

The Extended Role of Health Facility Cleaners in Maternity Care in Kenya

CONTEXT: A growing body of evidence indicates that nonclinical health care facility staff provide support beyond their traditional roles, particularly in low- and middle-income countries. It is important to examine the role of health facility cleaners in Kenya—from their perspective—to better understand their actual and perceived responsibilities in maternity care.

METHODS: In-depth, face-to-face interviews using a semistructured guide were conducted with 14 cleaners working at three public health facilities in Nairobi and Kiambu Counties, Kenya, in August and September 2016. Results were coded and categorized using a thematic content analysis approach.

RESULTS: Cleaners reported performing a range of services beyond typical maintenance responsibilities, including providing emotional, informational and instrumental support to maternity patients. They described feeling disrespected when patients were untidy or experienced bleeding; however, such examples revealed cleaners' need to better understand labor and childbirth processes. Cleaners also indicated a desire for training on interpersonal skills to improve their interactions with patients.

CONCLUSION: Cleaners' direct involvement in maternity patients' care is an alarming symptom of overburdened health facilities, insufficient staffing and inadequate training. This key yet overlooked cadre of health care staff deserves appropriate support and further research to understand and alleviate health system shortcomings, and to improve the quality of maternity health care provision.

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Typically, cleaners maintain hygiene in a health care facility by sweeping, mopping, dusting, wiping surfaces, changing bed sheets, doing laundry and disposing of trash. A growing body of evidence indicates that, beyond these standard duties, cleaners and other nonclinical staff members in low- and middle-income countries provide services directly to maternity patients.^{1,2} Often, these services take the form of emotional, informational and instrumental support.³ Emotional support of maternity patients can include providing comfort before, during or after delivery through empathetic words or touch. Informational support can involve offering advice regarding labor, delivery or postpartum processes or information about the health care facility. Instrumental support can comprise help with tangible needs, such as obtaining food and other items for the patient, cooking and running errands.

However, more overt cleaner involvement in patient care has been documented. A study in India found that untrained support staff, including cleaners, administer IVs, sterilize instruments and pass instruments to nurse-midwives during delivery.¹ Research from The Gambia and Malawi revealed support staff bathing, feeding and escorting women within maternity facilities.² Also in Malawi, cleaners and other untrained support staff were documented performing deliveries when midwives were not available. A study in South Africa showed that non-medical personnel, including cleaners, were often involved

in patient visits, at times transcribing visit notes.⁴ And in urban Kenya, women reported opting to give birth at home, avoiding health care centers altogether, because such support staff as cleaners were providing care instead of clinical staff.⁵ Avoidance of health care facilities can directly affect health outcomes: More than half of Kenya's births occur at home or without the help of a skilled birth attendant, which contributes to the high national maternal mortality rate of 488 deaths per 100,000 live births.⁶

Support staff participation in patient care is often attributed to understaffing, with overburdened clinical staff in resource-limited, high-volume settings at times being unable to care for all patients.^{2,7–9} Understaffing is associated with poor-quality care and insufficient patient-provider time,^{7,9,10} which has been documented in Kenya.⁶ Yet limited research exists describing the extent to which cleaners are involved in the provision of maternity services within the country's health care facilities, specifically from the cleaner perspective. This qualitative study aims to explore cleaners' extended role—from their viewpoint—to better understand their actual and perceived responsibilities in maternity care in Kenya. In particular, we describe their emotional, informational and instrumental functions. We identify ways to better support cleaners in an effort to improve provision of high-quality maternity care at the facility level, given systemic constraints. Finally, we suggest recommendations for future research.

By Ginger Golub, May Sudhinaraset, Katie Giessler, Kendall Dunlop-Korsness and Allison Stone

Ginger Golub is senior research and business development manager, and Allison Stone is deputy country director—both with Innovations for Poverty Action, Nairobi, Kenya. May Sudhinaraset is assistant professor, University of California, Los Angeles Fielding School of Public Health, Los Angeles, CA, USA. Katie Giessler is senior research analyst, University of California, San Francisco Institute for Global Health Sciences, San Francisco, CA, USA. Kendall Dunlop-Korsness is senior engagement specialist, American Red Cross, Los Angeles, CA, USA.

METHODS

Study Design and Procedures

Study activities took place in August and September 2016 at two hospitals and one health center—all government-run facilities—in Nairobi and Kiambu Counties. These facilities were recommended by reproductive health coordinators from the respective county governments, and selected because they offered delivery and family planning services, had never participated in quality-improvement activities focused on person-centered care and reported more than 60 deliveries per month. Our study is part of a larger quality-improvement project examining how to enhance person-centered care in reproductive health services in these two urban and peri-urban counties; data presented here were collected prior to implementation of any intervention activities.

In collaboration with each facility's administration, our research team approached staff members across three health provider cadres considered to have most interactions with patients: doctors and nurses, pharmacists and laboratory technicians, and cleaners. Purposive sampling ensured that the study sample included a variety of staff across cadres. We described the study to 48 staff members and asked if they were interested in participating; all agreed. Prior to conducting in-depth, one-on-one interviews, we obtained written informed consent from the facility administrator and all 48 respondents—of whom, 14 were cleaners, the focus of this analysis.

The semistructured interview guide was developed by our research team and informed by cognitive interviews piloted among 10 maternity patients at two of the three study facilities, and then among four providers from control facilities in the larger project, to ensure culturally appropriate phrasing and comprehension, as well as interview length and flow. Question topics for all providers included typical roles and responsibilities; types of interactions with maternity patients; examples of person-centered care at the facility, including their definition of patient respect and views on the importance of respecting patients; privacy and confidentiality; communication; cleanliness; and challenges to providing high-quality interpersonal care. Questions were also asked about the presence and acceptability of verbal or physical abuse and bribery, how to improve care quality, and gaps in knowledge and training. Queries about abuse were potentially prone to social desirability bias, which may result in respondents overreporting favorable behaviors or activities and underreporting those that are less favorable.¹¹ To minimize the possibility of such bias, we phrased sensitive questions in a nonaccusatory manner. For example, questions about respondents witnessing such behaviors as yelling at or hitting patients began with the statement, "Sometimes women are abused...." This approach was designed to enable the interviewer to probe on sensitive topics while avoiding direct statements possibly indicating that a facility or provider was responsible for abuse of maternity patients.

Two female interviewers from the study team who were experienced with qualitative methodologies and trained on how to use the interview guide conducted interviews in English, Kiswahili or a mixture of the two, based on respondent preference. At the start of each interview, and reiterated throughout, interviewers ensured that respondents understood the anonymity and confidentiality of any information they disclosed—specifically that nothing they said would be shared with their supervisors or affect their performance evaluations. Because of the sensitive nature of the questions, each interview took place in a private setting, such as an unused room in the facility or an area on the facility grounds away from pedestrian traffic. All interviews lasted 30–60 minutes. Audio was recorded, with respondent consent, and transcribed verbatim by an external transcription firm, which translated Kiswahili recordings to English text during transcription. Respondents received mobile phone credit worth approximately \$1.50 as compensation.

The study obtained ethical approval from Kenya Medical Research Institute's Scientific and Ethics Review Unit, and the University of California, San Francisco's Institutional Review Board.

Analysis

Our team analyzed data using a thematic content analysis approach, which categorizes data from transcripts into patterns that are then interpreted into broad thematic categories. Questions from the interview guide provided initial themes through an inductive process of reading the transcript, coding and recoding for patterns. This method allowed for themes to emerge from the content of the transcripts, which is especially important for an under-researched topic. Three authors independently examined and coded the same initial transcript to develop the code book and check for intercoder variability. Each coding disagreement was discussed in detail; the study team revised code definitions using consensus to ensure a standardized understanding of each code and to minimize future discrepancies. We reviewed each transcript several times and organized key themes into categories of codes, coding and managing data using ATLAS.ti 7.

RESULTS

Participant Characteristics

Of the 14 cleaning staff members interviewed, all were females aged 21–59 (median age, 35). Nine worked at facilities in Kiambu County and five in Nairobi County. Cleaners had worked at their facility anywhere from four months to 17 years (median, three years) and reported working a median of 52 hours per week. Ten had not completed secondary school, three had finished secondary school and one had completed an associate's program.

Cleaners' Extended Roles

All cleaners described frequent communication and interaction with maternity patients; interviews revealed that cleaners spend a great deal of time in their presence.

One 33-year-old respondent from Kiambu County said, “You know we are the ones who spend the most time with those patients.” Another cleaner explained her considerable involvement with maternity patients:

“Most of the time, you are there with her. When you go to clean, you clean where they are. When you go to serve them, you serve them and you must talk to them.”
—24 years old, Kiambu County

Frequent interaction with these women is corroborated by the additional duties cleaners said were part of their daily role. Beyond their typical responsibilities, all cleaners described active involvement in maternity care, including providing emotional, informational and instrumental support to women—and in some cases instrumental support to clinical staff—during labor, delivery and postpartum recovery.

• **Provision of emotional support.** Most cleaners noted direct interactions with maternity patients, such as calming and coaching those who were in labor or delivering, and comforting postpartum women both verbally and physically. Nearly all explained that they console women in labor to help them cope with pain and ensure that they understand that the discomfort is normal and temporary:

“Some even say, ‘I’m dying’ or something. You just have to tell them, ‘It’s not death, it just comes for a span. The pain will come for now, and from maybe tomorrow morning, I’ll find you with a kid.’”
—23 years old, Kiambu County

Several other cleaners described similar interactions in which they offered reassurance and encouragement, thereby normalizing a woman’s labor experience. One explained her approach:

“Now, what I do is to encourage them, telling them, ‘Now, don’t be worried, don’t panic—it’s normal.’ I tell them, ‘Now, the way your mother gave birth to you, you have to experience the same; I too have gone through the same. So everything goes with plan, so just relax—when the time comes for the baby, it will come.’”
—44 years old, Kiambu County

Some cleaners also noted involvement at the postpartum stage, including when they sympathize and interact with women who deliver a stillborn baby. For example, one cleaner said:

“You try talking to her and you explain to her the way God will help her, and she will just get another child. Therefore, she should not worry. Human beings go through a lot.”
—41 years old, Kiambu County

Besides consoling women with words, many cleaners mentioned providing physical comfort. One described pausing her cleaning duties to soothe a woman in labor:

“When the pain becomes unbearable, some get ahold of your hand when you are passing by. ‘Come and rub my back.’ And you just have to do it. Because when someone is pregnant, it’s not easy. You rub her for a short while, then you leave back to your job.”
—23 years old, Kiambu County

• **Provision of informational support.** Cleaners revealed that maternity patients ask them general questions about the facility, request assistance in getting a nurse’s attention or

seek their advice on newborn care—mostly about breast-feeding. One 33-year-old cleaner from Kiambu County explained that women giving birth for the first time do not know how to breast-feed or what to do when an infant vomits. Another described how she sometimes provides breast-feeding coaching for new mothers:

“If she says she doesn’t know how to breast-feed, you help her sit properly on the bed and then you show her how she will breast-feed, because we all know they are taught here.”
—59 years old, Nairobi County

Several cleaners perceived their provision of informational support—inclusive of providing information on postpartum care for both mother and baby—as a job obligation. One 45-year-old cleaner from Nairobi County called it “our duty” for cleaners to explain to patients that infants needed tuberculosis immunization, saying, “So it is our mandate to advise them on the immunization that the baby is supposed to be given right from birth.”

• **Provision of instrumental support.** Several cleaners noted that they willingly run errands for maternity patients who need medicine, food, personal effects or other items from outside the facility. One cleaner explained how “she might ask you to get her something from the shop, and you will do that. Whatever she wants, she will inform me and I will get it for her.” Another described how she ensures that women are properly nourished for labor and delivery:

“Sometimes she says she doesn’t want to eat. So I stand there to tell her to eat, ‘Because if you don’t eat, where will you get the energy to push the baby? It’s good you eat.’”
—59 years old, Nairobi County

Respondents frequently mentioned performing tasks often associated with reception, clerical or other facility roles. For example, cleaners described giving facility tours to families and helping them locate a patient’s bed, discussing with patients the length of their stay and care costs, and escorting women to the toilet or to other departments. Importantly, some cleaners highlighted how their instrumental support sometimes extends to the clinical realm. Although support staff—given their lack of training—are not formally sanctioned to provide clinical support to patients, some cleaners reported that nurses at times ask them to help during delivery. For example, a 59-year-old cleaner from Nairobi County said that she dispenses drugs to patients and assists at the behest of nurses who may be working alone. Another indicated how she provides clinical staff with instruments and supplies required for delivery, with these activities prioritized over her cleaning duties:

“Sometimes when we are done with either the washing, or not, we are called to assist. When they are busy, they’ll call us to assist. When they ask for an instrument, you pass it to them. Because there are some tasks they cannot perform on their own. Because when she is helping deliver a baby, she is supposed to have everything with her, right? When she runs out of anything, she cannot touch items with bloody hands, see? So she has to call me for help.”
—47 years old, Nairobi County

Perceived Need and Desire for Training

Despite performing duties beyond typical cleaning responsibilities, cleaners did not express a desire to eliminate or even reduce these tasks; rather, nearly all wanted to be better trained to perform these duties well and expressed interest in opportunities for professional development, though the desired training varied. Several respondents wanted to be better versed in clinical skills to help in emergencies. Others indicated that the main challenge was effective communication. For example, a 23-year-old cleaner from Kiambu County said, “If only the patients would understand you, it will be better.” Most admitted that their lack of knowledge of effective communication techniques contributes to this gap; a 21-year-old cleaner from Kiambu County wondered, “Maybe the way I answer their questions isn’t the right way.” Others shared uncertainty about whether they interact with women effectively and appropriately. Several respondents specifically indicated that they would like training on how to manage anxious patients because, as one 38-year-old cleaner from Kiambu County noted, “[There are those] who come when they are angry, and so we should know how to handle them.”

Desire for such training aside, both cleaners and patients may benefit from efforts to increase cleaners’ knowledge and skills related to high-quality patient-provider interactions, as they are, in fact, performing these duties already. As one 47-year-old from Nairobi County noted: “Even though I am not learned, we still do it even without the trainings, right?” However, very few cleaners reported having received training on provider-patient interactions. One 35-year-old cleaner from Kiambu County, when asked about such training, replied, “Us, training! Have we really gone for a training, really?” This comment, interpreted as sardonic, suggests that the cleaner does not consider her status in the facility as important enough to warrant formalized training.

Perceptions of Respect and Disrespect

When asked about the importance of respect, cleaners unanimously acknowledged that respecting maternity patients is very important and that respectful care is “their right”; one 21-year-old cleaner from Kiambu County specified that it is critical for patients “to be respected by the nurses, as well as we, the workers.”

Many cleaners discussed the reciprocal nature of respect. A 59-year-old cleaner from Nairobi County said, “If you respect a patient, she will respect you back,” and a 21-year-old from Kiambu County said that cleaners had a “right to be respected by patients.” One cleaner described the need for mutual respect more overtly:

“They have to respect us so that they deliver in a clean place, and we must also respect them so that we continue working here. So respect is a must.”—38 years old, Nairobi County

Despite these sentiments, cleaners frequently noted feeling disrespected. A 21-year-old cleaner from Kiambu County said, “There are some patients who, despite the

fact that we assist them, they still despise us. Some think we are only here because we have no other option...some hurl insults at you.”

Several respondents used the word “despise” in relation to how patients view them. One 33-year-old cleaner from Kiambu County said, “The patient should first show respect to you. You know, they despise us cleaners. So when the patient looks down upon you, you find yourself reacting to that.” Besides verbal abuse or perceived disdain, cleaners sometimes regarded general uncleanliness, such as maternity patients dirtying the floor or bed or spilling their tea, to be disrespectful behavior. Respondents believed that some patients were more careless or untidy, knowing that support staff who are responsible for facility hygiene would clean any mess. One 33-year-old cleaner from Kiambu County recalled feeling taken for granted by a patient who repeatedly defecated on the bathroom floor; she maintained that the woman did this deliberately because the facility staff would clean it.

Some cleaners considered unintentional acts—including leaking bodily fluids during labor and delivery—to be purposeful and disrespectful, and the inability to control bleeding to be deliberate. One 33-year-old cleaner from Kiambu County asked, rhetorically, “When you are washing and the woman is walking [after] she delivered and is still bleeding—isn’t that disrespect?” Asked when it might be difficult to respect maternity patients, one cleaner described this scenario:

“Sometimes they are very stubborn. You clean a place, they again let their blood flow to the floor. You clean and tell them to place the cotton wool properly, but they still let their blood flow carelessly. So you find it very hard. You wonder if the patient is listening or not. Then there are those who are stubborn. After soiling their bed, they move to another patient’s bed, any other bed that is clean. They soil that one too, then move to where they came, back to that bed that you had given them.”—34 years old, Nairobi County

Such situations, cleaners noted, make it difficult to treat patients with respect. They admitted to leaving patients, giving them “the silent treatment” or even losing their temper with them. One cleaner described instances during which she initially comforted maternity patients but, because of perceived disrespect, verbally mistreated them:

“You know some behave so badly. I come and tell them, ‘Now see, you have turned to be a girl,...the way you were there screaming. Now you are here. Be happy.’”—35 years old, Kiambu County

Other respondents acknowledged that, even if they are angry with patients, cleaners must continue to show respect and “can’t talk back to them”—in part, according to a 38-year-old cleaner from Nairobi County, because “giving birth comes with some complication that makes people be stubborn.” However, cleaners admitted that rude treatment, verbal abuse and perceived disrespect from women dirtying the facility affects their work and self-esteem, and contributes to an overall decrease in job satisfaction. One

33-year-old cleaner from Kiambu County conceded that, “when a patient insults you, it really hurts. You wonder why she is insulting you, yet you are doing your work.”

DISCUSSION

To date, the global health community has not paid adequate attention to the role of health facility support staff in improving women’s experiences of care. This study is one of the first to describe the key role of cleaners, revealing their extensive involvement in women’s maternity care at public facilities in two counties in Kenya because of reported gaps in the country’s health system, and uncovering opportunities to better support cleaners and the provision of high-quality care.

Our findings demonstrate that cleaners at these facilities provide emotional, informational and instrumental support to women during labor, delivery and postpartum recovery—often performing numerous critical services that fall far outside their official scope of work. These results highlight potential failures at multiple levels of the public health system. First, although cleaners did not report providing direct clinical care, such as performing deliveries or managing complications, it is alarming that support staff with no medical training are handing instruments to nurses during deliveries and dispensing medication in lieu of clinical staff. These findings suggest that providers may be working in high-volume, overburdened environments, which forces them to rely on support staff to provide instrumental care and prevents them from spending sufficient, meaningful time with each patient. A study conducted in 2016 in the same public health care facilities as our study confirmed shortages of trained nurses and doctors;¹² challenges included high patient volumes, inadequate infrastructure, and insufficient numbers and quality of staff. We hypothesize that such constraints greatly contributed to the extended role of cleaners in our study.

Second, it is unclear the extent to which cleaners are giving accurate, or possibly harmful, advice and information related to newborn care, immunizations and breastfeeding practices to maternity patients, or whether they are referring questions to trained providers. Cleaners do not have the appropriate training—whether formal or informal—necessary to provide quality informational support, yet they report often being required to do so. One cleaner even called it her “mandate” to share immunization information. In addition to ensuring that the appropriate staff manage information-sharing tasks, facilities may find that cleaners benefit from efforts to increase their knowledge and skills related to high-quality patient-provider interactions, as they are already interacting closely with patients.

Third, the emotional support cleaners provide to patients emphasizes the need for dedicated support persons—whether they be a family member, friend or trained professional, such as a doula—to accompany women during labor and delivery. A 2017 study emphasized the importance of

a support person in influencing health outcomes, such as the increased likelihood of patient satisfaction, decreased instrumental interventions and lower rates of cesarean delivery.⁹ However, Afulani and colleagues found that having a support person from outside the health facility is a challenge in Kenya, where the limited use of curtains to separate beds would result in privacy concerns and the norm in public facilities is to not have anyone except providers present during childbirth.¹³ In this context, facility-based support persons or doulas could be more feasible and acceptable. Overall, our study highlights the need for staffing reforms and accountability across multiple players—from governmental health officials to providers and midwives—to ensure high-quality, respectful health care for maternity patients.

Our findings illustrate how cleaners are an integral cadre of staff in relation to providing such care, though their efforts are often overlooked or even belittled. The cleaners in our study unanimously acknowledged the importance of respecting patients and asserted that they deserved respect from patients. Yet some respondents noted feeling that patients speak and act disrespectfully because they “despise” and look down on cleaners. Some cleaners perceived messes caused during and after delivery—especially those that created additional work—as a form of disrespect. Statements that maternity patients should better manage their blood flow during and after delivery suggest that certain cleaners may have unrealistic expectations about women’s ability to maintain cleanliness—expectations that may arise from a lack of education concerning biological processes. Cleaners may benefit from receiving trainings on the process of childbirth to clarify these expectations. In the context of the health facility, these frustrations could stem from cleaners’ feeling overworked from long hours and few days off. Cleaners described losing their patience or getting angry when they experienced perceived disrespectful treatment, leading cleaners to ignore patients, potentially neglecting their needs, or verbally mistreat them.

These findings suggest several interventions to better support cleaners as well as health care delivery within facilities, and they inform recommendations for future research. First, facility leadership, including managers and doctors, should recognize the extended role that cleaners currently play, and then be trained on the appropriate roles and responsibilities of cleaners. Managers should schedule sufficient staff to both decrease cleaner workloads and ensure that they do not feel required to play other roles; in particular, the facility should provide a trained support person or encourage maternity patients to bring a support person who can be present during and after labor, if desired and feasible.¹ Should cleaners be asked clinical questions, facilities should establish well-defined protocols and outline appropriate communication channels between patients and providers. Importantly, cleaners need a clear understanding of what types of informational support they can appropriately

provide and how, as well as the circumstances in which they should refer patients to clinicians.

Second, cleaners' interest in improving their interpersonal communication skills should be leveraged for more effective and respectful interactions with patients. A study from Bangladesh in 2015 that focused on maternal and neonatal health care quality reported that cleaners indicated that regular in-service training could be helpful to improve quality of care overall,¹⁴ fortifying our study results. Given the high levels of mistreatment reported by maternity patients in low- and middle-income countries, including Kenya,¹⁵ paired with results from this study indicating a gap in effective patient-provider interactions, we recommend implementing person-centered care training and training on patient's rights at all levels of care—for clinical providers, as well as for such support staff as cleaners, security personnel and cooks.

Finally, these findings support an agenda to promote collaboration between clinical providers, facility leadership and cleaners to ensure that cleaners feel supported in their positions. Cross-collaboration efforts that engage cleaners as important health workers may include involving cleaners in staff meetings, facility leadership acknowledging cleaners for their contributions to provision of quality care and offering mentorship programs that pair cleaners with other health workers for training on appropriate extended roles and interpersonal skills.

Limitations

This study has some limitations. First, these findings may not be generalizable to cleaners at health care facilities in other parts of Kenya or private health facilities overall; we purposively sampled these three health facilities based on multiple factors. Because the health facilities were selected to be part of an impending quality-improvement intervention, facility managers may have been more likely to prioritize quality of care; thus, staff—including cleaners—may have different views than those at other maternity facilities in Kenya. Second, despite attempts to limit social desirability bias by asking indirect questions on sensitive topics, such as patient abuse, this study may have been vulnerable to such bias and the potential desire of the cleaners to favorably portray the facility to the interviewer. Cleaners who did not indicate that they had witnessed disrespectful care or outright abuse, such as shouting at or slapping patients, may have withheld such information to protect themselves, their colleagues or the facility itself.

Conclusions

Cleaners play an important role in a woman's maternity experience in Kenyan public health facilities. In the absence of adequate qualified staff, cleaners provide a range of services for which they receive no training—including emotional, informational and instrumental support—significantly extending their roles beyond their traditional job functions. Some of their perceptions about being disrespected by maternity patients

may derive from a lack of understanding about patient rights and experiences during labor and childbirth, as well as appropriate ways to provide respectful care. More research and attention are needed to determine how best to fill the human resource gaps in the country's health system, hold facility management accountable for adequate staffing and staff training, and appropriately train and support cleaners in the aim of improving the quality of maternal health care in Kenya and in other low- or middle-income countries.

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RESUMEN

Contexto: Un creciente conjunto de evidencia indica que miembros del personal no clínico de las instituciones de salud proporcionan apoyos que trascienden sus roles tradicionales, particularmente en países de bajos y medianos ingresos. Es importante examinar el rol del personal de limpieza de las instituciones de salud en Kenia—desde su perspectiva—para comprender mejor sus responsabilidades reales y percibidas en cuanto a la atención materna.

Métodos: Se condujeron entrevistas personales en profundidad utilizando una guía semiestructurada con 14 miembros del personal de limpieza que trabajaban en tres instituciones de salud pública en los condados de Nairobi y Kiambu, Kenia, en agosto y septiembre de 2016. Los resultados fueron codificados y categorizados mediante un enfoque de análisis de contenido temático.

Resultados: El personal de limpieza reportó que realizaba una variedad de servicios además de sus responsabilidades típicas de mantenimiento, que incluyeron la provisión de apoyo emocional, informativo e instrumental a las pacientes de maternidad. Describieron un sentimiento de falta de respeto cuando las pacientes estaban desaseadas o experimentaban sangrado; sin embargo, tales ejemplos revelaron la necesidad de que el personal de limpieza comprendiera mejor los procesos de trabajo de parto y parto. El personal de limpieza también indicó su deseo de recibir capacitación en habilidades interpersonales para mejorar su interacción con las mujeres.

Conclusión: La participación directa del personal de limpieza en la atención a pacientes de maternidad es un síntoma alarmante de sobrecarga de las instituciones de salud, de personal insuficiente y de capacitación inadecuada. Este grupo de personal de atención a la salud, clave pero ignorado, merece apoyo apropiado y se necesita mayor investigación para comprender y mitigar los defectos del sistema de salud y mejorar la calidad de la prestación de servicios de salud materna.

RÉSUMÉ

Contexte: La documentation et les données indiquent de plus en plus que le travail du personnel non clinique des structures de soins de santé s'étend au-delà du rôle qu'on attendrait ordinairement de lui, en particulier dans les pays à revenu faible ou intermédiaire. Il importe d'examiner – de leur point de vue – le rôle des effectifs de nettoyage des structures sanitaires du Kenya si l'on veut mieux comprendre leurs responsabilités réelles et perçues dans les soins de maternité.

Méthodes: Des entretiens en personne approfondis, suivant un guide semi-structuré, ont été menés avec 14 membres du personnel de nettoyage de trois structures sanitaires de l'État dans les comtés de Nairobi et de Kiambu (Kenya), en août et septembre 2016. Les résultats ont été codés et catégorisés selon une approche d'analyse de contenu thématique.

Résultats: Le personnel de nettoyage interrogé a déclaré effectuer des services allant au-delà des responsabilités d'entretien types, y compris l'apport d'un soutien affectif, informatif et matériel aux patientes des services de maternité. Il estimait subir un manque de respect lorsque les patientes présentaient une allure peu soignée ou saignaient. Ces exemples révèlent cependant la nécessité pour le personnel de nettoyage de mieux comprendre les processus du travail et de l'accouchement. Le personnel interrogé a également exprimé un désir de formation en matière de compétences interpersonnelles, en vue d'une meilleure interaction avec les femmes.

Conclusion: La participation directe du personnel de nettoyage aux soins de maternité des patientes représente un symptôme alarmant de structures sanitaires surchargées, d'effectifs insuffisants et de formation inadéquate. Cette catégorie d'effectifs sanitaires, essentielle mais généralement négligée, mérite un soutien approprié. Une recherche approfondie doit être entreprise pour comprendre et combler les lacunes du système de santé et pour améliorer la qualité de prestation des soins de maternité.

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Author contact: ggolub@poverty-action.org