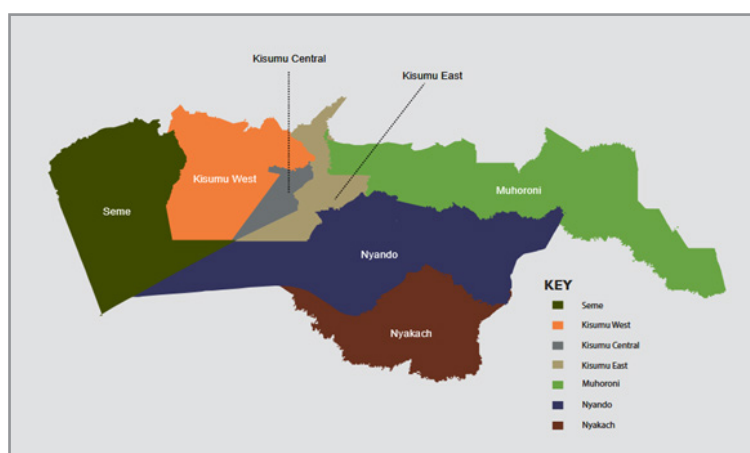
While there have been significant strides in enhancing postnatal care through professionalizing community health workers improved health facility delivery rates, targeted provider training, continued focus on increasing postnatal care utilization and comprehensive service provision remains critical to further improve maternal and newborn health in the region towards attainment of Sustainable Development Goal 3 [24, 25]. This qualitative study aimed to explore the realities of post-natal care utilization in Nyakach subcounty, highlighting community level factors associated with uptake and document strategies to improve practice.

## Methodology Overview

### Study Design and Setting

This was an exploratory qualitative study using a phenomenological design to explore the experiences of postnatal women with PNC services and identify barriers and facilitators influencing PNC utilization. Data was captured from two distinct sources: follow-up surveys administered to randomly selected postnatal women to document their experiences with PNC; and focus group discussions (FGDs) with postnatal women to capture their perspective on factors associated with PNC uptake and quality. This multi-method data collection strategy enabled a comprehensive, contextually grounded understanding of factors shaping utilization of PNC services.

The study was conducted in Nyakach sub-county, a largely rural setting in Kisumu County. Kisumu has a neonatal mortality rate of 21 deaths per 1000 live births, a skilled delivery rate of 98%, an under-five mortality rate of 45 deaths per 1000 live births, and a maternal mortality ratio of 343 deaths per 100 000 live births.



**Figure 1:** Geographical depiction of Nyakach Sub-county

Nyakach sub-county was intentionally chosen in partnership with the County Health Management Teams (CHMT) because of its notably poor performance in maternal and neonatal health indicators. The area is marked by a higher number (36 pc) of home

deliveries within the County, elevated community based maternal and neonatal deaths, and low PNC uptake. Furthermore, unlike other sub-counties, Nyakach has fewer collaborative initiatives between non-governmental organizations (NGOs) and the

government aimed at strengthening the local community health system (CHS) through capacity building and enhancing access to health information.

### Sampling Design and Participants

The findings reported in this study are derived from an MNH Impact project conducted between February 2024 and May 2025, aimed at elucidating the complex social and cultural determinants of maternal and neonatal mortality. This project involved a collaboration between Kisumu Medical and Education Trust (KMET), the University of Leeds (UK), and the Department of Health, Kisumu. Together, they facilitated training for community health volunteers (CHVs), implemented targeted PNC outreach activities, conducted community dialogue sessions, and undertook data collection alongside reproduction of job aids.

Follow-up surveys were administered to 95 postnatal women who had delivered within two months prior to project implementation. Eligible participants were identified from facility delivery records – covering births that occurred between February and March 2024 and January to February 2025 – and drawn from seven health facilities in five wards. Participants were randomly selected. Postnatal women with cognitive impairments, referrals from outside the target community units, and without consent/assent were excluded from the study. Data collected during follow-up interviews comprised demographic characteristics and detailed postnatal care experience across various domains: essential newborn care, support for exclusive breastfeeding, maternal health assessment (including anemia prevention and management), infection screening and treatment, mental health services, family planning, contraception counseling, and overall postnatal support.

In addition, a total of 23 focus group discussions (FGDs) involving 460 postnatal women were held across 15 community units where outreaches and dialogue interventions were implemented. Thematic analysis was used to identify, analyze, and interpret patterns or themes within the data. The analysis process involved familiarization with the data, coding, generating themes, reviewing and defining themes, and finally reporting the findings. The approach was preferred as it supports identification of nuanced insights into reported data sets, providing a structured yet adaptable way to understand participants' experiences, perspectives, and behaviors.

### Key Findings and Themes

A majority (33.7pc) of respondents were between 20-24 years, married, and in self-employment. Many had low parity with normal vaginal delivery. Spouses/partners were largely engaged in wage employment. Coverage of postnatal visits was inequitable with disparities in levels of knowledge and participation across different areas, health facilities, and age groups. Information on PNC services was inconsistently provided. While 98pc of women had delivered in a facility, only 77pc received PNC information before discharge. Some women reported receiving minimal or no guidance upon discharge, with some encountering unfriendly or dismissive attitudes from healthcare providers. These negative experiences discouraged return visits and impeded effective PNC delivery. Reported knowledge of PNC varied substantially across the five wards, from 50pc to 73pc, further highlighting the inconsistency in provision. The main sources

of PNC information mentioned were healthcare workers, community health providers, local media (radio and television) and social networks (matriarchal women, female relatives and traditional birth attendant). However, many women reported that the information was mainly available in English and frequently communicated using technical terms. These presented a major obstacle to transmission and reception of information. As a result, many turned to elder females or traditional birth attendants who 'have more understanding', communicate comprehensibly, and seemed more caring.

The majority (86.7pc) reported having accessed at least one postnatal visit at community level (within first two weeks of delivery) and 77pc at facility level (within 2 days of delivery). Some women made frequent use of facility-based PNC service. While engagement is widespread, the range of services provided is limited. FP Counselling, Immunization, Growth monitoring and general neonatal assessments were the common services received during the visits. Many (36 pc) women delayed attending PNC for more than four weeks. The main reasons for delaying PNC visits included lack of information, financial constraints, poor health seeking behavior, fear of harsh treatment from healthcare workers, climatic shocks and geographical distance. "I lacked transport (fare) that could take me back to the hospital...so I chose to use the little money I get to feed myself and my children." – Survey2024/03/014

"...I was with my husband. We waited and waited and waited at the facility to be seen by the 'doctor' (nurse). There was only one staff with many people waiting to be seen..." – FGD 23/114/24

In a few cases, new mothers reported being required to remain indoors for weeks (up to 40 days) after delivery in fulfillment of religious doctrines.

"In my church, a postnatal woman must stay indoors for 40 days or until the baby's skin lightness disappears, that's when you get out (local phrase used: 'kano nyathi')". – FGD010/128/24

Several women also reported that they did not come back to the clinic post-delivery for scheduled check-ups because they did not feel sick. One mother explained, "I was feeling well, so I didn't see the need to go back to the hospital."

– Survey 2024/04/001

Some women were discouraged by spousal/male partners or mothers-in-law from taking time away from their duties to attend a postnatal check-up,

"If it is a matter of giving birth you have already done so. What is this business of you going to the health facility every other time?" – FGD14/038/24

"I always ask my husband first ... then he asks what his mother thinks. After that, we would do what his mother says ..." – FGD08/002/24

Women whose babies had died on delivery (still births) reported not receiving any PNC services. Other reasons for non-engage-

ment included negative experiences with healthcare providers and lack of information on return dates.

Identification by clinical staff of conditions requiring additional care and counselling e.g. danger signs, nutrition support, incidences of intimate partner violence and mental health issues was weak and often missed. Only 4pc of women reported receiving mental health information with specifically, with 5pc of women mentioning receiving information about post-partum depression at or before discharge. However, a higher proportion of women (11pc) reported having experienced postpartum mental health issues than had received any pre-discharge information about such problems. Fifty-two per cent of women reported experiencing post-natal complications, a few of which were potentially very serious. Complications occurred mainly (59%) in the first week after delivery. Forty-five percent of women reported not having received any guidance on danger signs/post-delivery complications. Knowledge of danger signs among postnatal women surveyed was very narrow however, suggesting that health information transmission was limited in range and effectiveness. Fewer than ten percent of women identified common danger signs such as fits, smelly vaginal discharge, perineal infection, or leaking urine. Common complications reported were severe fever, headache, high blood pressure and infections such as urinary tract infection (UTI) and fungal infection. Most women did not have clear information on what to do when complications emerge.

Many women (91.1pc) reported having heard of postpartum family planning (PPFP). However, uptake was low. Key barriers to PPFP uptake were finances (some facilities charged for services) and unclear messaging on the service. These disparities highlight the need for targeted educational and resource-based interventions. On postnatal support, many women reported they received limited to no support at home after delivery. They were expected to resume duties including housework and farming.

“After giving birth my mother-in-law expected me to continue with the cleaning, cooking, farm work and when I took time to rest and sleep, she said I was lazy. This made me so tired, and it was difficult to attend postnatal care” – FGD016/311/24

Maternal relations (own mother, sister, aunt) were cited as the main source of postnatal support followed closely by spouse/male partner and other older children. Support was largely on childcare, house chores, financial and spiritual matters.

“When I gave birth, my mother came over to help with the baby” – Survey 2024/56/16.

“...my husband helped me a lot, he cleaned the house, cooked, took care of the children...”-

Survey 2024/002/22.

A few women also mentioned medical care/support especially from community health providers.

“Mama Grace (CHP) came and helped me with the baby’s cord and showed me how to breastfeed. After this, I was good.” – FGD15/22/24.

The effect of gambling/ sports betting was also highlighted by the women. Some women mentioned betting as an emerging

trend affecting the level of support received during postpartum phase. Postnatal women accused their partners of using the limited available resources i.e. time and money to fuel betting habits leading to poor nutrition, gender-based violence and increased stress in postnatal women.

“...betting is also a problem. Many young men in our community engage in betting... every small money they receive they bet. Even the little I make he will come and take to bet..so I have to leave my small baby and go look for work....” – FGD11/88/24

Respondent: “Yees there was a case in village. This is a young couple recently married. The man beat the woman ... they were fighting over money. The lady sells omena (silver cyprinid fish) and the man came, took all her money and bet on football. When his team lost, he came home...found no food...ate all the wife’s stock...”- FGD19/91/24

Interviewer: So, what did she do?

Respondent: What do you do? You cry and move on

## Discussion

Findings from the study highlight systemic weaknesses in the provision of facility based postnatal care (PNC). Several factors contribute to these gaps, including an emphasis on quantity rather than the quality of medical encounters, inconsistent follow-up mechanisms, understaffing, and poor integration of related health services. Numerous facilities had inadequate staff resulting in overburdened nurses who often conducted rushed or incomplete postnatal assessments. Additionally, the absence of respectful maternity care further deterred mothers from seeking continued care. Infrastructure limitations also affected service quality. Some dispensaries lacked private spaces for conducting postnatal examinations, while weak referral systems compromised timely emergency responses to neonatal complications.

PNC service delivery was irregular, particularly in rural areas where PNC was not offered as a distinct or consistently scheduled service. Record-keeping and follow-up procedures especially among community health providers were also deficient. Poor documentation of postnatal visits hindered tracking and monitoring, with no reminder systems or active follow-ups to ensure mothers returned for care. This lack of reliable data negatively impacted planning and resource allocation. Low integration of services represented a missed opportunity to enhance PNC. Post-natal care was rarely integrated with immunization, family planning, or child growth monitoring, forcing mothers to attend multiple separate visits. This fragmentation increased fatigue and contributed to higher dropout rates, further limiting the effectiveness of postnatal care interventions. These findings resonate with findings from various studies that revealed a lack of physical resources; infrastructure problems; cultural concerns; inadequate capacity building; inaccessibility of health services; unavailability of guidelines; a lack of communication with healthcare users and poor monitoring and evaluation as systemic challenges that hinder provision of postnatal care.

Culture and social norms were also found to influence postnatal practices. Religious traditions, reliance on traditional birth attendants (TBAs), gender related power imbalances and gambling/sport betting were mentioned. A few mothers observed tradi-



tional postpartum seclusion ("resting period") for up to 40 days limiting their ability to seek healthcare. This is similar across various African cultures where "cultural seclusion" related to religious norms required women to spend the first forty days after delivery in isolation to ward off potential 'evil eyes [26]. Older females and traditional birth attendants (TBAs) are still trusted over health workers in some communities to provide postnatal care and support, especially as they support practices like herbal baths, abdominal binding, and newborn massage, yet often lacked the skills to detect or manage postnatal complications and reinforced negative practices, myths and misconceptions relating to postnatal care. These results reflected observations made by earlier studies conducted by Kipkirui and Wangalwa which indicated that women preferred traditional birth attendants, otherwise referred to as midwives who gave alternative care to mothers [27]. Mochache suggests this lingering trust stems from the prevailing belief that ill health is because of evil spirits and traditional systems of health care were best placed to deal with them. These traditional based remedies practices, while culturally accepted, often delay timely medical intervention.

Gender-related power imbalances also greatly influenced access to and utilization of maternal health services. Studies suggest that gender dynamics affect how men and women negotiate health-care decisions and utilization in low-and-middle income countries. In many households, male partners made decisions on whether and when a mother should seek care [28, 29]. Most women interviewed were less economically empowered hence depended on their husbands to provide. Some respondents also revealed matriarchal figures, usually the mothers/mothers-in-law retained control over decision-making. This was reported largely among younger (below 25 years) post-natal women. These matriarchal figures typically provide general information to pregnant mothers, act as birth companions and play a critical role in the decision-making pathway. Continuous community sensitization and increasing scope of women's participation in decision-making are recommended strategies in building an enabling environment to overcome gender inequities [30, 31].

While there is a significant gap in current research regarding gambling behaviors and issues specifically within the postnatal period in African populations the effect of betting or gambling on maternal mental health and postnatal caregiving practises can be understood through the lens of mental health and behavioral coping mechanisms in postpartum women [32-35]. Data from 2019 indicated that the average Kenyan adult made more than six bets per month, and expenditure on gambling was 3.5 times higher than government spending on healthcare. Sports betting or gambling has been linked to poor maternal health care primarily through its associated harms on family functioning, intimate partner violence (IPV) victimization and perpetration, financial stability, and mental health [36, 37]. These challenges can reduce a mother's capacity to provide adequate maternal and postnatal care. In families affected by gambling problems, there is often financial strain that compromises the ability to afford necessary healthcare services. Additionally, parental gambling is associated with neglect, verbal and physical abuse, and dysfunctional family relationships, all of which can indirectly affect maternal health outcomes and caregiving quality.

Physical barriers such as poor terrains and lack of affordable

transportation were frequently cited by respondents. Mothers often had to make trade-offs between spending scarce resources on food or transport. Many villages were in hilly or remote areas, making travel to health facilities physically difficult, mothers, especially those recovering from childbirth, found it exhausting or unsafe to walk long distances for postnatal visits. Heavy rains made many feeder roads impassable, further isolating households, and straining follow-up efforts by CHPs. Public transport is limited or unavailable in many rural parts of the sub-county, mothers without access to private transport had to walk or rely on motorcycle taxis (boda bodas), which are often costly or unsafe. All these challenges contributed towards delayed or missed PNC visits.

In contrast, the role of CHPs in providing home-based care support, health education, counselling, referral, and follow-up support came out as critical in bridging the gap between the community and health facilities. Some mothers reported relying on CHPs for advice, reminders, and home-based follow-up after delivery. They conducted home visits, especially for mothers who could not travel, helping them overcome mobility, cultural, and financial barriers to accessing facility-based care. CHPs assisted in referring mothers with complications to health facilities, they followed up with mothers who missed appointments and encouraged continuity of care up to the recommended 6 weeks. However, the experience with CHP intervention was quite varied. For example, only two-thirds of postnatal mothers reported having received a CHP home visit at any point, and only 55pc received one visit within the recommended two weeks of delivery. There were also gaps in CHP coordination, supervision and knowledge. CHPs interviewed did not have job aids, information packages to support health cancelling and mechanisms to track mothers/households visited. Wangalwa demonstrated that community health strategy is an appropriate platform to deliver community-based interventions. CHPs are well-known and trusted, often more than facility-based staff, their cultural familiarity and shared language helped reduce stigma and fear around postnatal care. However, it did not have significant impact on postnatal care practises [38]. He recommends development of an optimal package of home visits and CHP training on recommended package of care to standardize home-based postnatal interventions. Wafula et suggests interventions that strengthening the quality of care at health facilities and bridging demand-side gaps can improve new born care and PNC practices and reduce morbidity and mortality in rural settings [39]. However, success is largely dependent on context, active participation of primary caregivers and integration within midwifery guidelines [40].

### Recommendations

From this study, comprehensive approaches that strengthen both the supply and demand sides of PNC services are needed to enhance postnatal care (PNC) outcomes in Kisumu County and similar rural settings. Specifically, prioritizing systems strengthening for rural health facilities in alignment with the Universal Health Coverage (UHC) framework to ensure equitable access to quality postnatal care without financial hardship. This includes increasing adequate staffing levels, ensuring consistent availability of essential MNH commodities and supplies, and enhancing the skills of healthcare providers at both facility and community levels. Additional efforts should focus on improving transmission of health information, documentation and sharing

of best practices across facilities and implementers. Further studies that explore methods to enhance the comprehensibility of health information, understand the shifting health-seeking behaviours and test the effectiveness of strategies to improve the coverage and quality of postnatal care are needed. These studies must address the specific needs and vulnerabilities of younger mothers (10-25 years) and those residing in remote or rural areas. Furthermore, leveraging existing social networks in delivering culturally sensitive health campaigns and education will foster greater community engagement and support for postnatal care services.

### Limitations

The study was conducted in a single rural setting, so its findings may not be applicable to urban areas of the County or other rural regions of Kenya that may have different cultural contexts. Additionally, the data came from a small, purposive non-probability sample, which limits the ability to generalize results. However, the study still offers valuable insights into women's views on the barriers to postpartum care and service utilization. Moreover, interviews were only held with a limited number of women, meaning the study did not explore men's perspectives on obstacles to postpartum care for women. Using Focus Group Discussions (FGDs) as a data collection method can introduce bias, as the opinions of some participants may influence others—a common issue in group settings. The facilitator made considerable efforts to maintain an open discussion and encouraged participants to share their honest views [41].

### Conclusion

In conclusion, although PNC coverage and awareness are widespread, the range of services provided is limited, with health-care workers placing greater emphasis on the number rather than the quality of visits. Utilization of PNC services remains inequitable with disparities in levels of knowledge and participation across different areas, health facilities, and age groups. In Kisumu County, especially within Nyakach Sub-Counties, systemic issues, cultural factors, and logistical obstacles continue to impede both the access to and quality of PNC services [42]. The proactive engagement of Community Health Providers (CHPs) presents a promising approach to delivering more community-focused care. While community-based PNC is generally accepted and deemed convenient, there is a clear need to enhance the skills of CHPs and actively involve local communities to increase the effectiveness of services and improve maternal and newborn health outcomes. This should be backed up with a functional referral pathway to link facilities in case of identified danger sign

### Declaration Section

#### Authors' Contribution

BO and SD participated in the design of the study and collection, analysis, and interpretation of data and in preparation of this manuscript and approved the final draft for submission. SD received funding for the projects contributing to this study. FO and BO participated in the collection and interpretation of the data.

### Funding Statement

The study was funded by University of Leeds, Faculty of Arts, Humanities and Cultures under the Maternal Mortality in East

Africa project implemented through the School of History.

### Conflict of Interest

The authors have no conflicts of interest to declare.

### Availability of data and Materials

While the raw datasets are not publicly accessible, summarized data supporting the study's results are provided in the paper. The materials used for data collection can be obtained by contacting the corresponding author.

### Acknowledgement

We are deeply appreciative of all respondents for their time and participation. We would also like to acknowledge KMET research assistants who were involved in the data collection and management of this study. Special thanks to all the field teams, county and subcounty teams from Kisumu and Nyakach respectively as well as all community focal persons from each of the wards. We thank our partners, Leeds University, without which this study would not have been possible.

### Ethics Statement

Ethics approval for this study was provided by the Institutional Review Board at Jaramogi Oginga Odinga Teaching and Referral Hospital (ISERC-JOOTRH), Kisumu, Kenya reference No. ISERC.IB/VOL.II/72/24, and by the University of Leeds' Faculty of Arts, Humanities and Cultures Research Ethics Committee Reference No. PVAR 17-095. Additional approvals were sought from the Department of Health, Kisumu and Sub-County Health Management team. Participants in the Follow-up surveys and IDIs provided written informed consent, whereas FGD participants provided group, oral consent as per the ethical review approvals.

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