Thesis

By

Charles Owuor Olungah

University of Nairobi

THE SOCIO-CULTURAL CONTEXT OF MATERNAL HEALTHCARE IN BONDO DISTRICT, WESTERN KENYA: IMPLICATIONS FOR SAFE MOTHERHOOD INTERVENTIONS

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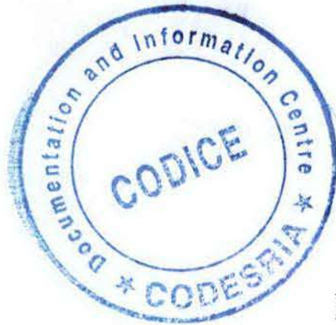

By

Charles Owuor Olungah

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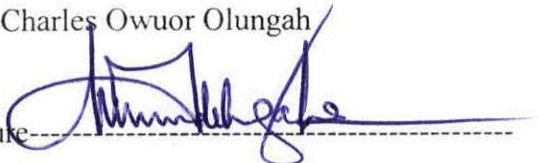
A Thesis submitted to the Institute of African Studies, University of Nairobi, in Fulfillment of the Requirements for the Award of the Degree of Doctor of Philosophy of the University of Nairobi

2006

DECLARATION

I declare that this thesis is my original work and has not been presented anywhere else for examination

Name: Charles Owuor Olungah



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Date-----------------14.11.2006--------------------------

Supervisor: Professor Collette A. Suda

This work has been submitted for examination with my approval.

Signature--

Date--

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Dedication

To my beloved wife Akoth and sons Ochieng' and Omondi. May you all live to enjoy the sweet fruits of academic hardship.

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The work presented in this PhD thesis was carried out both at the Institute of African Studies (IAS), University of Nairobi and the Danish Bilharziasis Laboratory (DBL) in Copenhagen-Denmark in collaboration with the Institute of Anthropology (IA)-University of Copenhagen.

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ABBREVIATIONS

ACK	Anglican Church of Kenya
AIDS	Acquired Immune deficiency Syndrome
ANC	Antenatal Care
BMI	Body Mass Index
CBS	Central Bureau of Statistics
CDC	Centers of Diseases Control
CHWs	Community Health Workers
CMA	Critical Medical Anthropology
CS	Community Survey
DANIDA	Danish International Development Agency
DBL	Danish Bilharziasis Laboratory
EDD	Expected Date of Delivery
EOC	Emergency Obstetric Care
FGDs	Focus Group Discussions
FGM	Female Genital Mutilation
IA	Institute of Anthropology
IAS	Institute of African Studies
IBP	Individual Birth Plan
IEC	Information, Education and Communication
ILO	International Labour Organization
IPPF	International Planned Parenthood Federation
IPT	Intermittent Presumptive Treatment of Malaria
KCCT	Kenya College of Communication and Technology, Mbagathi
KCPE	Kenya Certificate of Primary Education
KDHS	Kenya Demographic Health Survey
KEDAHR	Kenya Danish Health Research
KMMBS	Kenya Maternal Mortality Baseline Survey
KPMMN	Kenya Prevention of Maternal Mortality Network
LFU	Longitudinal Follow-up
MCH	Maternal and Child Health
MH	Maternal Health

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MMR	Maternal Mortality Ratio
MOH	Ministry of Health
NARC	National Rainbow Coalition
NGO	Non Governmental Organization
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PSRI	Population Studies and Research Institute
SAREC	Swedish Agency for Research Co-operation with Developing countries
SMI	Safe Motherhood Initiative
STDs	Sexually Transmitted diseases
STI	Sexually Transmitted Infection
TBAs	Traditional Birth Attendants
TFR	Total Fertility Ratio
TT	Tetanus Toxoid Injection
UK	United Kingdom
UN	United Nations
UNICEF	United Nations Children and Educational Fund
UNFPA	United Nations Fund for Population and Development
USA	United States of America
VCT	Voluntary Counseling and Testing for HIV/AIDS
VDRL	Venereal Disease Laboratory
VOs	Voluntary Organizations
WHO	World Health Organization

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ABSTRACT

This is a qualitative study of women's responses to pregnancy and childbirth among a selected sample of women in Nyang'oma division of Bondo district. In the study, close examination of the socio-cultural, economic, physical and service factors associated with low antenatal and postnatal health care services utilization patterns are examined. Pregnancy is put under a cultural microscope and the arena in which it is experienced examined.

The analysis is based on one year's field work (July 2002-July 2003) funded by DANIDA through KEDAHR on maternal health care in a socio-cultural context. The research involved a questionnaire survey involving one hundred mothers who had given birth in the last one year prior to the survey and a maternal cohort of twenty five(25) pregnant women recruited in their 4th and 5th months of pregnancy and followed initially weekly and later fortnightly beyond delivery and up to six weeks after delivery. The research also conducted key informant interviews, provider interviews, client-provider observations, direct facilities observations and the direct observations in the community on how pregnancy as a process is lived and experienced.

The results reveal low antenatal health care utilization patterns and even more low postnatal health care practices. It is also apparent that the division has very low maternal health care coverage and few facilities. The low utilization of services is attributed to several factors key among them is the power relational dynamics and the negative effects of culture that limits the female choices and reduces the woman to a spectator in her own pregnancy, the cultural definition of pregnancy as a normal natural condition rather than a pathological one that requires medical care. Analysis of the qualitative data resulting from the longitudinal follow-up, case studies and the narratives amplifies the female voices and reveals a pattern where low antenatal care services utilization results from a variety of factors. These include poverty, low maternal education/awareness, provider based inefficiencies, the poor infrastructure and the availability of competing/complementing but familiar alternatives that lend well to the cultural definitions of pregnancy.

Equally emerging is the reinforcement of the fact that pregnancy and the whole question of reproduction is not solely a biological affair, but rather a socially constructed process

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reinforced by the political and economic conditions prevailing in the environment in which it is experienced. The results from the previous Kenya Demographic Health Surveys (KDHS, 1993; 1998 and 2003) reveal a pattern of a very high antenatal attendance; however, the research indicates that the high cases observed in the surveys are examples of women who go to the clinics once for the sole sake of getting an antenatal card as 'security or passport to the unknown'. Most women cushion themselves against the possibilities of being turned away from health care facilities during delivery in the event of any obstetric complication, as the antenatal card is the passport to professionalized care. While the majority of women reported that they went for clinic at least once, there is a clear pattern of resistance that attempt to show women as conscious agents of their actions in trying to resist the medicalization of pregnancy and childbirth.

The emergence of home deliveries as a common practice and the preferred place by most women amplifies further this resistance as women want to be in-charge of their destiny without the biological intrusion of the professionals (most likely men). Home deliveries are seen to accord women the control over their own bodies and the entire process is mostly in the hands of women- the parturient woman, her female kin and the midwives. Luo culture even discouraged the presence of the husband at birth.

With respect to the safe motherhood interventions, the research recommends that the definition of reproductive health needs to be widened beyond the female person and beyond issues of pregnancy, delivery and contraception. The entire cultural arena in which conception happens, pregnancy is carried to term and delivery finally takes place needs to be revisited other than the present concentration in the improvement of antenatal health care facilities and the continued medicalization of pregnancy and training of health care personnel. An entirely holistic approach with the empowerment of women at the core and harnessing the beneficial aspects of culture are considered to be the best ways out of the maternal health burden.

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CHAPTER ONE

1.0. INTRODUCTION

Maternal and child health programmes are today given high priority in the international public health discourse. Maternal mortality emerged as an issue of international public health concern in the mid 1980s with the publication of the article "*Maternal Mortality- A Neglected Tragedy: Where is the M in MCH?*" (Rosenfield and Maine, 1985). In that article, the authors (maternal health advocates) took health professionals, policy makers and politicians to task for neglecting m
others in maternal and child health programming (Allen, 2002).

After the above hair splitting notification, International agencies started formulating policies to address maternal health in developing countries. In November 1985, WHO hosted the interregional Meeting on the Prevention of Maternal Mortality at the WHO headquarters in Geneva, Switzerland. The meeting brought together maternal health professionals, researchers and policy makers from 26 countries to review factors that contribute to maternal mortality in developing country settings (WHO, 1986).

At this meeting, the experts identified and defined maternal health risks in terms of the medical, reproductive and socioeconomic factors that contribute to the high rates of maternal mortality in many of the World's poor countries. They noted that a woman's age, her physical health, the number of her previous pregnancies, her socioeconomic status, and her desire to be pregnant all had a bearing on whether or not she would survive a given pregnancy. The physical distance from a woman's home to the health centre or hospital was also identified as an important factor that affected whether or not she would survive a given pregnancy should complications arise. They however, failed to give due attention to the role culture plays in the pregnancy outcome. In response to the issues raised at the meeting, WHO in collaboration with the World Bank and the UNFPA formulated a set of creative and preventive measures to help ensure that motherhood became a safe aspect of women's lives. This was billed as the Safe Motherhood Initiative (SMI) and launched at an International Conference in Nairobi in 1987. This joint international effort set out to reduce by half by the year 2000 the estimated 500,000 annual maternal deaths associated with complications during pregnancy, childbirth, and the postpartum period (Starrs, 1987).

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Further momentum to strengthening Safe Motherhood Initiative (SMI) was received at the International Conference on Population and Development held in Cairo, Egypt in 1994, fourth World Conference on Women held in Beijing, China 1995 and the WHO year of Safe Motherhood in 1998 (Mathew & Tim, 1999). All the above efforts however, did not put into account the anthropological view of how the politics of nation-state and culture play out women's bodies and affect women's reproductive lives. Illustrations of sometimes subtle and sometimes overt braiding of local, transnational and global political and economic decisions and trends with women's intensely individual reproductive experiences and choices and to present an anthropological perspective and a critical cross-cultural view that will enable them to understand cultural systems has been lacking.

Anthropologists have underscored the social nature and significance of birth and shown clearly how this biological and intensely personal process carries a heavy cultural overlay. In all cultures, birth is a rite of passage (Van Gennep, 1908) that embodies a culture's deepest beliefs, which are transmitted and reaffirmed during this critical transitional time. Birth practices have been noted to point "as sharply as an arrowhead" to the core values of the culture, telling the observer a great deal in it (Kitzinger, 1978).

Despite the anthropological input, there has been a general lack of the precise cultural knowledge, in the approaches adopted by the International agencies and Governments to increase provision of a basic package of essential maternal health services and the majority of women in developing countries are still not able to access those potentially life saving services. In poor countries, shortages of skilled health workers, equipped facilities, and the often-unequal distribution of existing health resources, create barriers to care for large segments of the population. Women's use of care tends to be further restricted by educational, social, cultural and financial factors. This has resulted from the struggle of control over reproduction that is continuously being negotiated by a range of local, national and transnational interests. Challenges of the cultural conventional thoughts and practices have stretched the dominant social ideologies in which biologization, technologization and medicalization of pregnancy and childbirth has been accomplished (Davis-Floyd, 1992; Martin, 1992 and Conrad, 1992).

Given the existing contradictions, the realities on the ground from recent estimates indicate an increase in maternal mortality surpassing the earlier figure. It is estimated that 585,000

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women die each year from pregnancy related causes (WHO & UNICEF, 1996) from what is believed by most as a healthy process (Rosenfield & Maine, 1985). More recently, WHO (1999) revised the maternal mortality estimates to 600,000. About 1 in 48 (Tsui et al. 1997) or 1 in 43 (Mathew and Tim, 1999) women in developing countries die of complications of pregnancy, delivery, puerperium, or abortion, compared with only 1 in 1,800 in developed countries (Tsui et al. 1997) or 1 in 5000 in the UK (Mathew and Tim, 1999). Earlier estimates indicated that between 30-40% of pregnant women or over 54 million women in developing countries are estimated to experience a pregnancy related complication annually (WHO, 1993b).

Traditionally, most communities in Africa believed and some still believe in the normalness of pregnancy and childbirth. The statistics here resulting from the medicalization of the process and the emphasis on epidemiology has altered this thinking so that in the contemporary world, there is almost no such thing as normal pregnancy or normal labour as giving birth without the assistance of prenatal testing, hospitals, clinics, foetal monitoring and drugs is generally considered unsafe despite the demonstrated safety of midwife attended out of hospital births.

Given the contradiction between beliefs and practice, maternal mortality and morbidity in Africa specifically still remain a burden to reckon with especially in Sub-Saharan Africa. Recent report of a study conducted by World Health Organization (WHO), UNICEF Children's Agency and the United Nations Population Fund (UNFPA) indicate that the Sub-Saharan African women are 175 times more likely to die from complications in pregnancy and childbirth than their sisters in richer countries (Robert Evans, 2003). Africa has a Maternal mortality Ratio (MMR) of 870:100,000 (UNICEF &WHO, 1996; UN, 1996). The reasons given for these high death rates in the continent are that on average, they are pregnant and deliver more frequently than women in other continents and each pregnancy is riskier.

According to WHO (1993c) and Aloo-Obunga, (2003), haemorrhage is the most common cause of death followed by sepsis and complications of unsafe abortion, hypertensive disorder of pregnancy (including eclampsia) and obstructed labour. The problem is further complicated by the fact that throughout the world, millions of women do not have access to good quality health services during pregnancy and childbirth. The problem is especially

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acute among poor, uneducated and rural women. It has been noted that less than half of the women in developing countries get adequate health care during and soon after child birth; despite the fact that most maternal deaths take place during this period (AbouZahr, 1997).

Motherhood should be a time of expectations and joy for a woman, her family, and her community. For women in developing countries, however, the reality of motherhood is often grim. For those women, motherhood is often marred by unforeseen complications of pregnancy and childbirth. Some die in the prime period of their lives and in great distress: from hemorrhage, convulsions, obstructed labour, or severe infection after delivery or unsafe abortion as noted above. All these amount to improper and lack of proper antenatal care.

For Safe Motherhood Intervention, it is important to take cognizance of the fact that human reproduction is a socio-cultural as well as a biological process (Jordan, 1980). Pregnancy and childbirth, though universally experienced, are culturally constructed through rituals, taboos, beliefs, values that govern women during that vulnerable period, creating very distinct patterns and strategies. It is this holistic view that the study set out to amplify and to see maternal health beyond the mere biomedical statistics. It is true that the causes of maternal mortality as provided by WHO and Aloo-Obunga apply, but it is equally true that their control lies in the biomedical facilities. The questions are, how do we change the cultural definition of pregnancy from a normal condition to a pathological condition to warrant facility based care?, then, how do we get the mothers to the facilities in the first place given the competing alternatives and other socio-cultural variables that limit their decision making power?

After getting them there, how do we ensure that the services are offered in a culturally sensitive way that ensures continuity and the subsequent delivery in the facilities? How about the idea of supplies and other shortages reported on a daily basis? Besides the above, how do we maintain the entire pregnancy process in the traditional hands of women without over medicalising it? The results of this research provides a wider basis of looking at maternal health care and suggests numerous ways of empowering women to take more direct and elaborate care of their health in a culturally rich environment. We are privy to the fact that since reproduction is so strongly associated with biology in the dominant nation-state ideology, viewing it through cultural lenses posse significant challenges to

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some of our basic tenets. Tensions arise in questions of agency vs control, nature vs culture, and identity constructions, reproducing under varying conditions and so on.

1.1. Maternal Health situation in Kenya: An Overview

Missionaries introduced Maternal and child health services in Kenya at the turn of the century, where, as an extension of their curative dispensaries, some expectant mothers were looked at and sometimes given food supplements (Raikes, 1990). Raikes further reports that tetanus toxoid and vitamin supplements were introduced in the late 1930s and the first maternity clinic was opened in the 1940s (1990: 29).

It has been suggested that the main aim of the missionaries in running the antenatal services was an extension of their missionary work, where they saw antenatal and child care as part of the work of producing as many candidates as possible for baptism (Doyal, 1979 reported in Raikes, 1990).

Reports and letters from that time indicate that the main pre-occupation of the missions was competition with other missionary societies for converts, and when the dispensaries appeared to attract new clients, they became a new element in the competition between the churches over converts. The development of maternity services for African women therefore, resulted from the wars of the missionaries (Mburu, 1980).

Recent analysis of the colonial maternal health policies indicate that maternal bodies served as the starting point from which British colonial interventions to modernize and transform native population were launched (Jolly, 1998a; Manderson, 1998). These "interventions in mothering" as anthropologist Margaret Jolly refers to them were articulated through policies and practices that involved the surveillance and supervision of pregnant and birthing women, mothers and wives.

It is unfortunate that at Independence, the Kenya government did not give maternity care any priority and it was the voluntary organizations (VOs) such as the Catholic Church that filled the void (Raikes, 1990: 30).

Raikes reports that the adoption of the Primary Health care approach (PHC) by the Kenyan government in the late 1970s affected the government's antenatal and maternity services

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policy in two ways: First, a PHC approach to pregnancy meant expanding the services and providing more maternity beds where possible and, secondly, the adoption of a "community participation" strategy necessitated a recognition of the roles played by traditional birth attendants (TBAs) in pregnancy and birth. This recognition, combined by the fact that there were limited amount of health facilities, in turn led to the development of a paradigm to train TBAs in Sterile Delivery Techniques. In some areas, only lip service has been paid to the new training policy, and there is some evidence that it is the VOs again that are investing more time and money on the programmes than the government.

In 1996, the Kenyan government launched its National Reproductive Health strategy with the aim of reducing maternal mortality by 50% by 2010. The goal of the safe Motherhood in this document is to reduce maternal mortality from 365/100,000 live births to 300/100,000 in 2000, to 230/100,000 in 2005 and 170/100,000 by 2010. Besides this effort, in 1997, the British government, through the white paper, "Eliminating World Poverty" made a commitment to reduce maternal mortality by 75% by 2015. More recently, Sessional paper no. 1 of 2000, "*The National Population Policy for Sustainable Development*" which expands on the previous policy guidelines to incorporate other reproductive health needs with an emphasis on the reduction of maternal mortality was passed (Ministry of Planning and National Development, 2000).

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Despite all the above efforts at policy level, the situation on the ground still remains pathetic with maternal mortality rates reported at 650/100,000 (MOH, 1998a). With an average of 4.7 (KDHS, 1998) or 5.0 (KDHS, 2003) births during her life time, a Kenyan woman, therefore, has 1 in 36 lifetime risks of dying from maternal causes. Indeed, maternal deaths represent an estimated 27% of all deaths for women aged 15-49 years (Kiragu, 2000). For every maternal death, it is estimated that additional 30 women experience serious, even life threatening morbidity (Ashford, 2002).

With respect to antenatal care, the KDHS (2003) report indicate that 9 in 10 mothers reported seeing a health professional at least once for ANC for the most recent birth five years preceding the survey (93% for urban areas and 87% for rural areas). Although it is said that early and timely visits promote essential screening of high risk mothers and emergency preparedness, the study revealed that only 14% of women visit in the first trimester and only 6 in 10 women attend ANC services four or more times as recommended. What is missing

from the above data is the quality of interaction and what the women received during the visits. Equally worrying is the fact that the visits were never followed by facilities deliveries or by a reduction in maternal health burden. The report also does not clearly spell out the cultural environment in which pregnancy is carried to term and the environmental (both physical and cultural) burden that women have to bear in this process. It also looks at antenatal care from a biomedical lens with minimal or no regards to the cultural knowledge and practices.

On deliveries, the report indicates that only 4 in 10 births in Kenya are delivered by a health professional and a similar proportion of deliveries take place in health facilities. The report indicates a decline in the proportion of women who seek medical assistance during delivery from 50% in 1993 to 42% in 2003. The report also indicates that the total fertility ratio has increased from 4.7 in 1998 to 5.0 in 2003. On the disease burden, the report indicates that HIV/AIDS is very prevalent at a national prevalence rate of 6.7 with women more infected (women 8.8 and men 4.2).

The major causes of maternal mortality and morbidity in Kenya include Hemorrhage, infection (sepsis), obstructed/prolonged labour, and complications from abortion. Other indirect causes are anaemia and malaria in pregnancy (Aloo-Obunga. 2003). It is now emerging that there are a host of other factors that accelerate maternal burden such as the state of medical services, quality of care, and ability to respond to obstetric emergencies among others (Rogo et al. 2001). Rogo asserts that maternal deaths result primarily from delays in receiving emergency treatment at the critical moment when the women need attention most.

The present concern emanated from the high maternal mortality in Kenya and Nyanza Province in particular (KDHS 1993 and 1998) which is higher than the national index. The study explored the various socio-cultural factors that influence the adequate provision and utilization of maternal health care services in Nyang'oma Division of Bondo District. The maternal mortality in the District stands at 620/100,000 (KDHS 1998). Every minute of everyday, a mother dies following pregnancy related complications. The paradox here is that most of these maternal deaths are preventable and although maternal health is a very complex issue, it is not an insurmountable problem.

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World over, the distribution of resources in every society is uneven giving rise to economic inequalities and other forms of disadvantages including the inability of individuals to adequately take proper care of their health. It is also clear that from a geographical and ecological standpoint, particular areas inhabited by specific communities, families and individuals are more prone to particular forms of illness, diseases, and untimely deaths greater than those of others. From a Critical Medical Anthropology perspective, various factors outside the health care system are equally responsible for this sorry state of affairs. Issue of political correctness, ethnic punishment, discriminative government allocations, corruption and the world global economic forces all in one way or the other contribute to poor maternal health care. The other issue of concern is the extensive medicalization of pregnancy and childbirth that has not only removed the process from the traditional female control but also created a clear contest between cultural knowledge on one hand and biological/professional practice on the other. The process of pathologizing pregnancy and childbirth has left many women confused and pondering over the relevance of their cultural knowledge.

In the entire African Continent, many parts especially the rural areas still rely on very 'rudimentary' services and have not come to terms with the advances in medical technology. In every environment, all health issues are heavily intertwined with the social, economic and cultural matrix of society and greater expectations in the delivery of health care services are seen as the preserve of any government. King (1966) sees the delivery of medical care as one of the very first priority of any government. This view has the net result of creating too much reliance on the official health care system thereby limiting individual's initiative in a very contradictory environment.

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A number of explorative studies have been conducted in the last decade in Kenya that explores the reasons for the utilization of maternal health services (KMMBS, 1994, vol. II & I; UNICEF 1997; Makokha et al. 1994; Kimani et al. 1995). Through these studies, identification of patterns related to utilization of formal and informal health services and the difference between communities related to knowledge and attitudes of maternal health matters can be discerned.

Most of the above studies have tended to attribute the pattern of maternal health care service utilization to '*service factors*' such as accessibility, affordability and other elements of

quality: '*Patient factors*' such as personal characteristics (e.g. age, parity, education and level of awareness) and '*cultural factors*' such as traditional perceptions (beliefs), gender roles and the decision making process.

Mosley (1985) had also talked about the importance of economic circumstances as an indicator to the use or non-use of maternity services. Suda (1997) in her study of the fertility and the status of women in Kericho District had observed that women's reproductive and caring roles are many and varied, and so are the reproductive issues which concern them. She underscored the fact that the responsibility of housework, child bearing and rearing is essentially regarded as the domain of women and falls heavily upon the majority of women. She further observed that despite the changes in women's roles and the erosion of some traditions under rapid social and economic change in Kenya, reproductive patterns are still largely structured by cultural value systems and social attitudes which continue to define the status of most Kenyan rural women.

The biggest shortcomings of these studies have been their economic, sociological and epidemiological orientation. Little information is available that takes care of the woman's own voice on her perception of pregnancy, their motivation and ability to access the maternal health care services. Little is also available on the deeper cultural influences and societal social dynamics. It is this void that the study intended to fill by providing rich ethnographic account of how women interact with the health care delivery system and how that interaction is culturally patterned.

It is hoped that the results of the study will improve policy maker's understanding of the complex cultural web and serve as an important tool to the Safe Motherhood Intervention Programmes.

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1.2. The socio-cultural context

The Luo in Historical Perspective

The Luo are a Nilotic group of people currently occupying the larger parts of Nyanza Province around Lake Victoria (Ocholla-Ayayo, 1976; Odaga, 1980). On the whole, hard work and perseverance are virtues that are highly regarded by the Luo. A person (both male and female) who is not able to have a family and take care of it was of no consequence and

was disregarded and not respected by the community. In this regard, children were valued, and they were therefore, taught the value of hard work at an early age (Ominde, 1952).

In traditional Luo society, the women were not supposed to give their views openly on any important matter. But privately, they were consulted (Ocholla-Ayayo, 1976; Odaga, 1980). However, before a man took an important decision which affected the family, he might say "*We adhi apenj orindi mondi*" "wait let me consult the headrest before I give my view". This headrest was in most cases a wife, frequently, the first wife (*mikayi*). This could have a lot of implications in the decision making process with respect to maternal health care given that the Luo are polygynous.

Luo Perceptions and Practices related to pregnancy and childbirth

The Luo are heavily religious and believe in *Nyasaye*, *Were*; the Supreme Being. He is believed to control people's lives and from whom all powers originate. Besides the "Supreme Being", they contend that each individual has his/her own god, *Nyasache* who in collaboration with the ancestors of that particular individual is responsible for his/her luck and wellbeing including the "gift of birth" (Ocholla-Ayayo, 1976).

The Luo believe in the powers of magic and medicine. According to them, the dead and the living communicate. The ancestors are therefore, considered to be alive and play an important part in the lives of the living who must appease them regularly with great gifts of sacrifices to be on the safe side. This partly explains why dead relatives are buried with care and pomp among the Luo (Odaga, 1980). The ancestors are kept alive by naming the children after them. The gift of birth is also seen to be heavily dependent on the good will and blessings from the ancestral spirits. They believe that man is moulded in the womb of the mother. The uterus that is considered the point where life begins is called *Nyasach dhako* (Woman's god). It is here that God's moulding work is carried out. Reference to the uterus means that a woman's social strength and power rests on her ability to give birth and to continue the lineage of her husband. When a woman gave birth, there was rejoicing and people made reference to the fact that God had helped her (*Nyasaye osekonye*). If she got a boy, it was said that she had brought forth the handle of the spear (*bol*) in reference to future male responsibilities and if she brought forth a girl, then she had produced the wild cat (*ogwang*), a symbol of unknown abode (Odaga, 1980; Mboya, 1938). Clinic attendance in

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this regard only aids or is seen as not being responsible for safe deliveries. Some of these practices persist to date.

The Luo refer to the forces or spirits that exist beyond the immediate presence of life on earth as *juogi* (Ocholla-Ayayo, 1976). When the living are dead, they are referred to as "*Juok ka kwaro*", the spirits of the ancestors. Therefore, if a child assumes the names of his grandparents, it gets the names of *juogi* or simply, *nying juogi* which means, names of spirits (The spirits in this case will be the child's guardians ensuring his/her good health). Naming also involved the consultation of medicine men. Babies were also given names according to the seasons, time, place and position of birth. Naming also followed important events in the community.

Endurance in birth was a virtue and people could boast about how they delivered on their way to fetch water from the river, firewood from the thickets, to the markets and so on (All these have important implications and consequences for safe motherhood).

There is an important sentimental attachment to children among the Luo. Marriage as an institution is honoured and greatly respected. People who do not marry are seen as worthless misfits. Marriage was only complete after the bride-wealth payment (paid in Livestock) had been done and a child born of the marriage. Traditionally, the Luo expected the bride to be a virgin on her bridal night. This was a source of great honour to the parents, the husband and the girl herself (probably, this explains why teenage pregnancies are frowned upon). Cases of premarital pregnancies were traditionally very rare. This rarity resulted from the conscious efforts of the girls themselves to guard against it (Ominde, 1952).

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In the past, if a woman gave birth to an illegitimate child, her only chance of marriage was to an old man with a number of wives. Everything was done to get rid of her as soon as possible (Ibid). This has implications for maternal health particularly the teenage mothers and this could be part of the reason why many teenage girls prefer abortion as an option or simply shy away from using the maternal health care services for fear of the community members).

In the Luo community, polygyny was respected and the more wives and children a Luo had, the richer he was considered to be. Children are seen as gifts from God which you cannot refuse or limit in number or of whom there cannot be enough (Ocholla-Ayayo, 1976; Odaga,

1980) (This position viewed against the present biomedical information regarding fertilization and child birth, may have negative consequences on maternal health). This view and the high regard for children placed great importance on fertility and childbirth. Childlessness was frowned upon and when a barren woman died, a cat was tied on her neck before she was buried (Mboya, 1938; Ocholla-Ayayo 1986; 1988). This ensured that she went with her bad spirits responsible for the misfortune. Further, child death and miscarriage were both considered closely related to barrenness and often identified by diviners to be the work of witches and sorcerers (Ocholla-Ayayo, 1976).

In a place where there are still strong beliefs about witches and sorcerers and where redress can only be through magicians and medicine men, the introduction of modern health care facilities and their subsequent utilization becomes problematic and not straight forward as would be expected. The frequent cases of jealousy and co-wives rivalry in polygynous marriages and plural unions may also affect the health-seeking pattern of the members of such unions with greater implications on maternal health care as is exemplified in the findings of this research.

The Luo kinship value is stressed more to the patrilineal or agnatic kinship. The value of parental and brotherly love is so strong that the Luo will call all who are related to the father's brothers as fathers and all who are related to the mother's sisters as mothers. The kinship value called *wat* (relative) is regarded as an infinite value that must be maintained at all costs, and death alone cannot separate its members (Ocholla-Ayayo, 1976). This creates a great number of significant others in the therapy managing group which in essence determines the utilization of health care facilities and services.

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There are other issues in the Luo community otherwise referred to as "*Chira*" that are related to childbirth and childcare that are of importance here. Nagashima (1981) cites such five taboos and avoidances. These are:

1). From the day of birth of his child to the ritual intercourse (*ng'ado imbo nyathi*) with his wife, the husband must spend the nights in her hut and should not have intercourse with any other woman. Breach of this rule brings *chira* to the baby.

2). If one of the parents holds a suckling in his/her arms after committing adultery, the baby will suffer from *chira*.

3). If a suckling woman and a woman in *sirowa* period pass each other on the road, the

former should look back and squeeze her breasts to shoot milk in the direction of the latter. Otherwise, the baby of the former will suffer from *chira*. (*Sirowa* is the period between the ritual intercourses performed by the couples who have lost a child and a woman's next menstruation).

4). Suckling women should not fight each other. If they do so, the baby of one of them will suffer from *chira*.

5). The second youngest sibling should perform ritual holding of the newborn baby in his/her arms. Otherwise, he/she must not hold the babies born thereafter in his/her arms. If he/she does, the baby will be attacked by *chira*. This was probably a child spacing measure that ensured that children were spaced in such a way that they did not follow each other very closely. However, the implications of *chira* and related practices had profound effects on postpartum care as emphasis was on the household and home deliveries.

There are other behaviour patterns related to marriage that may also result into *chira* (see Nagashima 1981; Ocholla-Ayayo 1976; Mboya 1938). These laws forbid sexual immorality and fornication and also spell out rules regarding appropriate behaviour patterns. The order in which siblings marry and the parental responsibility are all-important issues. In this community, any immoral person was seen as unfit to bring up children and infidelity in pregnancy was not condoned at all.

The Luo diet is rich in variety. They eat meat. chicken. some birds, fish, vegetables, and blood of animals among others. All these are mostly taken with ugali (*kuon)* that is a staple food among the Luo. The foods eaten without ugali are: *Nyoyo* (mixture of beans and maize), *rabuon* (sweet potatoes), *budho* (pumpkins), *nyuka* (porridge) and *kon'go* (native brew).

The community had their own food customs. Some men did not eat foods such as eggs because they had a low opinion of such foods. All Luo men did not eat the kidneys of livestock. It was forbidden for women to drink milk or eat chicken, mutton, hippo meat, rabbit meat, porcupine and some other foods (Mboya, 1938). Some women did not eat mudfish and other foods because of pride, while some foods were not eaten because of the belief that they caused certain diseases such as leprosy, smallpox and other diseases. Others did not eat certain foods because their clan traditions did not allow it. They had different food customs depending on the clan (totems).

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There were certain food customs and taboos observed by expectant mothers, which merely reflected the social attitude of the Luo women to the birth of their children. The aims of the food customs and taboos can only be appreciated in light of the social desire for the woman to give birth without difficulty (Ominde, 1952). Most of the food avoidances were based on the understanding that they made the baby grow too big in size leading to difficulty in delivery.

Pregnancy as a process places great psychological stress on the woman and it was an arena where power was displayed. The woman became a captive of the society, community, clan and even the unborn child. There is a factor of great psychological significance in the belief that Luo mothers begin to yield to the will of their babies long before they are born. Among them are some who, during pregnancy, develop a habit of eating dried mud and other peculiar foodstuffs, one baby causing a mother to eat these and the next turning her appetite against them (Ibid). These strange habits of eating are attributed to the will of the expected child; it is believed that the domination of the child over the mother, enduring through the early part of life begins in the period of pregnancy.

Although some of the cultural observances affecting expectant mothers have very largely yielded to the influence of Christianity, there are still remnants of old regulations, such as those connected with sitting, still observed by women. An expectant mother is required to sit with a straight back. Neither should she put one of her legs on top of another, because it is believed that the expected child in assuming similar position would be difficult to deliver. A person standing behind an expectant mother may also be driven away in the fear that if that person's birth had been difficult, the birth of the coming child would equally be difficult (Ibid).[1]

There were customs that were related to conception. When a woman conceived during the mourning period, *kopidho olele*, nobody other than a person who was also bound by the same rules, *pidho olele* should touch her. Otherwise, she could develop gynecological problems in which case she should inform her mother-in-law or her husband or an aunt. When the mother-in-law was informed, she could contact a cleansing woman to bring the appropriate

[1] I can remember my own mother teasing me not to stand on her back whenever she was expectant telling me that she did not wish to give birth to an ugly baby like me. The assumption here was that standing at one's back led to a resemblance to the unborn baby.

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cleansing medical herbs, *yadh olele* for her daughter-in-law to relieve her of the pains (Mboya, 1938).

When a young woman was expecting her first baby, while she was supposed to keep her hair unshaved (*pidho olele*) during the mourning period, she should not shave, cut her nails, or pluck out the eyebrows and nobody should remove anything from her body or touch her except those who were also in the mourning and were bound in the same circumstances (see details in Mboya, 1938). This actually had a lot of implications for maternal health. This custom restricted maternal mobility and their freedom to choose and limited their healthcare options to what could be provided within the homestead and by people in the same condition.

When a woman was six months pregnant, a tatooer (*jakedo*) was called to tattoo her. The operation was done besides the granary of the mother-in-law. Except for a papyrus fibre string tied around the waist, the woman undergoing the operation was naked. After the operation, the tatooer washed off the blood. The day oil was applied to the wounds, the woman returned to her homeland to fulfil the tattooing customs (*tero kedo mar nindo oko*). When she came back, her parents gave her flour to be used to make native beer and dried fish to bring home. She took them to the mother-in-law. At present, some of these customs have diminished though there is still a strong associational link between pregnancy, childbirth and cultural knowledge that is in conflict with the safe motherhood programmes that reify biological knowledge at the expense of the cultural knowledge and practices.

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With respect to delivery, the assistance a woman receives while giving birth depended on the circumstances in which she finds herself. There was no ruling laid down as to which particular people should help her; this obligation merely rests on whosoever happens to be present. The assistance of a midwife was required more for a first child than for the following (Ominde, 1952).

When a woman was giving birth for the first time, an experienced old mid-wife was summoned. If the delivery was difficult, the father-in-law went to collect grass from a 'denudated' home. He tied it into a small bundle and brought it in the house where the woman was delivering. He then untied the grass on the woman. He then wiped her with a grinding stone as he prayed in these few words: "*Please mother, if it is you, let these people's daughter deliver safely. I pray for the evil to be removed*". This prayer was meant to appease

the living dead whose spirit was supposed to guide the birth process. If the afterbirth, *thuon* was not smoothly released, a specialized medicine person or a knowledgeable woman was brought to put her hand in the woman's uterus to remove the afterbirth. Many women died from this process (Mboya, 1938). During birth, the presence of the husband was not considered necessary unless the case was a difficult one (Ominde, 1952).

When the cord had been cut, the child's mother finely crushed some charcoal between her teeth and then put it on the wound to block the artery (*odin ligewo*) and also on the umbilical cord which was cut off. If the birth took place at night, the afterbirth of the baby was buried in the morning and if it took place in the morning, it was buried in the evening when the cattle came home from grazing. A boy's afterbirth was buried on the verandah on the left as the house was entered and the girl's was buried on the right side of the verandah. On the day of birth, finger millet was prepared for the mother. The parents, the mother and the father also ate ugali in a calabash (*kuon agwata*), to show that this was their first born (Mboya, 1938). This was an important Luo custom and symbolized the couple's mutual regard for each other. The idea of placenta burial has persisted to date and is one of the cultural reasons advanced by wives as well as husbands for not preferring facility deliveries.

On the day the baby was taken outside the house for the first time after birth (*chien'g yiego nyathi*), a fish was cooked and salted with *rabongi,* so that the baby can develop good eyesight. The mother also put an axe in the washbasin on this day when she washed the baby; but for a baby boy, the mother put the axe in the washbasin every time she washed him. On this day also, the baby was laid on the threshold of the door. At around ten o'clock, the mother was shaved. Feathers of the red-eyed eagle, *koga* and of the woodpecker, *teltel* were prepared for the boy and the mother to wear, for if this was not done, the day that one of the birds sung or fluttered around, the baby would certainly die. On this day, the parents had their first sex since the birth of the child (to break out the obligatory tie of a newborn child, (*ing'ado imbo nyathi*). More elaborate and customs specific rituals followed the birth of twins. The important thing to note here is that these customs placed emphasis on the role of *Nyamrerwa* (Traditional birth attendants) and the significant others living no room for hospital based delivery and care. All the customs and rituals were to be done within the homestead and the spiritual as well as the ethnomedical protection of the mother and child were vital.

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The Luo social structure was and still is organized around patriarchy in which clan leadership is provided by a small group of male elders. Three elements of Luo social structure, **bride wealth, polygyny** and **patrilineal descent** (Patrilocal post marital residence) combine to exert powerful influence on gender specific roles and responsibilities. Luo culture gives only men the right to own property. Women do not own property. Instead, it is transferred through them to their sons. The Luo concept of respect, or *luor*, is important in the definition of manhood in relation to women (Luke, 2000).

Certain types of behaviour are expected of Luo women. These include **obedience, bearing many children**, particularly male children, support of the family and taking care of the domestic homestead guided by the authority and control of the husband and at times the mother-in-law. An unwed, disobedient, sexually unwilling, unfaithful, infertile, or indolent woman would thus, be labeled disobedient. Such 'misbehaviour' by women can have serious consequences, including divorce; separation or a husband taking additional wives into the household. Beating women appears to be a common and culturally acceptable practice (Moore et al., 2002)[2]. All the above practices leave little room for a woman as a principal actor in her own pregnancy and limits her choices and curtail her reproductive freedom.

In addition, the African family relationship have been looked upon as socially dominated by men in the community, with women striving to maintain any form of economic independence (Ocholla-Ayayo, 1988). Women continue to be primarily responsible for domestic work at home and other related care-giving chores around the household. Women can only look to members of their own family for assistance with domestic chores and family affairs. This heavy workload among the Luo continues in pregnancy and a woman was expected to provide for her family at all times.

Since marriage among the Luo is harmonized via the payment of bride wealth in livestock (*nyombo*), a wife for whom cattle has been paid has more value than a casual consensual partner (known in Kenyan parlance as '*come we stay*'). When a woman marries, she initially moves into her husband's father's homestead and under the direct control and supervision of the mother-in-law. Traditionally, after a few years of marriage, a husband would establish his own homestead near his father's (Luke, 2000; Mboya, 1938).

[2] There is the belief in Luoland that wife beating is a sign of love and discipline. In some instances, when a wife dies before being beaten by the husband, he is expected to symbolically beat her before burial or else, he can never discipline or beat any other wife in future if he remarries.

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Because of this pattern of Luo household, a mother-in-law has domestic authority over a wife or co-wives. For the first period of her residence immediately after marriage, a new wife must cook in her mother-in-law's house, and a mother-in-law exerts strong influence over many aspects of her movements, including illness, care seeking for both the woman herself and her children. Senior co-wives have influence over junior co-wives. Co-wifehood may be a source of jealousy between women who rival each other for the husband's attention. This rivalry is expected in Luo families, and is embodied in the term for co-wife, *nyiego*, which literally means jealousy (Luke, 2000).

Among the Luo, pregnancy is not regarded as a pathological condition that requires closer observation and assistance with the domestic workload. It is regarded as a normal condition (Khayundi, 2000). Household responsibilities such as cooking, looking after children, washing clothes and dishes, fetching water (which can be from a real long distance), and fetching firewood are all traditional duties of the women. Besides the above, she is also expected to go gardening and produce food, market the surplus and to ensure that the welfare of members of the household and at times, the whole homestead or clan is well taken care of. Traditionally, female children were socialized and indeed, they assisted their mothers in the domestic front. Today, they go to school and are not available to give a lending hand thereby doubling the domestic workload. All these issues have important implications for safe motherhood.

Medically, pregnancy and childbirth in Luo society were and still are majorly the domain of herbalists and traditional midwives (*Nyamrerwa (singular) and Nyamreche (plural)*. These groups give advice to women during pregnancy about diet, exercise and work besides prescribing daily doses of "pot medicine" (Moore et al., 2002; Mboya, 1938). In their work, they encounter some medical and obstetric complications that are perceived to be within the domain of the *Jok*, the ancestors, or of witchcraft. Once complications are attributed to spiritual causes, they are best dealt with through prayers and herbal medication (Luke, 2000).[3] This worldview differs radically from the epidemiological driven and medically defined obstetric complications where redress can only be found in health care facilities through the intervention of technology and medical specialists who represent a different construction of reality.

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[3] Some of the complications had fatal results. Many women died in difficult labour. If a woman died before birth, it was considered a very bad omen and a stranger had to be paid to cut her open and remove the dead child before the burial. No relative of hers was allowed to touch her (see Ominde, 1952; Mboya, 1938).

The Luo Traditional Economy

Ocholla-Ayayo (1976) has described the Luo traditional economy as Pastoral-Agrico-Fishing society. They practiced Agriculture, kept livestock and did quite a great amount of fishing in the water masses surrounding their country. They admire strong industrious people who can farm well, and buy livestock from others and be in a position to help their relatives (Mboya, 1938). The society thinks highly of a man whose hard work provides food for his family throughout the year and who prospers through hard work. This same principle also applies to a woman in whose house there always will be something to eat and who is generous.

Livestock keeping and fishing along the beaches of Lake Victoria, Lake Kanyiboli, River Nzoia, and River Yala among other water masses compliments the agriculture practiced. Agriculturally, the Luo grew finger millet, maize, potatoes, cassava, beans, simsim and a variety of vegetables such as *boo, dek, mitoo,* pumpkin leaves among others. Farming activities go around the household with every wife being responsible for the food security in her house.

On the side of livestock keeping, all the livestock in a homestead belong to *jaduong*-the old man who is the owner of the home. It was the duty of the younger men and boys in the home to take care of the livestock. The old man divided his milk cows among his wives who had the "use rights". The first wife (*Mikayi*) received more than others. He also gave heifers to his sons who had married and here. he also followed the order of their marriage seniority. Once he had given out a cow to his wife or sons, he could not take them back or use then without their permission (Mboya, 1938).

All in all, the Luo were very rich people culturally and socio-economically. Communal existence ensured that nobody went without food and there were cultural cushions against adversities. Perhaps, this explains why there are very few street children from the Luo community (Owuor, 1996).

From the above ethnographic journey back in history, the following issues, which are critical to Safe Motherhood Initiative, emerge:

- The Centrality of Cultural Practices in the life of a pregnant woman which include the role of ancestral spirits in conception and birth, nutritional proscriptions in pregnancy, the role and importance of *nyamrerwas* (TBAs) in pregnancy

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management and delivery, importance of traditional herbal medicine, the ritualistic importance of the placenta, ritual eating to symbolize togetherness, protective practices for both the mother and the newborn, ritual sex that breaks the obligatory ties of the newborn.

- Other important emerging issues include the institution of polygyny and co-wife rivalry, the lack of husbands' positive direct involvement in pregnancy management, the subordinate status of women and the pressure on them to be fertile and bear as many children as possible, the large kin network resulting from the value of *Wat* (relative) that act or make decision on behalf of the pregnant woman and the importance of 'being hardy' and 'endurant' against all odds.
- The idea of women yielding to the demands of their children even before birth for instance in soil eating or developing negative attitude towards other relatives, change in dietary patterns among other habits.

All these issues have important bearing on maternal health care and the maternal behaviour in relation to the utilization of health care services as the study found out.

Although there are changes that have been occasioned by modernization/westernization and industrialization that has seen the Luo migrate in search of paid labour and others joining Christianity, majority in the rural environments still observe traditional cultural practices.

1.3. Problem statement

In most parts of Sub-Saharan Africa, there are higher risks associated with pregnancy and childbirth as well as high rates of unintended pregnancies, maternal mortality and morbidity. There is also uninformed involvement of men in family decision-making processes relating to women's reproductive health and family planning. Further more, there are even more acute risks in the rural areas than urban centers. Even, within a country such as Kenya, there are regional disparities with some areas being 'high risk' as compared to others. It is evident from the KDHS, 1993 and 1998 reports that Nyanza Province lags behind with regards to maternity related services. The latest preliminary report (KDHS 2003) indicates that 9 in every 10 mothers reported seeing a health professional at least once for Antenatal Care (ANC) for the most recent birth (93% in urban areas and 87% in rural areas). The same report indicates huge regional disparities with Nyanza Province lagging behind (Nairobi 94.7%, Central 92.7%, Coast 86.9%, Rift Valley 88.5%, Western 90.8%, Eastern 91.1% and Nyanza at 86.6%). The only region with the lowest attendance was North Eastern with

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25.3% and this could be as a result of religion and geographical isolation. What this report does not say just like in other researches as is exemplified in the literature review is why, despite the high antenatal health care attendance, the maternal mortality rate has till remained high. It also does not spell out the quality of care, the difficulties experienced by women in accessing the facilities, the circumstances of their attendance and the number of times they attend besides the first visit for a "passport" (Moore et al., 2002; Neema, 1994; Allen, 2002), and above all, the cultural constraints they face in the pregnancy process. All the above issues are too crucial to maternal welfare and to safe motherhood interventions.

Important to anthropological discourse would be the way and means women themselves as conscious agents of their actions deal with the different and radically opposed construction of realities where on one hand, they posses the cultural knowledge and on the other, they are bombarded daily with the biological knowledge of the importance of pathologizing pregnancy and making it a health care issue. Additionally, pregnancy is one of the areas of female life in sub-Saharan Africa in which cultural expectations and responses still influence and at times dominate health status either for good or for bad. Therefore, in order to improve birth outcomes, it is essential to understand socio-cultural health beliefs, the impact they have on pregnant women's health behaviour and to determine the effects of these beliefs on birth outcomes. Ethnic cultural beliefs associated with pregnancy and childbirth, are reinforced in the traditional community by the husband, the mother in law, the head communal female figure and other family members.

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On delivery, the report indicates that only 4 in 10 births in Kenya are delivered by a health professional and a similar proportion takes place in health facilities. There are regional disparities with Nyanza as one of the provinces doing poorly (Nairobi 78.5%; Central 68.8% and Nyanza at 40.7%). In terms of facilities delivery, Nairobi is the highest with 77.2%, followed by central at 67.6% and Nyanza at 38.2%. This is a clear manifestation of a problem in Nyanza province that requires urgent attention.

Besides the above, the report further indicates the burden brought about by the HIV/AIDS epidemic. It reports a high prevalence level with Nyanza being the worst hit region. With a national prevalence rate of 6.7% for both sexes, Nyanza recorded the highest of 14% with women in their reproductive age group of 25-29 being the worst affected. Despite the recent efforts to educate people on family panning and birth control, the report indicate an increase

in the Total Fertility Rate (TFR) from 4.7 in the 1998 KDHS report to 5.0 in the 2003 report. It also reports a Maternal Mortality Ratio (MMR) of 11 deaths per 1000 women (1100/100,000 that is higher than the earlier projections of 590/100,000).

A report by Oyando (Daily Nation Newspaper of 15th June 2000:15) indicates that a recent facility assessment of Siaya District conducted by the Kenya Prevention of Maternal Mortality Network (KPMMN) revealed that most maternity hospitals both government and private lack the capacity to provide essential emergency obstetric care. Additionally, both the 1989 and 1999 population census results indicate that the majority of Kenyans are rural based with inadequate maternal healthcare facilities, have poor infrastructure, are poverty stricken, and have strict adherence to socio-cultural prescriptions and traditional beliefs and practices that limit women's use of modern maternal healthcare facilities. In places where the physical facilities exist, there is lack of adequate trained personnel to offer specialized services and shortage in supplies.

Magadi (1997) observed that the problems of availability, accessibility and use of basic services like; transport, hospitals or medical centres, safe drinking water, well trained medical personnel, basic health facilities/equipment as well as public toilets are either lacking or are inadequate. Such pathetic conditions make mockery of the entire process of providing health care to the vulnerable groups in society. Suda (1997) on the other-hand found out that poverty, frequent births, low literacy levels, poor health care facilities, strong cultural traditions and beliefs, low status of women in society, lack of decision making power and polygyny are some of the major barriers which limit women's ability to protect and promote their health as well as the right to control their own fertility.

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This study therefore, tried to explore all those socio-cultural factors that influence the utilization of maternity services such as antenatal care, postnatal care, and proper nutrition of mothers during pregnancy particularly with regard to protein in-take and maternity related food avoidance. The research situated a woman in the 'cultural forest' and tried to explore how she navigated and waded through the turbulent and rough terrain in pregnancy till delivery in the midst of patriarchy, the different constructions of pregnancy, world capitalist system and other forces that impeded her freedom to free choice. Issues regarding service factors and facilities based incompetence, poor infrastructure, and poor communication networks as well as poverty were looked at with regard to how they contribute to the non-use

of antenatal care services and subsequently to the grim statistics presented on maternal health care. The research undertook the task of providing an anthropological contribution in situating the statistics in their rightful cultural contexts and giving them meanings in local terminologies.

Additionally, the research has brought out the differential worldview on the contested definition of pregnancy as 'locally known' and as 'officially imposed'. The health care system pathologizes pregnancy and childbirth and sees its successful outcome to be a concern of biomedicine, whereas the local definition still sees pregnancy as a normal condition whose outcome is still within the domains of a variety of local health care options other than the facility based experts.

1.4. Research Objectives

1.4.1. Overall Objective

To explore the provision and utilization of maternal health care services from a socio-cultural perspective among the Luo of Bondo District, Western Kenya.

1.4.2. Specific Objectives

- To identify and describe the sources of maternal health care provision available to the local populace in Nyang'oma Division- Bondo District
- To assess the awareness with regards to the available maternal health care services among women in Nyang'oma Division-Bondo District.
- To explore the socio-cultural perceptions and practices of pregnancy of the women and the 'important others' and their influence on maternal health and health care services utilization.
- To explore the role of 'service factors' in the provision and utilization of maternal health care services.

1.4.3. Research Questions

In order to achieve the above objectives, the following questions guided the research:

1). What is the level of coverage and the distribution of the maternal health care facilities both biomedical and alternative within the study area?

2). What is the level of knowledge among women and their therapy managing group of

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the existence of the identified facilities and their own view of how to make every woman aware of the facilities for improved care?

3). How is pregnancy culturally conceptualized in the community and how does that conceptualization affect the practices related to it and the ultimate outcome?

'Service factors' in the fourth objective refers to issues of health care availability. affordability. infrastructural support. accessibility and other provider based constraints to proper maternal health care service provision and utilization.

Specific questions that guided the study here were:

4). What do the women think about the professional health care providers and the entire hospital system, and how do they interact with this system in their day today experience of pregnancy and childbirth?

5). Where is the point of departure between the providers' and the consumers' view on maternal health care services and how does service constraints affect care seeking patterns and the ultimate pregnancy outcome?

The answers to the above questions have therefore, formed the basis for this thesis and the subsequent recommendations to safe motherhood interventions.

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1.5. Justification for the study

From the past researches and community observations. it has been apparent that maternal health care is not only an issue of facilities based care. but a true problem that goes deeper than is currently assumed. The assumptions and belief in antenatal care has not provided clear guide on how to effectively tackle the socio-cultural constraints and has failed to accord women their reproductive rights and freedom as it should be.

The high maternal mortality and morbidity in Nyanza Province calls for a more deeper ethnographic and insightful account in order to bring out to the fore the more intricate and hidden factors that are responsible for the sorry state of affairs. This research has therefore, explored all the cultural constraints and has come up with culturally relevant interventions to safe motherhood programmes.

The results of this research can assist in programmes interventions, safe motherhood policy formulations and inform the health care system of the need to rethink their present maternal health care strategies. Further, the results can be used as powerful instruments by the maternal health advocates for a correction in the cultural lag in the attitudes of men and other therapy managers in the area of study.

The concentration of the research on maternal concerns other than the normal mix of Maternal and Child Health (MCH) has elevated the status of mothers as the prime bearers of pregnancy and as the sole individuals whose health can guarantee the well-being of the unborn child other than the reverse. This research therefore, makes the mothers the centers of attention in maternity concerns and has the potential of ensuring safe motherhood.

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CHAPTER TWO

LITERATURE REVIEW

2.0. Introduction

Most of the literature from previous studies in Kenya have tended to focus mainly on family planning issues (Ocholla Ayayo and Otieno, 1987; Opia Mensah et al., 1994; Alando, 1992; KPMMBS, 1996; Magadi 2003; Owino 2003). They have also been carried out under the Population studies perspective with quantitative approaches as the prime methodologies and the provision of statistics as key. Although there is a relationship between maternity services, safe motherhood and family planning programmes, the two are not necessarily the same. The existing literature will be considered under sub-themes:

2.1. An overview of antenatal health care and deliveries

2.1.1. Antenatal/Prenatal care

Resulting from the concerted efforts to curb maternal mortality, the safe Motherhood Initiatives identified the provision of prenatal care as one of the four essential elements of the Global Safe Motherhood Strategy to improve maternal health outcomes (Mahler, 1987).

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According to Ebrahim (1968 and 1972), the aim of maternal health services is to ensure that;-

1). Every expectant mother maintains good health, is prepared both physically and psychologically to look after her child, goes through a normal delivery and bears a healthy child.

2). Every mother brings up her child in healthy surroundings, receives proper nourishment and adequate protection from diseases.

3). Communicable diseases are controlled in the vulnerable groups by taking adequate preventive measures and by health education to the mothers.

4). Sickness is detected and treated early before it becomes serious or chronic.

5). Simple statistical data on morbidity and mortality are maintained on regional and national levels.

Ebrahim was of the opinion that many of the health problems encountered by mothers in the developing countries are preventable either by means of health education or regular supervision and proper service provision. However, Ebrahim's assertion may be complicated by the local perceptions and view of pregnancy as a lived experience.

Several past studies (Harrison, 1985; Mashini et al., 1984; Magadi, 1997; Suda, 1997; Rattanporn, 1980; Owino, 2003; Mekonnen & Mekonnen, 2002; Moore et al., 2002; Neema, 1994 among others) have underscored the importance of antenatal care (ANC) and its success in reducing maternal mortality in all age parity groups. However, there are several conflicting views that are local and cultural that reduces the level of health care utilization patterns.

Njaramba (1994) observed that antenatal clinics, child welfare clinics and family planning activities are all aimed at improving the health of the mother and child. K'Okul (1991) emphasizes the need for proper care of mothers with specific reference to the Samia since they are easily susceptible to infectious diseases because they deliver in poor health conditions, already chronically anaemic and weakened immunologically. Lactation adds further strains if dietary intake is insufficient.

Utilization patterns have been reported to be influenced by several factors. Important among them is what Sundari (1994) calls "Patient factors". These are what are deemed as faulty actions on the part of the patient, for which the health care system is not responsible and about which it is helpless to do anything. Included in the patient factors are:

- Refusal to go to hospital, Patient delay in arrival
- Handled by TBAs and relatives
- Delayed medical aid or patient not presented
- Patient non compliance, refusal of treatment
- Patient or relative's attitude
- Interference with pregnancy and lack of adequate ANC
- Termination of pregnancy by unqualified personnel, late presentation e.t.c.

All the above Sundari concludes results from the failure of health care system to reach the population with appropriate health messages to enable them diagnose danger in time, and above all, from the different paradigms in which biomedicine and ethnomedicine are founded. She sees the etiology of any illness as a determinant of the subsequent therapeutic options.

An important factor in the utilization of maternity care services in Africa is the cultural background of the woman (Leslie and Gupta, 1989; Pelto, 1987; Allen, 2002; Raikes, 1990). The cultural perspective on the use of maternal health services suggests that a medical need

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is determined not only by the presence of a physical disease, but also by a cultural perception of illness (Addai, 2000).

The definition of pregnancy and the need to attend biomedical services are compounded by local views. Neema (1994) for instance reports that the local view among the Ankole people of Uganda is that the hospital is a place to go when one is sick, and a place to deliver when a "woman fears the baby". The dilemma here is therefore, should childbirth be a hospital or a home based event?

Another emerging issue in literature is that most women go to the clinic in order to get antenatal card which acts as a "passport" to professionalized care in case of complications at delivery (Moore et al., 2002; Neema, 1994; Allen, 2002; Raikes, 1990). Allen for example reports that in Tanzania, the antenatal card is the key component of the risk referral system. It is meant to function as a tool for the efficient evaluation of a pregnant woman's health status, a kind of mobile hospital record that facilitates and ensures consistent prenatal care (2002:159). Further, the card also functions as a screening device. Nurses mark the appropriate boxes on the front of the card to indicate whether the woman is considered to be at high risk for experiencing obstetric complications.[4]

Allen observes that the decision to finally begin prenatal care does not necessarily stem from any form of conviction that prenatal care and of itself is in their best interest health wise. Rather, their goal is getting a prenatal card. For some women, possession of the card appears to be an end in itself; it is the entry ticket to the maternity ward that ensures their admittance should complications arise during birth. In other words, women eventually register for prenatal care even quite late in their pregnancies because of the risks they face, if they do not- they may be insulted or hassled by nurses for not having a prenatal card or be turned away completely (Ibid: 167)[5].

It has also been reported that a number of women visit more than one ANC clinic during pregnancy, and the availability of biomedical personnel and medical technology may influence their decision to seek care in a hospital when their delivery time arrives (Begun,

[4] In a recent facility review in Lugari District, it was noted that the nurses made marks on the cards indicating that specific services had been provided whereas they had not. In three cases, they marked that they had provided malaria prophylaxis whereas the truth was that the malaria drugs were out of stock.

[5] Women presented themselves very late for the first antenatal visits as late as 36 weeks of pregnancy at the Lugari District Hospital as well as the dispensaries in Nyang'oma Division.

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Seguera and Hassan, 1994). Women also consciously choose on the providers to attend to them. Their choices are influenced by previous experiences and their proximity to the individual provider.

Raikes (1990) on the other hand, sees health system factors as the core determinants of whether ANC is successful or not. This she says include the existence and extent of a health care programme or service, covering staffing, drugs and equipment, costs and quality of service. She asserts that, while the degree to which any programme has staff in place, and the distribution of drugs and equipment are both important and measurable, wider issues relating to 'quality of care' are often as more important but less easy to evaluate. For example, in a situation where staff, drugs and equipment are all in place, the services may be underutilized due to factors often related to quality of care. She offers further elaboration by saying that quality could be related to the poor staff training and services distribution or at another level, it relates to the wider issue of the functions of the health services which affects -in turn, how the services are perceived and run. Incases where staff are poorly trained, this may reflect a situation where the main function of the service is seen as part of a controlling one, and the staff are seen as part of a coercive programme and may therefore, be resented.

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It is usually acknowledged that the health systems management of childbirth has many functions, but the assumption most often put forward in relation to the antenatal and maternity services is that they are run to improve the outcome of childbirth by providing universal access to medical care and medical solutions (Ibid: 40 and as indicated by Ebrahim, 1968 and 1972). However, Raikes cautions that this may not be the case. She notes that the history of maternity services as is known in Kenya today and the model upon which it is built originated from Europe. Here, she asserts, the problem was looked at holistically and even the improvement of the people's living standards formed part of the process. Not only did they properly train the midwives in Britain, but also incorporated better care, more check-ups of pregnant women, more hospital beds under specialist supervision, more antenatal clinics were set up, establishment of a system of medical auditing and certain pregnancies defined as "high risk" where special arrangements for care and confinement of these women were made (Raikes, 1990: 42).

However, there have been counter arguments where all pregnancies should be regarded as "high risks" (Allen, 2002; Mekonnen & Mekonnen, 2002). It has also been argued that the

medical establishment exerts a controlling function through the medicalization of pregnancy, removing the birthing process from the hands of women, their families and midwives and putting the authority of the birthing process in the hands of the medical bureaucracy controlled by men (Oakley, 1984; Neema, 1994; Strathern, 1992; Martin, 1992; Davis-Floyd, 1992). Oakley argues that women's experiences of childbirth were never considered in the shaping of maternity services and that there are various presumptions about reproduction that lie behind gynaecological decisions that need to be challenged.

The overall issue of risk factors in pregnancy needs to be revisited as it poses a great challenge and danger to safe Motherhood Interventions. Allen (2002) argues that official definition of risks do not always accurately reflect the realities of women's experiences of pregnancy and childbirth; that these incomplete or inaccurate definitions of risks have sometimes led to the development of inadequate solutions for reducing maternal mortality; and that some of the solutions proposed as a result of relying exclusively on official definitions are, in turn, perceived as risks themselves by local community members. She asserts that the two (biomedical and non-biomedical (local healers)) different systems of maternal health care respond to two different perspectives on maternal risks. She comes up with two different views to the definition of risks and that is, Risk OF Motherhood (as articulated in the government Safe motherhood Strategy and Risks TO Motherhood as articulated through the healing strategies adopted by women in the community.[6]

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Literature on maternal health however, classifies the risks of motherhood in several categories as shown below:

- **Medical risk factors** which include haemorrhage, infection (sepsis), obstructed labour, eclampsia (high blood pressure), unsafe abortion, anaemia and malaria
- **Reproductive risk factors** which according to WHO (1986) include age at birth (less than 20 years or older than 35 years are classified as high risk), previous pregnancy (safest 2nd and 3rd, whereas more than six births are at 3 times the risk of dying from a given pregnancy, unwanted pregnancy which according to WHO (1986) leads to illegal unsafe abortion and the mother may be less likely to seek prenatal care in a biomedical setting, and unattended births.

[6] There are also a spiritual set of risks such as ancestral displeasures, sorcery practiced by jealous family members, relatives and neighbours. As a result of these perceived risks including barrenness, local healer's advice on their prevention and these are often followed more closely than advice handed out by health personnel in hospitals and clinics.

- **Socioeconomic risk factors** which include female status and female illiteracy. These affect in three ways; leads to less access to health information and therefore, women may be unaware of the need for prenatal care, leads to limited job opportunities owing to low skill, which means less money available for health care and finally, lower wages which results in greater economic dependence on spouses/mates/husbands which may result in less autonomy for individual women.

Also important are the danger signs in pregnancy that every woman and her family should be aware of in order to seek appropriate medical intervention (See Appendix 2).

Researchers have identified the sources of delays that are seen as responsible for maternal health burden. In the paper by Thaddeus and Maine (1994) entitled: "*Too far to walk: Maternal Mortality in context*", they grouped factors that contribute to the delayed treatment of obstetric complications in the developing world into three broad categories which they called "**the three phases of delay**". These are:

i). Delay on part of the pregnant woman, her family or both in deciding to seek care.

ii). Delay in reaching an adequate health care facility, and

iii). Delay in receiving adequate care once the facility has been reached.

Here, the first delay belongs to the socio-cultural domain already mentioned. The last two delays can appropriately be placed under service factors which are discussed elsewhere in the thesis. The distance from health care facilities, financial costs, previous experience with the system of health care and the perceived quality of care that is available all influence the decision to seek care (Murphy and Baba, 1981; Stock, 1983).

Though the process of medicalizing pregnancy and childbirth has been ongoing, it is noted that in many countries in Africa, the process has not yet been completed, leaving large numbers of women still experiencing childbirth in the traditional ways (Raikes, 1990). The contradiction is that some scholars argue that this process is part of the destruction of the traditional value system, and an imposition of foreign and exploitative political and economic system (Onoge, 1975). This view is often shared by the users of services themselves who view the medicalization process as imposing a different world view hitherto unknown to them and denying them the only source of traditional prestige, that of childbirth and control of the process. I posit that it would be therefore, crucial to look at the process of development of antenatal and maternity services, the functions they are assumed to serve and

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the role they play in improving the outcome of pregnancy for women, as well as seeing what other functions latent or manifest these services perform.

2.1.2. Deliveries/Childbirth

Most women have traditionally given birth at home where they have had control over their own bodies, and where childbirth and delivery have been an affair of women- the parturient woman, her female kin and midwives. In her study of childbirth among peasant women in the Yucatan Peninsula of Mexico, for example, Jordan (1980) argues that home births provides women with support in a time of crisis because of the extensive assistance of female relatives, neighbours and the traditional midwife.

Home deliveries are perceived to be compatible with cultural understandings of female modesty, and minimize medical procedures which are often regarded as unnecessary and frightening. The many reproductive rituals of most communities to the female body at the time of pregnancy and childbirth (Raikes, 1990; Neema, 1994; Allen, 2002; Mboya, 1938; Trangsrud & Thairu, 1998; Kyomuhendo, 2003), provides each woman with a model of comprehending and interpreting her own physical and psychological experiences. This in turn affects the choice of birth location, attendant at birth and the medicine consumed (Neema, 1994). Among the Fulani and Hausa of Nigeria, the "secret of pregnancy", the feeling of shame and the uncertainty about the outcome are so strong that no preparation is made concerning labour and delivery by women and their husbands. The home therefore, becomes the natural place for delivery; it is more familiar and less threatening than a medical facility and does not expose one to shame (Public Opinion Polls, 1993).

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Raikes (1990) reports that among the Kisii, insecurity about witches make women want to deliver alone. The teachings at circumcision where girls are told that they will achieve status by giving birth alone and not crying out, cutting the umbilical cord, massaging to encourage the placenta to come out and the application of soft leaves to stop bleeding are all culture specific and puts pressure on women to deliver at home. Praises abound in several African cultures for women who give birth unaided or in very difficult circumstances where birth represents a rare opportunity for a woman to demonstrate the proverbial virtue of courage and honour to her husband and herself (Kyomuhendo, 2003).

Many researchers (Townsend and Rice, 1996; Symonds. 1996; Allen, 2002, Raikes, 1990; Neema, 1994; Magadi, 1997; KDHS, 2003; Rozario and Samwel, 2002; Jolly and Ram, 1998) have concluded that home births remains a preferred option for most women because of their dislike and fear of hospitals, the importance of the traditions that might be followed in the home, the continuity of care offered by the midwife and the handling of the placenta and other after births.

The traditional midwife in most communities is a pillar to maternal health and is responsible for a variety of things other than delivery. In some communities, she is responsible for ensuring conception, maintaining the pregnancy, caring for the pregnant woman and preparing her body for birth, and supervising labour and delivery. Postpartum, the midwife's role is even greater in ensuring the woman's recovery and future health (McGilvray, 1982; McConville, 1988; Islam, 1989). In India for instance, not only does she supervise birth, but involves herself in cutting the umbilical cord, disposing off the placenta, cleaning up the birth blood and clothes, massages the woman, cooks for her family, cleans and washes the house and takes part in "bathing and stepping out" ceremonies (Jeffrey, Jeffrey and Lyon, 1989). The point here is that home deliveries give women an opportunity to have a helper beyond the birthing process and a helping hand in the domestic chores.

The present appropriation of childbirth by medicine has been blamed to ignore women's own beliefs and the social and cultural meanings of childbirth, or rather, medicine declares such beliefs as ill informed, ignorant or irrelevant (Rice & Manderson, 1996). Scholars lament that birthing has increasingly moved from familial and social domain to that of the hospital-based medicine, for many an alien institutional setting and knowledge base. Oakley (1975) for the UK and Shorter (1984) for the USA and others have documented the transition of the control of birth from midwife to the doctor, and the increasing medicalization of birth that has been part of the process in industrialized countries from the 19th century. In most industrialized countries, pregnancy and childbirth are seen as diseased state, a physical bodily disturbance (Cosminsky, 1982:225); the woman's body is the subject of control by medical professionals and technology (Davis-Floyd, 1987); Michaelson, 1988; Martin 1987). A woman is required not only to give birth in hospital where she may have little or no control, but she is also given the message, as Davis-Floyd (1987:479) points out, about her "powerlessness", "defectiveness" and her dependence on science and technology. This shift in understanding and the care of the pregnant and parturient woman is arguably even more

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alien in non-western states, where obstetric definitions of pregnancy and childbirth as "Unnatural events of Illness" are diametrically opposed to the indigenous understanding of birth as natural and normal.

Sundari (1994) reports that in some cultures, practices such as the consumption of special foods, after-birth rituals and the lack of sympathy and understanding among the attendants are major limiting factors.

As has been noted, several reasons are advanced to explain why women prefer home deliveries. In her study, Allen (2002) found out that some of the reasons women advanced in Tanzania included the following:

- High costs (Transport, medicines, supplies, food for women and family members accompanying her to the facility),
- Avoiding hassles as it entails giving birth away from home
- Belief that birth is a 'risk free' process more common in multi-paras.

Equally, the essential processes of labour and birth management[7] were not always evident. She reports that there appears to be a consistent lack of attention to the labouring women on the maternity ward of the government hospital. She observed nurses sitting around a table laughing and joking and virtually ignoring the labouring woman, may be once or twice calling out to her to quit crying and making so much noise (2002:189).

In their research in Guatemala, Colgate-Goldman et al. (1994) report how four departmental hospitals with adequate facilities and skilled personnel to manage serious complications were highly underutilized because of the following concerns:

- Traditional birthing position (Squatting and kneeling were not permitted, Neema, (1994) also reports that only dorsal position allowed instead of squatting)
- No provision made for respecting the woman's privacy (see also Allen, 2002)
- Language barriers making communication between providers and women and their families virtually impossible (see results of the study).

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[7] Birth Management is essential and it entails regular monitoring of the pregnant woman's vital signs during and after labour and of the baby's before and after birth, combined with the positive enforcement and encouragement of the birthing woman's efforts throughout (See Allen, 2002: 188-189 for details)

As reported elsewhere in the thesis, lack of attention and maternal complaints of neglect during delivery is a common barrier to facilities based care. It is important to note that these staff attitudes are artificial and can be changed for positive outcome. This was exemplified by Allen (2002) when she noted that the atmosphere in the labour ward was less hostile when the nurses knew the birthing woman personally, either as a friend, neighbour or a relative; or if the woman was of high social standing or economic class. She notes that only newly employed staff and nursing students treated women more kindly. Resulting from this revelation, one may pose a question; what is it that develops as one gets grounded in the service provision sector that changes their approach and respect for patients with time? Aren't we reminded of the old adage that old is gold and experience is the best teacher? In this context is experience therefore, the worst teacher? Now that Government facilities in Kenya are known for their poor services and mostly attract the low-income earners, these people's needs must be respected if maternal health is to be improved.

2.2. The socio-cultural context of reproductive health

Every, conception, birth and death occurs within a specific social, cultural and spiritual context. Every society has its own traditional beliefs and practices related to health care. Beliefs in supernatural powers, i.e. God, beliefs in holy rituals, salvation, offering and sacrifices are applied at different stages of life from birth to death. Pregnancy in the case of a woman is the midpoint of life and death and therefore, there are many such practices, rituals and beliefs and offerings which are meant to protect a mother from influences of evil and supernatural powers. People have taken pleasure in using traditional beliefs and practices for a along time. The beliefs and practices are linked to culture, environment and education and are of great importance in understanding health care.

Contextual factors contribute to the specific environments in which births and death take place. Local contextual factors often have more influence in delaying use of skilled care than the 'universal barriers'- recognition of obstetric danger signs, cost, distance, and transport. In this section, we revisit certain cultural practices and the social construction of gender and their implications and influence on pregnancy, childbirth and motherhood.

Tradition is an ambiguous concept. It has been invoked both to stigmatise as well as to celebrate African cultural practices. Native practices have been portrayed as "backward and harmful" (Allen, 2002:107). Such perceptions have led government officials to implement

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policies that sought to transform traditional native cultural practices into those seen in the developed parts of the world. In the case of Kenya, the statement below at the recent (2003) National Congress on Quality Improvement sums it all:

> "In Kenya, the MOH is charged with the responsibility of ensuring that the public health is not endangered in any way by any harmful practices or products that presents themselves as health care provision services. Therefore, this widespread use of traditional medicines and other alternative/complementary medicines present certain public health challenges to the ministry" (pp 7 of the Introduction) (**Second National Congress on Quality Improvement in Health Care, Medical Research and Traditional Medicine. November 24th-28th, 2003. KCCT, Nairobi, Kenya**).[8]

There was an evident contradiction between the theme of the workshop, which was "*Ensuring access to Quality Health Care for All Kenyans*" and the policy position of the ministry of health as stated above. However, the same report acknowledges the fact that many Kenyans use traditional medicine therapies to help meet their primary health care needs. The report explains that this is because, it is accessible and forms part of the belief system of many communities. As we will see below, traditional medicine is a reality, and serving a greater cross section of Kenyans and in some situations, the only available alternative. We will also be able to clearly see the difficulties under which the official services are delivered and their limitations and what the clients of those services think about them.

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2.2.1.Traditional medicine and Motherhood

Maternity services and issues of safe motherhood as presently known in most rural communities is seen more as a western ideological concept that fails to lend well with the people's cultural framework. In Safe Motherhood Initiatives, tradition has been implicated in the low status accorded women in the developing world, in poor outcomes when births are managed outside of the biomedical contexts, when women refuse to attend antenatal care in health facilities and in cultural practices that adversely affect pregnant women's overall health.

Addai (2000) reports that in most African rural communities, maternal health care services coexist with the indigenous health care services and women must choose between the options. Rozario and Samuel (2002) believe that women seek services/treatment only from

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[8] It is important to note that all traditional treating practices and medicine had been criminalized and outlawed by the 1925 ordinance by the colonial government and branded "witchcraft"

the practitioners they know, trust, whose services they can afford and to whom they have easy access. The oscillatory and zig zag nature of health seeking pattern is viewed as a pragmatic way by women to maximize the chances for their welfare and that of their unborn children. Thai women for instance hold particular beliefs and follow specific practices relating to pregnancy, birth and puerperium for their overall good (Rajadhon, 1961; Hank, 1963; Muecke, 1976; Rice, 1994; Jirojwong, 1996). These beliefs and traditions have been passed over the generations and are core to their understanding and practices in maternity. Women are encouraged by their close family members, and other relatives to observe several rules to ensure the safety of their health, that of their infant, throughout pregnancy and delivery. Among these people, the use of traditional herbal medicine, massage and spiritual ceremony, are the primary forms of treatment (Thompson, 1967; Whittaker, 1996).

In most traditional communities, change is not always accepted; rather, it is sometimes perceived as a deviation from the traditionally prescribed ways of life. Woods (1977) hypothesized that the persistence of traditional beliefs is the most widespread reason for the continued use of traditional practitioners with minimal reference to modern health facilities. Beliefs, be they related to religious or cultural practices, can govern the type of medical treatment sought, the perception of the health needs and the general level of health in the households.

Margaret Read (1966) and Benjamin Paul (1955) had long described the influence of cultural factors in health and disease. They were of the opinion that every human society has developed an elaborate set of ideas, attitudes and modes of behaviour in response to the threat of illness and the whole complex is passed on from generation to generation. It is within the framework of this observation that some of the services offered in health facilities have been considered socially unacceptable as they largely ignore the participation of the local communities and the patient's view of his or her health needs. Pillsbury (1979) encapsulated the necessity for utilizing indigenous medical resources in health care delivery when she asserted that if the majority of the rural populations in developing countries have to be reached by some form of official health care, then efforts have to be made to use local resources. She further noted that large numbers of rural people do not always utilize existing official health care services, as most of them are suspicious of Western medicine, partly because it does not accommodate local beliefs and behaviours related to health issues. This

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view is still relevant today with regards to antenatal care and delivery in most African rural set ups.

According to Nchinda (1976), any medical system must have the ability to meet four criteria of accessibility,[9] acceptability[10], availability and dependability. Good (1987) on the other hand sees ethnomedical systems as comprising of "all the resources and responses available to a community in addressing its health problems, organized partially and changing over time" (1987:17). In the words of Fabrega (1977), the traditional medical care of any community includes medical taxonomy, folk knowledge, guidelines, traditions and values, health behaviour rules and patterns, supportive social institutions and identified personnel and structures for the delivery of preventive and restorative therapy. It is a fact that a people's medicine consists of those cultural practices, methods, techniques, and substances, embedded in a matrix of values, traditions, beliefs and patterns of ecological adaptation, that provides the means for maintaining health and preventing or ameliorating disease and injury in its members. The enculturation process grounds us into a particular world view and to change from that view requires a reconstruction of reality which biomedicine has not really attempted to do, but its practitioners expects us to have changed because of the 'modernizing' effect of the practice.

Allen (2002) reported that the use of herbal medicine in pregnancy management is a common phenomenon and its aim is to ensure that the pregnancy is successfully carried to term. The medicine serves several functions such as protecting the mother against foreign invasion including witchcraft, preventing miscarriage, protection against stomach ailments, for nausea, general health problems, to alleviate pain and to prevent the spoilage of breast milk (2002:173). This proves that traditional medicine serves many purposes and responds to the cultural thinking of the people. Among the Kisii for example, Raikes (1990) reports how individuals have to protect themselves against the negative effects of witches and other evil people during pregnancy. This holistic view is never the case in the biomedical facilities.

The Luo as spelt out in their historical perspective believed in spiritual mediums and the pregnancy process was in the hands of women. Each woman had her *nyamrerwa* who was

[9] Issues of accessibility have to do with wide partial coverage and important aspects of infrastructure and medical networking, making it possible for people to access the services under minimum cost if any.
[10] "Acceptability" has a lot to do with the cultural framework of the people, the definition of illness/disease, their health seeking behaviour and other related concerns that may at times not be medical in any way.

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responsible for her well being and administered herbal medicine to ensure good health of the woman and that of her newborn child. This knowledge would be criminalized and viewed as stupid, superstitious and traditional in biomedical parlance thus creating tension and misunderstanding.

People's medicine or medical system and its therapies must of necessity from an anthropological standpoint have a holistic and ecological view of human beings and disease characteristics. This view is exemplified by Ayurvedic medicine,[11] which postulates life as the union of body, sense, mind and soul. One may wonder the relevance of building up a case for a people's medical system in the present research. The reason is simple, to talk about the socio-cultural barriers to any services, there is every need to know or speculate on what gives rise to the barriers. It is indisputable that the culture of the people, the taboos and restrictions, values and attitudes, their environment, power structure and decision making process among others are very important determinants in the use or non-use of services. The cultural power game and the lived experience of most women in traditional societies limit their choices and freedom in determining their own destiny even in matters relating to their own bodies.

Any research that does not put into account the people's own view of their predicament and speculate on how they have always managed their affairs is bound to fall in the trap of researchers who have descended upon rural populations, armed with survey and observation techniques, an array of interview questionnaires with the objective of compiling consultancy reports but with pre-conceived and pre-determined view of their researches. As the topic indicates, this research is designed to be a 'transformative' and 'instrumental' participation in-order to adequately develop a case for safe motherhood intervention, which takes into account both the risks **OF** and **TO** motherhood.

2.2.2. Cultural definition of pregnancy

For proper antenatal and postnatal care, the traditional definitions of pregnancy are vital. Most communities consider pregnancy as a time of well-being and it is only labour and delivery that are anticipated with some trepidation (Tsui et al., 1997). Among the Luo community for example, pregnancy was seen to be a normal condition that did not require

[11] Ayurvedic medicine is the traditional Indian medicine, which has been used all over India and is highly developed with its recognized schools, unlike traditional medicine in Africa.

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closer monitoring and attention (Ominde, 1952). Ominde reports that the assistance a woman receives when giving birth depends on the circumstances in which she finds herself. There was no ruling laid down as to which particular people should help her; the obligation merely rested on whosoever happened to be present. In this community, pregnancy and childbirth are central domains of concern. The proper development of a pregnancy and delivery of a mother are understood in their own cultural terms and they involve not just the individual mother, but her family, neighbours and community. At the same time, they often involve interaction with biomedical health workers, whose cultural construction of pregnancy and birth differs from that of the local women in important ways.

Cultural factors and the definition of pregnancy are often closely linked to barriers to use of services. They are important in the utilization patterns as traditional beliefs about pregnancy, infant feeding patterns, as well as perceptions about ill health and well being, have been shown to influence health seeking behaviour (Raikes, 1990). Given different illness episodes, cultural factors may influence whether the traditional healer, a grandmother, someone in the village shop may be chosen in preference to the health facility.

Cosminsky (1982) reports that pregnancy and birth are culturally patterned and women's knowledge, belief and behaviours are shaped in this context. She observes that pregnancy is seen as a "natural" state rather than pathological, one that needs supervision but usually not medical care. There emerge two paradigms that often come into conflict. On the one side, is the biomedical paradigm based on statistics of mortality rates and the belief in the safety of hospital births (Also based on the differential power patterns and the criminalization of indigenous knowledge and the extensive medicalization of pregnancy) and on the other hand, the indigenous knowledge passed on from generation to generations (Neema, 1994).

Elsewhere, Wedderborn and Moore in their study of a Jamaican community were told by a Jamaican woman that "*having the baby is life and death------ it is not a slice of cake*" (1990:26). This was with reference to labour and delivery. Most cultures and traditions subject most observed complications that require immediate and urgent hospitalization to spiritual interventions and other culture-bound therapies without reference to the health facilities (Examples: Belief in Nigeria, that bleeding causes pregnancy only to be interrupted and the woman will take more than 9 months to deliver; In Bolivia, belief that pain in the back, vagina and belly as well as vaginal bleeding as pregnancy related complications are

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attributed to the poor position of the baby and are managed by massage of the abdomen or advice on rest (Tsui et al., 1997:134)). These are beliefs that reinforce the idea that pregnancy is a normal condition and none of its facets should worry anybody.

Mc Kinlay (1972) has used his understanding of the "sick roles" to insist on the "normalness" of pregnancy. He argues that pregnancy is different from illness in western society, based on behaviour exhibited when people get sick or are in a sick role, since pregnant women do not follow the four expectations of a sick role, which are:

i). The sick person is exempt from the performance of normal social role obligations and responsibility for his/her own state

ii). They must be motivated to get well as soon as possible

iii). They should seek technically competent help

iv). They should cooperate with medical experts.

From the above, Mc Kinlay has been criticized for not including abnormal pregnancies or deliveries in his descriptions: I would add that the idea of being exempted from performing normal social roles in the African context, results from the tradition of bravery and the maternal burden as is indicated elsewhere in this thesis.

However, in contrast, not all scholars believe that pregnancy should be seen as a normal condition. Hern (1975) argued strongly that pregnancy was an illness, and that pregnant women required medical supervision. He defined pregnancy as an "episodic" and "moderately extended chronic condition" with definable mortality risk, changes and complications.

Jirojwong (1996) reported that Thai women's perceptions differ markedly from the biomedical understandings[12]. Pregnant women maintain certain behavioural patterns in order to avoid "risks" to their health or their babies' health, but the prescriptions and proscriptions of pregnancy and birth treat these as extraordinary life events rather than illness. In consequence, women's perceptions of risk during pregnancy are not concordant with those of obstetric, or staff of antenatal services. These may provide the overall blanket explanation why at least some women's disinterest in presenting for antenatal care, have a poor comprehension of its purposes, and why campaigns for regular prenatal attendance in order

[12] The biomedical model describes the illness pathophysiology, clinical manifestations, laboratory findings, complications, differential diagnosis, treatment, prognosis, epidemiology and behavioural aspect.

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to reduce infant and maternal mortality have not been entirely successful (Mac Cormack, 1982; Grace, 1996; Hunter, 1996; Cabigon, 1996).

The findings of this research as well as reports in literature indicate that a good percentage of women say that they did not attend antenatal care because they saw '**no need**' of doing so. As long as the definition of pregnancy is seen as a normal condition, the uses of biomedical health care services are least likely to attract a substantial number of pregnant women. The cultural attitude is that health centers are places one visits while in poor health and not leisure places one goes if not sick.

2.2.3. Sex in Pregnancy

Traditionally, communities viewed sex in pregnancy differentially with local values attached to the process. The Luo for instance regarded any sexual relationship continuing after the sixth month of pregnancy as excessive (Ominde, 1952). However, the only social stigma attached to sexual relationship if it continued for the greater part of pregnancy, was that it could provoke an open rebuke from the midwives or other women. Ominde reports that there were no hard and first rule placed on the time of the temporary termination of the marital relationship and it was generally left to the good sense of the woman and man concerned.

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In other communities, researchers have reported a very strict code that regulates sexual relationship in pregnancy. Jennaway (1996) reported that among the Punyan Wangi community of North Balinese village, sex in pregnancy was described as "night work" and was seen as mandatory. There is a belief that maternal blood alone is insufficient to nourish the foetus. The husband's sperm is also seen as vital for the foetal growth. The imperative to maintain sexual intercourse during pregnancy seems to be connected to notions of paternal-patrilineal claims on the child. Also related to the cultural idea of paternal contribution, Neema (1994) reported that among the Banyankole of Uganda, sex in pregnancy continues up to the last months to aid in the child's full growth.

Among the Kisii community of Kenya, Raikes (1990) reports that sex was often used by men to control women and to punish them. Men in her study described how they would have sex with their wives or women, whenever they wanted. If a woman tried to avoid it (during pregnancy, illness, in labour or just after delivery) they would force the women just to show her that she could not use illness or labour as an "excuse" to say no. It was generally believed

by both men and women that no woman in Kisii could refuse a husband's demand for sex at any time (1990:70).

Among the Abelam, Anna (1996) reported that women are not allowed to have sexual intercourse while pregnant (there is a belief that the mother would be defiled) or while breastfeeding (The breast-fed child will become weak and will not be able to walk), which often occurs up to three years. There were similar postpartum practices among the Luo (Muthanje & Suda, 2003; Mboya, 1938). Traditions have been invoked at the International and National levels to convey beneficial aspects of African culture. Some population experts, for example, have noted that, in the past, cultural prohibitions on sexual relations during the postpartum period enabled women to safely space their births (Lesthaeghe et al., 1981; Muthanje & Suda, 2003).

Relational experts at then McKinley Health Center at the University of Illinois at Urbana Champaign[13] say that if a woman is in good health, she can have intercourse and orgasm with complete safety throughout her pregnancy. They report that the foetus is well cushioned by the amniotic fluid that surrounds it and a healthy woman with a normal pregnancy can continue to have intercourse into the ninth month of pregnancy without fear of injury to herself or to her feotus. They however, caution that the basic guide to intercourse during pregnancy is the woman's own comfort. There are two general warnings about sex during pregnancy. The first is for the partner to avoid blowing air into the vagina during oral sex (this is likely to be uncommon in the Luo set up as sex traditionally was for procreation and issues of oral sex was unknown). This has been known to result in air embolisms which would endanger the mother's and the baby's lives. The second warning is to use a condom for intercourse with a partner who may have a sexually transmitted disease, such as herpes, genital warts or chlamydia. They report that if a woman becomes infected, the disease may be transmitted to her baby with potentially dangerous consequences. The second concern is where the major problem lies as will be seen in the findings in chapter four where a mother was diagnosed to be suffering from STI but the husband refused treatment and continued having unprotected sex with her.

At a general level, the McKinley Health Center provides some of the reasons worth considering in sex in pregnancy that include the following: history of miscarriage, history of

[13] This is a web link reference at http://www.mckinley.uiuc.edu/health-info/womenhlt/sex-preg.html

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premature birth, presence of infection in either partner, presence of multiple foetuses, bleeding with intercourse, pain with intercourse and breaking of the amniotic sac (bag of water) or leakage of fluid from the vagina. The problem with the above prescriptions is the limiting nature and subordinate status of women in the African set up where they are not the sole determinants of their reproductive health.

2.2.4. Gender, Power and maternal health Care

Choices of maternity care and change to modernity are always saturated by power of gender differences, class differences ethnicity and other social considerations outside the medical system (Jolly & Kalpana, 1998). Mortality and Morbidity are mediated through cultural and social circumstances. Being female or male affects the risk of infection, the social experience of illness, care and outcome, resulting in what Ojunaga and Gilbert refer to as the "significant disparities" that exist between men and women (1992: 613).

In societies where importance is placed in reproduction, it is believed that women gain authority and autonomy with aging. In most societies, procreation is a woman's greatest achievement and the means by which she gains some power; at times, it may be the only means by which she has any authority. Women gain status when they bear children, or secure their personal status within the husband's lineage because of their success in producing a child from their own body (Kang-Wang, 1980; Rice, 1995). The contradiction is that this power is only felt within the household and at times, it is a power that is also used against the common good of the women folk as shall be seen in the authoritative power of the mother in-law in relation to their daughters in laws. The struggle for recognition resulting from a birth of a child also imposes mental pressure on women and demonizes those who cannot fulfill this obligation.

Women will also only seek maternal health services if they and/or their family members perceive these services to be important for the health of the mother and child. It has been reported in literature that most societies regard women as "vessels" in the reproduction process. Gottschang (2000) writing about China, reports that in most situations, women are invisible as agents in themselves but as relegated to physical bodies through which the nation can reproduce and develop.

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In a similar view. Jaggar (1989) noted that in most cultures, pregnant women "are viewed less as individuals than as the "raw material" from which the "product" is extracted. In modern circumstances, it is possible to understand then, how the physician rather than the mother comes to be seen as having produced the baby" (1989: 311). This view ties well with the Luo idea of the primacy of the product where the well being of the child is seen as more important than the bearer.

Gottschang further asserts that the status of women is further undermined by the state through legislation. She reports on how the Chinese law protecting child and maternal health attempt to eliminate women's authority over their bodies and defines the ways the state, in the collective interest of the nation, can legitimately regulate and control reproduction. Mothers in Chinese law and policy are thus vehicles for reproduction, and their autonomy and interest are subsumed by the state's authority.[14] Generally, gender relations within their cultural contexts have been used to explain ritualistic patterns of subordinating women as in the case of feet binding, suti in India, clitoridectomy, female genital mutilation (FGM), wife inheritance among the Luo, female infanticide common in Asia and other cultural practices that are detrimental to the female welfare and enjoyment of full reproductive freedom (Raikes, 1990; Ayieko, 1997; Achieng', 1999).

WHO (1998) noted that in many parts of Africa, women's decision-making power is extremely limited, particularly in matters of reproduction and sexuality. They further noted that husbands or other family members who in most cases are not even conversant with the risks and danger in pregnancy often make decisions about maternal care. Women end up being covert users of services such as family planning because of the controlled decision making process (Muthanje & Suda, 2003). Raikes (1990) also reports how men in Kissi use sex to punish their wives even in the extremes of situation as in labour or illness.

Roudi and Ashford (1996) observed that culturally, men in Africa play a significant role in decisions relating to family size and family planning. They reported that the communication between husbands and wives about family planning is highly associated with the couple's contraceptive use. The two researchers also spelt out the need for policy makers and program

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[14] This whole question of state and church control is practiced in Kenya and can be said to have been responsible in the recent media hype of the aborted fetuses. Rarely is the view and predicament of the aborting mothers considered other than the morality of the situation and the rights of the unborn.

planners to give increased attention to all sexes including men in counseling services and information, education and communication programs (IEC).

In the same vein, Uche (1994) underscores the need to include men in the various programmes since men play important roles as heads of households and are viewed as the custodians of their lineages and are the protectors and providers of their families. The social and economic dependence of wives on their husbands gives men great influence in family decisions. This pattern is reinforced by Opiah Mensah et al. (1994) whose study in Ghana under the auspices of John Hopkins University showed that communication between spouses was the most significant pathway to the family planning adoption following Information, Education and Communication campaign.

In many communities of the world, women are disempowered and have to get permission in most cases to attend to antenatal clinics. SAREC (1995) in their research bulletin reported that many women in Tanzania have to ask their husbands or other older male relatives for permission before they can seek medical service/advise- thereby losing valuable time that could make the difference between life and death.

Ezeh (1993), and Lyon et al. (1989) see women's decision about whether or not to bring a pregnancy to term as most frequently made in consultation with, under the constraint of, and sometimes in resistance against networks of significant others—mothers, mothers-in-law, sisters and other kin, neighbours; sometimes husbands or male partners. It is further noted that some female kin networks may present direct barriers or antagonisms. Jealous or violent husbands or vigilant in-laws may prevent women from visiting clinics, using condoms, getting abortions, attending workshops on women's health. These not only constrict women's 'choices' but also increase the risks of unwanted pregnancy, maternal mortality and morbidity and exposure to STDs (Heise, 1992; Protacio, 1990).

With reference to South African community, Klugman (1993) reports that generally, married women are not allowed to make any decisions or say anything that contradict their husbands. They cannot use contraception of any kind because they should "*give birth until the babies are finished inside the stomach*". It does not matter whether you give birth ten or fourteen times.

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In a recent study by Smith et al. (2004) on the knowledge, attitudes and practices related to maternal health in Bla Mali, women's health seeking decisions were found to be a function of a hierarchy of decision-making power within the household. For decisions about whether or not to seek care in the face of danger signs during pregnancy, over 70% of women and household heads cited the husbands as the principle decision makers. They therefore, concluded that husbands should be knowledgeable on maternity issues in order for them to make informed decisions that are beneficial to the female welfare instead of the decisions based on power and authority.

As shown in the above studies, the process of decision-making involves a hierarchy of socio-familial relations. The permission to leave home to seek skilled or other care, to spend money for obstetric costs cannot be granted in the absence of male head of the household or family. The elders also exert powerful influence and are the key determinants of whether a woman uses skilled professionalized care or is attended to by the traditional healers in any given pregnancy episode.

Another contentious issue related to power and knowledge in most African backyard is the common say that only the mother knows or can tell who in fact the actual father of her child is. This is based on the obvious verity that it is the woman who posses the womb in which the mysteries of life that result in a child take place. Women can be seen to be pregnant; men can only claim parenthood by association. Unlike paternity, motherhood obviously does not need to be proven by legal recognition on the part of society (Obbo, 1980). This is contentious and a determinant of how services are utilized because, when a man suspects infidelity on the side of the wife, he will make it very difficult for her to go for maternal health care on the basis that he did not father the child.

Overall, gender power relations which are a function of socialization impose values that are detrimental to the welfare of women and limit their choices in accessing quality health. The decision to go for antenatal care cannot be solely made by the bearer of the pregnancy, but by other people as already mentioned who in reality lead to delay or to no care at all. Patriarchy is still persistent in households despite the growing concern for gender equity (Magadi, 1997).

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2.2.5. Religion and traditional beliefs in pregnancy and childbirth

Alando (1992) has reported that studies done in Africa South of the Sahara has shown that the persistence of high fertility and by extension issues of maternity are broadly related to issues of traditionalism and religious beliefs among others.

According to Caldwell (1969b). the real obstacles to family planning programmes in Sub Saharan Africa are social and economic such as Lack of finance, shortage of trained personnel, insufficient publicity, uncertainty of government support, difficulty of supplying remote and rural areas, rural illiteracy and suspicion on the part of those holding more traditional attitudes. In the words of Ocholla-Ayayo and Otieno (1987), the rules that govern heterosexual relationships in and outside the marriage institution are to a large extent composed of traditional norms, beliefs and values or religiosity. These rules define the type of actions, which are normally disapproved and therefore, constitute taboos and the ones, which are ethically forbidden, therefore, unethical. The same rules determine the use and non-use of maternity services. In most communities, there is a tendency to attribute illness to socio-cultural and supernatural factors. Magadi (1997) reports how such beliefs lead people in Ndhiwa Division of Homabay District to believe that some diseases such as measles cannot be treated in hospitals.

With respect to the spiritual therapies and the zig zag nature of health seeking patterns, Wolte Van Steven et al. (2002) reports the influence of Pentecostal, Independent and holy spirit churches with regards to hospital based care in Zaire. They assert that the therapeutic niches are often consulted simultaneously; often health seekers turn first to the available medical health care. However, the need to strike a balance with the wide variety of somatic and psychosomatic and culture-bound syndromes calls for spiritual interventions.

Allen (2002) reports that in addition to physical risks, women in Tanzania associate pregnancy and childbirth to a spiritual set of risk factors, such as ancestral displeasures, sorcery practiced by family members or neighbours. As a result of the perceived spiritual risks, local healers' advice on the prevention of these risks was often followed more closely than advice handed out by health personnel in hospitals or clinics.

On the same note, Adetunji (1991) had earlier asserted that the use of modern health services in most African rural communities in situations where maternal health services coexist with

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indigenous health care services is often influenced by individual perception of the efficacy of the modern health services and the religious beliefs of the individual women.

Right wing religious movements that seek to restore what they perceive as 'family values' and 'community traditions' may harbour some men's distrust of the community's women and make their aim to refortify the conjugal dyad, where women are isolated from natal and friendly bounds[15]. There is a belief among scholars that the negative influence of traditional religion in rural areas may be attributable to the traditional spiritual explanations of events, including diseases. Traditional explanations of events may tie followers to the use of traditional medicine and encourage use of formal systems only when traditional options fail (Mekonnen, 1998; Allen, 2002).

Just as is shown among the Luo in the ethnographic background, birth is seen as a unifying factor between the living and the dead. Naming of children and other birth practices are done in honour of the ancestral spirits (Mboya, 1938). Further, Moore et al. (2002), reports that the Luo community has great spiritual connections to a *dala (*ancestral home). Ideally, a baby should be born in a *dala* as this increases one's stakes in family claims. Unless the newborn's umbilical cord is buried within the *dala* almost immediately after birth, the child may have trouble in adult life establishing inheritance rights because of the parents' failure to observe this tradition. There is thus an inevitable conflict in the community between 'safe' birth in a facility and the traditionally sanctioned home birth. In situations of plural marriages where each wife wants to increase her stakes in family property, it may even be more difficult to convince women to give birth in facilities unless clear arrangements are made for the placenta to be taken back home for 'burial' immediately after delivery.

Besides religious beliefs, most communities have after birth practices that are not only painful but also very harmful to the women in the long run. The Hausa people for instance, practice mandatory hot ritual baths taken after childbirth and *gishiri-cutting* in obstructed labour[16]. Those baths are undertaken with a pot of very hot water, often prepared with the

[15] Examples of such right wing religious movements that bar their adherents from seeking hospital care are the Legion Maria, Mungiki sect among others. In most cases, these sects have very low regard for women
[16] In traditional Hausa ethnomedical system, the balance between hot and cold is an important concept (Wall, 1988). Postpartum women are felt to be particularly "open" and thus exposed to deleterious effects of cold. Puerperal Hausa women are kept hot in order to prevent them becoming ill by having them rest on a clay bed built with a small fireplace underneath it that is stoked with hot coals. More important than this "roasting" on a bed of hot coals are the hot ritual baths that all puerperal women are expected to undergo for at least forty (40) and sometimes as long as ninety (90) days after delivery (Wall, 1988).

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addition of various herbal ingredients that are purported to have medicinal powers. According to Trevit (1973), the actual water temperature can be as high as 82 degrees Celsius just prior to the start of these ritual baths. All these have serious health implications making child birth a dangerous undertaking.

Other related studies that have mentioned cultural issues as important variables include KDHS (1998) report, where most of the reasons respondents gave as accounting for their non-use of contraceptive services and other maternity related issues fell within the domain of socio-cultural explanations.

Ojala (1999) also reports that the cultural attitudes and beliefs still influence people's choice of therapy especially those who believe that non adherence to traditions (taboos) has a disease causal mechanism or influence. Jelliffe et al. (1962) stressed that the structure of the community, the functioning of the family and its attitudes towards innovation, beliefs and attitudes of the people with regard to child bearing, disease causation and food must all be taken into account for successful introduction of modern maternal health care. In line with this, Fendall (1973) considered cultural changes as one of the prerequisites for the organization of family planning. He was of the opinion that if maternal health care programmes were to be effective in the contemporary, changing social environment, they must concern themselves not only with the immediate causes of morbidity and mortality, but more importantly, with the types of social organization and the values, aspirations and particular problems that characterize the lives of the under-served populations and the lived experience of women.

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In the course of their studies, sociologists and anthropologists have for long stressed the role of norms (guides to behaviour) that emanate from institutional settings in shaping attitudes and actions of people. According to Nam and Philliber (1984), norms have been referred to as the basis for understanding variations in population related behaviour. They also provide a linkage among the macro, medial and micro levels. Freedman (1963) argues that it is through norms that broad institutional mechanisms are elaborated and specified for the individual. It is a fact that controls on fertility and issues of maternal safety are available in all societies, but cultural prescriptions (what to do) and proscriptions (what not to do) regarding sexual practices and contraception are indicated by the consensus of each group and then imposed

or taught to the group members. Frequently, the norms and values on which they are founded are focused on certain themes.

Generally, the traditional Luo society and to some extent the present situation in most rural hinterlands,[17] having many children was justified as a means of compensating for the high mortality among infants and children and as a force for maintaining strong kinship ties in a community. Traditionally, among many Kenyan communities, children were and still are regarded as a virtue and the desire to have them is a desire for righteousness. It is a custom whose moral good is said to be equally intrinsically good. It tends to reject the use of any method perceived to be potentially harmful such as the use of contraception, induced abortion and maternity services that do not lend well to the cultural understandings.

In the past, many communities in Kenya practiced prolonged lactation and postpartum sexual abstinence[18] as a cultural rule of childbirth. Some recent studies (Ominde et al., 1983; KDHS 1993) indicate that the practice is reducing in duration and that there is a shift from breastfeeding to bottle-feeding, which has effects both on fertility and mortality in many rural areas. A breakdown in this practice is seen to increase the chances of early pregnancies after childbirth and infant and child mortality due to malnutrition. It has been speculated that the prevalence of high maternal mortality and morbidity in Nyanza Province results from high fertility and low contraceptive prevalence not to mention HIV/AIDS that has entered the scene with extreme severity.

Sen et al. (1994) reported that beliefs and practices regarding women's bodies and sexuality have important health consequences. Beliefs that women should not know about sexuality can result in high risks of STDs, unwanted pregnancies and inability or reluctance to seek healthcare. The restriction and societal view of single women and adolescents may bar them from approaching family planning services for fear of being seen as sexually active and therefore, societal misfits or prostitutes.

Wall (1988) report with regards to Hausa of Nigeria shows clearly how women/female sexuality is regarded as dangerous. This results in the need for women to be controlled and

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[17] The word hinterland refers to places within Luo land where the modern technologies have not adequately penetrated and the high infant mortality rates are cancelled by the high birth rates without regard to the problems of maternity and related complications.
[18] Also, see KDHS 1993, Republic of Kenya, 1984.

supervised by men in a secluded environment, and the cultural definition of a virtuous woman as one who is modest, deferential, and submissive (as well as fertile), further, Rehan (1984) reports how Hausa women believe that producing many children is thought to bring respect and honour to the family and to the mother who bears them. Few women therefore, have any knowledge of birth control, and most consider "family planning" the moral equivalent of murder. In the same note, abortion is something that only an unbeliever would even contemplate. These have important consequences for the health of Hausa women and their health seeking behaviour patterns.

On the maternal workload that is culturally sanctioned, Trevit, (1973); Moore et al. (2002); Kenya Maternal Mortality Baseline Survey (1994) and Trangsrud and Thairu (1998) among others report that women continue to perform household chores during pregnancy without any special consideration. Pregnancy is expected not to interfere with the woman's daily chores. Pregnant women continue to spend long hours working at home, in the fields or in offices. Overall, a general effort is made to ignore pregnancy, particularly the first, as the girl begins the transition to full womanhood. More elaborate view and understanding of the maternal workload is reported in chapter four.

2.2.6. Maternal Nutrition and food taboos

Biomedically, a woman's nutritional status during pregnancy influences birth weight of the child and the overall well being of the mother. Castello (1986) indicates that maternal nutrition plays a central role in the determination of child health and survival; its influence is exerted directly during pregnancy and later indirectly during lactation.

Allen (2002) asserts that poor nutritional status begins in childhood and is exacerbated in adulthood for women as a result of their heavy workloads and high fertility rates; energy requirements during pregnancy are also thought to be rarely met for those women. On average, it has been noted that pregnant women are expected to consume an additional 300kcalories per day and at least 30grams of protein to achieve an overall desired weight gain of 10-12 kilos during pregnancy (Hamilton et al., 1984). It is however, estimated that malnourished pregnant women on average were gaining only five to ten kilos during pregnancy (IOM 1990).[19] Just as Allen, Nyikuri and Nangendo (2003) in their study of

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[19] A woman with a low Body Mass Index (BMI of less than 19.8) should gain a total of 12.5-18 kgs during pregnancy, a woman with a normal BMI (19.8-26) should gain a total of 11.5-16 kgs during pregnancy, a

child's gender and the length of breastfeeding in Usigu, Bondo District, concluded that gender discrimination begin at birth where male children are accorded privileged position through prolonged breastfeeding than the female children.

Every community has some food related prescriptions, proscriptions and taboos that have to be observed by its adherents. These affect mostly women and more especially those who are pregnant. In Asia, most food taboos relating to pregnancy derive from the humoral notions of the body that is prevalent throughout South East Asia (Manderson, 1987). Foods, which are excessively hot or cold, are proscribed for pregnant women, lest they should harm the foetus. Pregnant women may only eat small amounts of watery fruits such as oranges, paw paw and mangoes. All these foods are classified as cool, verging on cold, and may be deleterious to the baby's health. On the other hand, "hot" foods particularly red meat such as goat, buffalo, dog and pig, are completely proscribed, with the exception of the purified pig meat that is eaten on ceremonial occasions (Rice and Manderson, 1996).

Anna (1996) reports that among the Abelam of Papua New Guinea, pregnant women are not allowed to eat fruit like fig and wild palm fruit. Mothers who are pregnant for the first time should not eat a lizard, cuscus, snake or pig that has chased a dog. If she consumes these foods, some of the envisaged problems would be; difficult delivery, the infant will be afraid to come out and it will cling to the uterus or stay inside like a lizard or the umbilical cord will wrap around the child's neck like a snake.

Still in Asia, Jirojwong (1996) reported that among the communities in southern Thailand, a number of foods were prescribed to ensure the birth of a good-looking baby. Examples she cites included the consumption of coconut juice and papaya (responsible for the birth of a baby with fair complexion), palm sugar (makes beautiful eyes), foods with names similar to "easy", "slippery", "flowing" are recommended i.e. sweet potatoes, fresh water eel or flowing fish (ease in delivery). She however, reports that twin fruits such as twin bananas were avoided as they were presumed to cause twin pregnancies.

Among the African communities, similar prohibitions have been reported. Neema (1994) reported that among the Banyankole of Uganda, foods such as sugar cane, pepper, eggs and

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woman with a higher BMI (greater than 26-29) should gain a total of 7-11.5 kgs during pregnancy. (BMI is calculated by dividing the body weight in kilograms by the square of ones height in meters).

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chicken and too much salt were never recommended in pregnancy. Consumption of these foods resulted to the birth of a child with segments, red eyes, and rashes all over the body.

Most of the traditional food taboos for pregnant women often prevent them from eating nutritious foods such as fresh milk, eggs, pawpaw, liver, mutton, some types of fish, groundnuts, and butter among others. The Kenya Maternal Mortality Baseline Survey (1994) report indicated that most of the above foods are believed to make a child too big for normal delivery. The report further indicated that pregnancy is not widely believed to require improved nutrition. In many families, husbands and children are served first, while women are left to eat whatever food remains, regardless of their pregnancy status.

According to WHO (1996), the combined effects of heavy workloads during pregnancy and traditional practices that limit the types of food pregnant women are allowed to eat result in an overall poor nutritional status of pregnant women. The resulting malnutrition leaves women susceptible to disease and frequently vulnerable to complications during pregnancy. More elaboration on the food avoidances and their consequences are in the chapter on results of the research.

2.3. Economic Factors

Poverty and financial constraints have been identified as primary obstacles to proper antenatal care. Most women complain of the high costs of services and their inability to afford them given their low economic status. Magadi (1997) sees child survival to be primarily determined by the social and economic status of the child's family, which is essentially expressed by two indicators; maternal education and economic circumstance of the household. Mosley (1985) had earlier written in support of the economic circumstances of the household as primary determinants of services utilization. Various other studies in Kenya (Muganzi, 1984; Odhiambo, 1991; and Ouma, 1991) have reported the significant relationship between socio-economic factors and infant and child survival. These studies have confirmed that chronic malnutrition is linked to the high rates of infectious diseases and maternal morbidity and mortality. In a related study, Suda (1997) found out that broader issues of women's economic circumstances, education, living conditions, family environment, gender relations and socio-cultural factors have important implications for women's reproductive health and behaviour. She further observed that a number of rural low-income Kenyan women could be exposed to pregnancy related health risks and may also

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have inadequate control over their fertility. Khayundi (2000) in his study of local people's response to malaria in pregnancy among the Luo concluded that healthcare is heavily influenced by socio-economic factors.

Throughout the World, the general outcry is that the desolate economic situation in many developing countries has severely affected people's health. The general argument according to Gould (1970) is that material resources devoted to health are short of the needs while the demographic pressure and the changing age structure of the population drives them steadily upwards. The cost of the medical care is so heavy that many countries are reviewing their needs with a view to achieving better results. With regards to Kenya, the introduction of Structural Adjustment Programmes (SAPs) which advocate for strict economic policies especially with regard to public expenditure in the social sector has resulted in reduction of State spending in the health sector leading to the emergence of what is referred to as "cost sharing" (Odada and Odhiambo, 1989). The introduction of cost sharing has severely affected the poor who cannot raise the hospital fees. What follows logically is that many of the poor have resorted to cheaply available remedies, which have no blessings of professional advice.

There is consistent evidence throughout the World as reported by Whitehead (1989), that poor people without economic ability suffer a heavier burden of illness and have a higher mortality rates than their better off counterparts. Whitehead (1990) observes that socio-economic inequalities in health are a major challenge for the health policy, not only because most of these inequalities can be considered unfair, but also because, a reduction in the burden of health problems in disadvantaged groups offers a great potential for improving the average health status of the population as a whole.

Popkin et al. (1988) analyzed demand for modern maternal health care in Philippines in which he wanted to establish whether user charges for maternal services significantly deters use. He found out that money and at times prices had a negative influence on the choice of delivery. Similar research by Stahlie (1959) in Thailand had stressed that the impact of health services on maternal health is doomed to be sterile unless simultaneous measures in the context of community development are taken. Accordingly, the development of the country in socio-economic and educational aspects is a prerequisite for the improvement of maternal health.

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The KMMBS (1994) reports from their Focus Group Discussions show women complaining that facilities required them to provide examination gloves and to bring with them suturing materials, needles, syringes and occasionally, ergometrine for delivery. The cost of such supplies limits ANC attendance and drives those without the economic might away from the facilities. In a recent study, Moore et al. (2002) reported that women complained that money was the single most item that one must have to attend clinic, prepare for delivery and even to determine where to deliver in preparing a birth plan. One of their respondents summed this up "everything you do and everywhere you go, you must have money" (2002:25).

Generally, researches such as those of Bailey and Phillips (1986) and Trangsrud and Thairu (1998) among others have produced results that strongly suggest that low household income is a barrier to the utilization of modern health services even when they are partly provided. The present level of unemployment in Kenya, coupled with the twin issues of civil service restructuring (retrenchment) and the high cost of living resulting from inflation are likely to contribute adversely to maternal health.

Related to cost concerns are the issues of accessibility in terms of distance to facility. Data in KDHS (1993, 1998), show that nationwide, only 50% of Kenyan women live within five kilometers of a health facility providing ANC and about 68% live within one hour's travel time to such services. The cost of transport at times far outweighs the services cost and is a big barrier to proper antenatal care. This is made worse in some Districts where the road network is impassable. The same reports indicate that only 32% of the women in Kenya live within five kilometers of facility that offers delivery care. This distance can be impossible to cover when a woman is in labour or when road conditions are poor, as is the case during the rainy season.

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2.4. Maternal Education

Besides economic development, maternal education has featured prominently as a necessary prerequisite for improved maternal health. In the literature on maternal health care and child survival, education or schooling has been seen to not only instill faith in western science, but also equips individuals with knowledge and skills in literacy and information processing. Education is said to transform identities and to give autonomy and a sense of responsibility, as well as raising self-esteem and self-confidence (Katahoire, 1998; Caldwell, 1979 and Cleland and Kaufmann, 1994). In the same breadth, Magadi (1997) confirms that education

is now recognized around the World as a basic prerequisite for development. There is a general consensus that benefits of education, measured in increases in productivity and in overall quality of life, multiply with the increased participation of women and girls.

According to WHO (1996) and Allen (2002), maternal education raises female status and empowers them to fully take charge of their destiny. Allen in her study of maternal health in Tanzania concluded that maternal illiteracy affects in three ways enumerated as follows:

i. Leads to less access to health information as they may be unaware of the need for prenatal care

ii Leads to limited job opportunities or low skilled labour which attracts low wages, which means less money for health care.

iii Lower wages leads to greater economic dependence on a spouse or mate which may result in less autonomy for individual women.

This lack of autonomy, according to WHO (1986) means that women have less input into decisions that affect the number of children they will have. Overall, it limits their sexual freedom and freedom of choice and therefore, unhealthy reproductive lives.

Several other scholars have reported the positive correlation between maternal education and the positive utilization of maternity care services (Addai, 2000; Addai, 1998; Magadi, 1997; Magadi 2003; Fernandez, 1984; Beker et al., 1993; Owino, 2003; Akin and Munevver, 1996 and Celik and Hotchkiss, 2000 among others). Suda (1997) for example, underscores the importance of education and its important implications for women's reproductive health and behaviour. In her research, she found out that many uneducated rural women in Kericho District did not receive antenatal care while some of them said that they visited antenatal health facilities much later in their pregnancy.

In their descriptive analysis of the utilization of maternal health care services in Kwale and Kirinyaga areas of Kenya, Mwabu, Kimani and Wang'ombe (1991) found out that lack of knowledge of the need for antenatal care was the main reason for not attending clinics. Earlier research by Mwabu (1984) in Meru District had equally found out that education, quality of service and religion had a large effect on the choice of health facilities.

Education should be viewed as a transformative device whose benefits are far beyond visible behaviour patterns of individuals and their interaction with health facilities alone. Le-Vine et

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al. (1994b) regard the schooling process as a transformative device from quantity to quality and introduces individuals to a bureaucratic life course of which health care system is part of. The above literature draws a close associational link between schooling and the propensity to better social services users because of the improved and enhanced self-esteem and confidence. Overall, maternal education changes the perspective and worldview of the mothers, empowers them to effectively deal with the health care bureaucracies, enhances their chances of engaging in productive/wage labour and enables them appreciate the advantages of antenatal as well as postnatal care. They become more conscious of their health and welfare.

It is generally believed that as their levels of education and income increases, many women will be more conscious of their rights to have complete, accurate and up to date information and will be able have the necessary reproductive freedom to make informed decisions about their health and well-being (such information may include what contraceptives to use and their known effects, need to attend all maternity services and to know what to expect from the providers of these services and other health related issues including the nurturing and nursing of their children, the number of children to have and when to have them e.t.c.) (Katahoire, 1998).

Although the benefits of education are well known and appreciated, many Kenyan women still lag behind in educational achievement. The 1998 and 2003 KDHS reports indicated that a very high percentage of women have not adequately attended formal education. Statistics indicate that there are three times as more women who have never been to school than men. The report revealed that forty one percent (41%) of the male respondents were likely to reach secondary school than their female counterparts at twenty nine percent (29%) and nearly twice as likely to continue beyond the secondary level. Education is a big empowering tool that enhances the use, demystifies the health system and brings it closer to the people. Education empowers one with the appropriate communicative devices and elicits respect from the service providers and should be encouraged at all costs.

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2.5. Service Factors

These include the health system factors that impede the proper delivery of services. It includes the existence and extent of a health care programme or services covering staffing, drugs, equipment, costs and quality of services. The quality of services, staff attitudes, their

behaviour towards clients and the way they communicate with them are important determinants of health care services utilization. If health policies and programmes have to treat reproduction and women holistically across the life cycle, and through means appropriate to women's social situations, they require comprehensive services with well trained staff and adequate facilities for all women. At present, the quality of reproductive health services is widely reported to be poor. Yet, quality is believed to be a key factor determining how private consumers utilize fee- for service providers and whether or not public services, even if free are utilized.

It is reported that women are dissatisfied with hospital deliveries and the low quality of care (Rice, 1996; Manderson, 1996; Moore et al., 2002: Allen, 2002). When one woman receives low quality care or is reprimanded for whatever reason while attending ANC, information from this woman is passed on to others and this sets a precedent in which pregnant women associate ANC attendance with being scolded and reprimanded by health care personnel (Jirojwong, 1996). In most third world countries, arriving at a facility is not a guarantee that you will receive care. There are always shortages of personnel and equipment (Sundari, 1994). The health facilities are often unable to cope even with the small proportion of affected women who against all odds arrive there.

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In situations where they get the care, the quality is often far from satisfactory and may be summed up as **'doing too little too late'**. The following are some of the 'health service factors' identified in several studies (Bhasker, 1984; Crowther, 1986; Bullough, 1981; and Boes, 1987) as responsible for maternal deaths:

- Delay in diagnosis, wrong diagnosis, failure to diagnose
- Delay in treatment, wrong treatment, failure to initiate appropriate treatment
- Delay in referral, inappropriate referral, delay in consultation or transfer given "too little too late"
- Medical shortage i.e. nursing staff shortage, medical staff shortage
- Failure or delay in operation, poor operative techniques
- Over transfusion, anaesthetic problems, and defective obstetric care.

The above list is a clear indication that quality of services in the public health care system is pathetic and not attractive to most clients.

Health personnel on the other hand, stated the following reasons which in their opinion were responsible contributants to maternal mortality (Murru, 1987):

- Scarcity of medical and para-medical personnel especially in rural areas
- Poor on the job training of health staff at all levels
- Low salaries, poor working conditions, leading to lack of motivation.

Closely related to the above health systems problems is the question of equipment. Lack of equipment has been mentioned in several studies (Aggarwal, 1980; Allen, 2002; Moore et al., Trangsrud and Thairu, 1998; KMMBS, 1994) as a constraint to adequate care. This has been seen to lead to overcrowding, patients sharing beds making them vulnerable to cross infection, lack of clean linen, or even basic equipment such as gloves and antiseptic solution.

Studies have also found out that there is absolute lack of privacy for provider-client counseling in most facilities (Seoane and Castrillo, 1995) and general lack of client education materials. With the need to have a personalized touch with every woman who comes for services, collective provision of services and the lack of both visual and auditory privacy are likely to negatively affect the turn out. Ndele (1989) in his analysis of the factors that influence demand for health services in the city of Nairobi found out that the behavior of staff and quality of treatment were statistically significant determinants of demand for antenatal care. He concluded that positive staff behaviour had a positive effect on immunization while negative staff attitude had a net negative effect.

Oyando (Daily Nation, Thursday 15th 2000:15) pictures a pregnant woman in labour precariously balancing at the back of a bicycle or a wheelbarrow on a dark night in a village somewhere in Kenya being pushed to a health center some six or ten kilometers away. She is of the opinion that six kilometers can be a long distance if you are pregnant and in labour and concludes that having a baby in Kenya and most parts of Africa can be fraught with complications, making it a dangerous and potentially life threatening undertaking given that even reaching a dispensary ultimately is no guarantee that medical attention will be available.

Sundari, (1992) further elaborates that even when a patient finally reaches the hospital or dispensary, she must content with shortages of supplies and equipment, lack of trained (and often, lack of caring) personnel, and the interminable internal delays involved in making

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marginal systems work (All of the above factors are complicated by the fact that the systems are already stretched to the breaking point as most African health care systems still suffer from the legacy of misplaced colonial priorities. chronic under-funding, understaffing more particularly where required specialists such as gynaecologists are lacking), mismanagement and rampant corruption. The whole of Siaya District for example has only two clinical officers and most of the health centers are headed by nurses including the sub-District Hospital. Bondo District Hospital has only two nurses providing antenatal care and whenever one is on leave. there is only one provider to take care of all the mothers at the facility.[20]

Observations in other two Districts in Western Kenya region (Busia and Lugari) reveal similar patterns of chronic shortage of personnel in the facility and more so in the ANC department. In Lugari District for instance, the providers in the District Hospital operate in a politically upgraded health centre space and this cannot satisfactorily be used for all the referral cases in the entire district.[21]

With regards to the service provision, if women are to be empowered to speak out in clinical settings and to make claims about sexual and reproductive health needs, particularly where the quality of care is inadequate, they must have a 'culture of health awareness', which may in turn rest on their having opportunities for economic independence and political self determination (Basu, 1990)[22].

Experts say that antenatal care can be more effective in avoiding adverse pregnancy outcome when it is sought early in the pregnancy and continues through the delivery. Obstetricians generally recommend that antenatal visits be made on a monthly basis to the 28th week (seven months), fortnightly to the 36th week (eighth month) and then weekly till the 40th week (until birth).[23] It is further important to ensure that there is assistance and medical care at delivery.

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[20] Personal communication with the District Medical Officer of Health in Siaya District, July 2004 and observation as well as Antenatal care Providers interview at the Bondo District Hospital in 2003 and 2004

[21] Personal tour of the facilities during a pop council funded focused antenatal research in selected districts in western Kenya region (August 2004).

[22] In the present context, healthcare provision is structured in such a way that the providers are presented as knowledgeable and the women come in a subordinate position patronized and controlled by the providers. They are seen in an inferior position and are made to feel little and in need of professionalized care.

[23] The present policy guideline unlike the previous one recommends a focused ANC approach. It recommends a maximum of four comprehensive personalized ANC visits (1st visit before 16weeks, 2nd visit at 20-24 weeks, 3rd visit at 28-32 weeks and 4th visit at 36 weeks) during pregnancy offering better quality services at each visit and with a clearly defined purpose. (MOH-DRH/DOMC/JHPIEGO July 2002, *Focused Antenatal Care and Malaria in Pregnancy, Orientation Package*

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We turn to the theoretical underpinnings that have been applied in understanding the utilization patterns of maternal health care services and the overall maternal burden.

2.6. Theoretical framework

Studies such as Jordan (1980), Michaelsen (1988), Tsui et al. (1997), Kalpana and Jolly (1998), Allen (2002), Raikes (1990) among others have highlighted women's experiences of pregnancy, childbirth, the postpartum and the days of early mothering, and draws attention to the degree to which these events of reproduction are cultural and social as much as they are biological. They equally highlight the extraordinary variability across cultures of the roles played by others-kinswomen, husbands, children, traditional birth attendants in the management and care of the new mother and the unborn/new born child.

These studies highlight the importance of reproduction to women with respect to their personal identity and social status, and in terms of the ways in which their lives have been centred around the events of biology. The studies have also provided some critical lenses and theoretical constructs through which the process of medicalizing pregnancy and childbirth has been seen. Scholars such as Rice and Manderson (1996) have noted that the process of medicalizing birth has been silent on women's own care of their bodies. They are of the view that this silence which maintain discretion and privacy is one which also controls, and the dominance of medical understanding of women's bodies reinforces this control, creating an illusion of discharges as abnormal: sexual dysfunction as aberrant; blood and other exudations as dirty and polluting; fertility, infertility and the end of fertility mysterious and frightening, and in this process. they conclude that women's health is jeopardized.

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In view of the above scenario, these studies conclude that women resist from reporting and seeking care for sexual health problems, for example, out of embarrassment and for fear that any abnormality will be interpreted as social aberrance, physical symptoms of disease as evidence of breaches and impropriety. Frequently, women themselves assume that changes in bleeding, discharge, and so on are evidence of immorality, perversion of sin as these negative constructions of women's bodies are always internalized. They observe that lack of education about reproductive and sexual health maintains the silence and hence the discomfort that women experience (Rice and Manderson, (1996).

Anthropologists assert that medicalization and power are ideas that must be grounded historically and culturally, as must resistance, agency and autonomy. This is the reason, why the study takes departure in critical medical anthropology to try and understand the power game and how women themselves fit in the system as conscious agents responsible for their actions and how they interact with foreign constructions of health care vis a vis their cultural knowledge. Scheper-Hughes (1992) believes for instance that the many different forms of "foot dragging" used by women are calculated responses designed to annoy in situations of repression and orthodoxy.

Authors such as Strathern (1992), Yanagisako and Delaney (1995) have illustrated the complexity of women's responses to the process of medicalization. The responses have ranged from selective resistance, to selective compliance, although women may also be indifferent. Their essays however, suggest that ambivalence coupled with pragmatism may be the dominant mode of response to medicalization by women. Lock and Kauffert (1998) in the same vein cautions that women are not passive vessels, simply acting in culturally determined ways with little possibility of reflection on their own condition, nor are they inherently suspicious of and resistant to technological interventions. Rather, women's relationship with technology is usually grounded in existing habits of pragmatism. For by the force of the circumstances of their lives, women have always had to learn how they may best use what is available to them. They have equally created innovative structures to support them in their daily existence and try to deal with the problems of poverty and the world systems for instance the merry go- rounds (*Nyoluoro*) (Ouko, 2003).

Overall, reproduction has come to be seen as a potent site for political contestation and resistance. The control of reproduction through population policy, global planning, and International Development Initiatives has been the subject of numerous feminist studies. In the process of feminist analysis, they have discovered how the relationship between discourse, knowledge and power have seen programmes presented in a non-neutral language i.e. "saving lives", presenting particular versions of reality as truth and fact, and in the process "reasserting the inevitability of institutional practices" (Pigg, 1995:48).

The present study took departure in Critical Medical Anthropological perspective (CMA). The proponents of CMA are of the opinion that it reflects both the turn toward political-economic approaches in anthropology in general as well as an effort to engage and extend

the political economy of health approach (Baer, Singer and Johsen 1986: Morgan 1987: Morsy 1990). From the perspective of CMA, health is defined as access to and control over the basic material and non-material resources that sustain and promote life at a high level of satisfaction. Health goes beyond some absolute state of being and encompasses an elastic concept that must be evaluated in a larger socio-cultural context. In this view, health and disease are conditions that people in a society encounter, depending upon their access to basic as well as prestige resources.

CMA therefore, attempts to address the nature of health related issues in indigenous societies as well as in capitalist and socialist oriented state societies. It understands health issues within the context of encompassing political and economic forces including forces of institutional, national and global scale that pattern human relationships, shape social behaviours, condition collective experiences, reorder local ecologies and situate cultural meanings (Baer et al. 1997). CMA further argues that as part of an effort to transcend the contradictions of the Capitalist World System as well as the remaining socialist oriented societies, it proposes the creation of a democratic ecosociolist world system and the pursuit of health as a human right.

The basic underpinning in CMA is the inequality prevalent in the world. It views social inequality and power as the primary determinants of health and health care. Critical Medical Anthropologists maintain that research in social relationships and small communities must be conducted with the recognition that disease and its treatment occur within the context of capitalist world system (Wallerstein 1979). Emphasis and focus in this regards should be on understanding the specific structure of social relationship that give rise to and empower particular cultural constructions. This would help us understand the imposition of western medical ideology and how to incorporate it in the local worldview for a proper internalization and behaviour change.

The Critical perspective presently advanced by Baer et al. (1997) and for which the study is grounded has its taproot in Marx and Engels, the critical theorists of the Frankfurt School, and C. Wright Mills (1959). They are here more concerned with the ways power differences shape social processes, including research in medical anthropology.

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Although it was Baer and Singer who were the first to coin the label "Critical Medical Anthropology" in a paper presented at the 1982 American Anthropological Association meeting, either preceded them in the effort to incorporate a critical or political economic approach into medical anthropology (Frankenberg 1974; Young 1978). It is however, believed that the initial efforts to forge a critical re-direction for medical anthropology can be traced to the symposium "Topias and Utopias in Health" at the 1973 Ninth International Congress for Anthropological and Ethnological sciences, which ultimately developed into a volume with the same title (Ingman and Thomas, 1975). An explicit turn toward political economy of health tradition within medical anthropology was later to be advanced by Soheir Morsy's (1979) review essay titled "The Missing Link in Medical Anthropology: The Political Economy of Health."

According to Lock and Scheper-Hughes (1987) who are critical theorists, there are three distinct bodies in health care. These are: The individual body, the social body and the body politic. People's images of their bodies, either in a state of health or well-being or in a state of disease or distress, are mediated by socio-cultural meanings of being human. The body also serves as a cognitive map of natural, supernatural, socio-cultural, and spatial relations. Further more, individual and social bodies express power relations in both a specific society and the world system.

CMA just like Chrisman and Kleinman (1983) who developed the explanatory model that recognizes three overlapping sectors in health care systems advances four levels in health care system. These are:

1). Macro-social level

2). Intermediate social level

3). Micro-social level and

4). Individual level

The individual level entails consideration of the patient's response to sickness or sufferer experience. CMA is sensitive to what Scheper-Hughes and Lock (1987) term the "Mindful body". In their view, an individual's body physically feels the distress that its bearer is experiencing. The critical approach to the individual level begins with the recognition that sufferer experience is constructed and reconstructed in the action arena between socially constituted categories of meaning and the political-economic forces that shape the context of daily life. Recognizing the powerful influence of such forces, however, does not imply that

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individuals are passive or impersonal objects but rather that they respond to the material conditions they face in light of the possibilities created by the existing configuration of social relations. Also involved here is the patient's personal support network what Jansen (1978) refers to as the "therapy managing group"- a set of kinfolk, friends, acquaintances, and community members who confer with the healers and representatives of his/her support structure in the healing process.

At this level would be the individual woman who is experiencing the pregnancy and her response to the situation. It would also include her experience and the societal definition of her condition and the array of social networks around her. The woman makes pragmatic choices based on her material conditions in consultation with the powerful forces around her to either seek official health care in pregnancy or consult other providers within her community.

At the Micro-social level, we have the 'physician-patient relationship' and an extension of the therapy-managing group that overlaps from the individual level. At this level, the major initial diagnostic task of the physician is heavily mediated by social factors outside the examining room and similar medical treatment. The other major task of the physician is not determined solely by the needs of the patient but also serves the special needs of the physician and other powerful sectors within and outside the health care system. The physician's role, in fact, performs two key functions for the encompassing social system and its existing distribution of power:

1). Controlling access to the special prerogatives of the sick role and

2). Medicalizing social distress.

It is at this level that medicalization of pregnancy takes shape. The woman's condition is defined within the overall confines of biomedicine and pathologised and she is therefore, subjected to the mercy of the providers and has to accept the subordinate status and be able to receive help from the professionals in a way they deem fit and not in accordance to the needs of the pregnant woman.

At the Intermediate level of health care systems, hospitals that vary in sizes from a gigantic medical center to a rural hospital, has become the primary arena of social relations. At this level, although physicians exert a great deal of control over their work, because of their monopoly of medical skills and the congruence between their version of disease theory and

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capitalist ideology, they find themselves subject in hospitals to bureaucratic constraints. The existence of a wide array of health workers means that the medical hierarchy replicates the class, racial/ethnic, and gender hierarchy. The biggest irony and perhaps what explains the inability of staff to offer adequate facility based care is that the health workers with the lowest status and least power in the hierarchy are the persons who come into the most continuous and intimate contact with the patients in the hospital settings.

The client-provider relationship and the idea of control and the mysterious nature of the medical profession further alienates the ANC clients making them spectators and therefore, controlled beyond. The capitalist system further makes it possible for the low cadre/placed staff to blame their inadequacies on the bureaucracy and the un-functional system in which they are part of, but strategically divorce themselves from as a form of escape from blame.[24] When the provider frustrations are offloaded to the clients, their only pragmatic way of response is to boycott their services and seek for alternatives despite the fact that at times, they are aware of the benefits of biomedical care. Those with the resources, both financial and intellectual resort to seeking help from private biomedical providers whose profit motive make them more accommodative to ensure increased patronage, but expensive and beyond the reach of the majority.

At the Macro-social level, CMA recognizes that the development and expansion of a global economic system represents the most significant, transcending social process in the contemporary historic epoch. Capitalism has progressively shaped and reshaped social life. CMA attempts to root its study of health-related issues within the context of the class and imperialist relations inherent in the capitalist world system. Capitalism is seen as producing structures of class relations. The profit making orientation has caused biomedicine to evolve into a capitalist intensive endeavour heavily oriented to high technology, the mass use of drugs and the concentration of services in medical complexes. The Multi-National companies, Breton woods institutions and other donor agencies heavily influence health policies in most Third World countries. The policies end up serving the interest of the developed nations in a very imperialist way. Paul (1978) argues that medicine has from the beginning functioned in the service of imperialism, supporting logically the voracious search for ever-wider markets and profitable deals. The ruling elites that control the Third world

[24] This is a form of strategic provider way of explaining happenings in facilities in ways that absolve them from facility based incompetence and blame lack of supplies and other issues on their seniors and others higher up in the bureaucracy (observed during the research).

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countries collaborate with international agencies, foundations and bilateral aid programmes to determine health policies (Justice, 1986). This is the arena in which conception takes place, pregnancy is carried to term and finally the birthing process is accomplished. In this context, CMA explains the medicalization of births as reflecting the capitalist ideology of profit. It alienates the women from an arena in which they have always had control to a level in which it is the doctor who 'delivers' the baby. The appropriation of this power, subordinates women further and some scholars are now even questioning the primacy of motherhood (Strathern, 1992) that was initially taken as a given and undisputable fact of biology (Obbo, 1980).

Strengths of CMA

CMA (the political economy of health perspective) offers a different perspective and a 'window' through which biomedicine can be observed. It believes that biomedicine portrays the body as a machine that requires periodic repair so that it may perform assigned productive tasks essential to economic imperatives. Even in the case of reproduction, as Martin (1987:46) so aptly observed, "birth is seen as the control of labourers (Women) and their machines (their uterus) by managers (doctors), often using their machines to help." CMA brings out clearly the effects of the global market economy on health. From the research, it has been observed that the idea of professional birth attendance assumes that the women giving birth do not know anything and must be accorded professional assistance. This position medicalises an event earlier seen culturally as social and within the domains of the lineage system and from which women derived prestige and status.

With regard to ethnomedicine, CMA offers away of thinking and looking at the specialists and how they relate to their patients within the framework of power differentials. It also explains the role of power structure and inequalities in health care. CMA rejects a simple dichotomy between "anthropology of medicine" and the "anthropology in medicine" that separates theoretical from applied objectives (Foster and Anderson, 1976). Rather, critical medical anthropologists seek to place their expertise at the disposal of labour unions, peace organisations, environmental groups, women's health collectives, health consumer organizations, self help and self-care movements, alternative health efforts, national liberation struggles and other bodies or initiatives that aim to liberate people from oppressive health and social conditions. In sum, through their theoretical and applied work, CMAs strive to contribute to the larger effort to create a new health system that will "serve the people" the

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system that will not promote the narrow interest of a small privileged sector of society. This requires a radical transformation of existing economic relationships. In this regards. CMA sees the maternal health care professionals, the referral chain and bureaucracy as being responsible for the poor health of mothers and the lack of proper antenatal and postnatal care in society. It also views the power structure and the poverty and powerlessness of women as limiting in the choices of care and their care seeking patterns/practices. It further views the female social, emotional and economic dependency as an obstacle to the full enjoyment of reproductive rights and culture as a traditional site of insubordination and control.

As a remedy to the noted obstacles in proper healthcare and reproductive freedom. CMA advocates for the emergence of a critical mass of maternal health advocates who will participate in the process of health awareness where women will be able to know and understand their bodies and be conscious of their reproductive health. This in the long run will enable women to attend services with a conscious knowledge of the functions of the services other than just to receive an antenatal card as a security against future emergency as is the case today. It further calls for a healthcare system that respects the dignity and pride of its clients.

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Weakness of CMA

Critical medical anthropologists have sometimes been accused of being "especially blunt. outspoken critics of other theories in medical anthropology" (McElroy and Townsend 1996:65) and further, of believing that the critical approach is "superior to other models" (McElroy 1996:519) (McElroy and Townsend are Ecological theoreticians).

Some theoreticians maintain that critical medical anthropology has split into two contending camps, the so-called political economy/world systems theorists and the Foucaultian poststructuralists (Morgan 1987). Scheper-Hughes and Lock (1986:137), principal proponents of the latter "camp," while granting that political economy of health perspective served as a useful corrective to conventional medical anthropological studies. asserted that it has "tended to depersonalize the subject matter and the content of medical anthropology by focusing on the analysis of social systems and "*things*" and by neglecting the particular, the existential. the subjective content of illness, suffering, and healing as *lived* events and experiences."

More recently. Scheper-Hughes argued for the creation of what she termed as a:

Third path between the individualising, meaning centered discourse of the symbolic hermeneutic, phenomenologic medical anthropologists, on the one hand, and the collectivised, depersonalised, mechanistic abstraction of the medical marxist, on the other......To date much of what is called Critical Medical Anthropology refers to....the applications of Marxist Political Economy to the social relations of sickness and health care delivery (Scheper-Hughes 1990:189).

This statement and the position it propagates indicate that critical medical anthropology has not really distanced itself from the political economic perspective. CMA is seen as a breed between the politico-economic and cognitive/symbolic views which try to connect macro and micro-level insights in social processes (Hardon et al. 1995:19). In this regard, the theory cannot be used in isolation to explain the processes at the micro-level where women have their lived experiences without connecting the local with the Macro-level.

Relevance of CMA to the study

It should be noted that in spite of the above noted confusion caused by contending camps in CMA, maternal healthcare cannot be properly understood without connecting the individual, the macro-social, immediate as well as the macro-social levels. All these levels function to either aid or hamper proper reproductive health.

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Critical Medical Anthropology helps in creating a critical mass to address all shortcomings in maternal health. Maternal health care is to a large degree affected by the differential economic levels created by the world economic system, local power play and the structure of authority in every society. The amount of resources allocated to safe motherhood is relatively less in the poor countries. It is also evident that 'natural' childbirth has been heavily appropriated by institutional medicine. A feminine researcher Gloria Steinem (1978) quoted in Sargent and Brettell (1996) once asked what would happen if men could menstruate and by extension conceive and give birth. "Men would brag about how long and how much. Boys would mark the onset of menses----with religious ritual and stag parties. Congress would fund a National Institute of Dysmenorrhea to help stamp out monthly discomforts. Sanitary supplies would be federally funded and free... Military men, right wing politicians, and religious fundamentalists would cite menstruation as proof that only men can serve in the Army.... occupy political office,.-. be priests and ministers,...or rabbis." In this provocative thought exercise, Stein draws attention to the way in which women's biological processes

throughout the life cycle are constructed within a cultural context (Sargent and Brettell. 1996). This clearly shows how female-based biological processes are demeaned and given low priority in planning and development.

From a policy and biomedical perspective, Haire (1978) is of the opinion that the birth experience has been distorted in many countries priding themselves with modernization into a pathological event rather than a natural physiological one for child-bearing women. Among the aspects included in the medicalization of the birthing process that has a great influence on the utilization of biomedical maternal health care services are:

1). The withholding of information on the disadvantages of obstetrical medication.

2). The expectation that women give birth in hospital

3). The elective induction of labour

4). The separation of mother from familial support during labour and birth,

5). The confinement of the labouring woman to bed

6). Professional dependence on technology and pharmacological methods of pain relief

7). The delay of birth until the physician's arrival

8). The requirement that the mother assumes a prone position rather than a squatting one

9). The routine use of regional or general anesthesia for delivery and

10). Routine episiotomy.

Given that many high risk pregnant women came from chronically poor families (Bullough and Bullough 1972), health providers must understand how their feeling of powerlessness which results from societal inequality deter them from seeking prenatal care. The inequality and powerlessness lead to a feeling of hopelessness and fatalistic attitude that deter any attempt to improving their lifestyle. Such people consequently, place little value in seeking preventive care. In addition, the fear of hospital bureaucracy, long waiting hours, lack of professional care and the attitude of hospital staff emanating from the differential control of resources combine to determine the health seeking behaviour of patients with regard to maternal health care.

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This theory guided the study in understanding the external as well as the internal factors surrounding the pregnant woman in the process of seeking care and possibly offer advocacy to proper maternal welfare. The theory has proved very useful and handy in understanding some of the socio-cultural and socio-economic dynamics at play in the society and how they interact to determine the pregnancy outcomes. Examples here include the differential constructions and definitions of pregnancy, the differences between biomedical and cultural realities and the distinctive patterns of power at play.

Theoretically, it is assumed that the level of awareness accompanied by availability and accessibility of health services and the desirability of pregnancy are important variables in the use of antenatal care. The basic underlying assumption in CMA is that women's autonomy is a necessary prerequisite to proper maternal health care service utilization. Bloom et al. (2001) working in a north Indian City found out that women with freedom of movement obtained higher levels of antenatal care and were likely to use safe delivery care. This is very relevant in the Luo situation given the patriarchal relationship that limits the female power and control placing her under direct control of others. In line with Janzen's (1978) therapy managing group, the Luo stressed the patrilineal and agnatic kinship whose value was of great importance. The value of parental and brotherly love is so strong that the Luo will call all who are related to the father's brothers as fathers and all who are related to the mother's sisters as mothers. This kinship network and good neighbourliness and peer group create a greater number of people in the therapy-managing group for the women who determine the health care seeking behaviour and patterns and in most cases, cause delay.

The cultural practices among the Luo of ritual observances and spiritual guidance in pregnancy which reifies the "living dead" (Ocholla-Ayayo, 1976; Mboya, 1938) placing them in a position of life givers and true protectors of the living creates another level of control that negates the primacy of antenatal care at the facilities. The Luo contend that each and every individual has his/her own god. *Nyasache* who in collaboration with the ancestors of that particular individual is responsible for his/her luck and wellbeing including the "gift of birth" (Ocholla-Ayayo, 1976). Sacrifices, offerings and libation done in consultation with the medicine men and other folk practitioners were a frequent phenomenon among the Luo.

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In recent attempts to address maternal health in Kenya Dr. Stephen Ochiel[25] who by then was the Chairman of the Kenya Obstetrical and Gynaecological Society while addressing the conference whose theme was "Safe Motherhood and Its Challenges", observed that the reduction of maternal deaths requires a supportive social, economic and legislative environment with long term political commitment (Daily Nation 23rd Feb. 2001:6). In further attempts to tackle maternal health, a meeting convened by the International Labour Organization (ILO) in Nairobi to discuss their Maternity Protection Convention, the participants were reminded by one speaker that women,---"biologically the only ones equipped to carry and bear children should not be penalized for this vital role" (Daily Nation May 23rd 2001:6). This is the framework through which the study was based.

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[25] Presently, Dr. Ochiel is the Chairman of Kenya Medical Association. He is embroiled in the abortion saga where he is calling up on fellow doctors to rally behind the doctor who has been accused of providing abortion services and is facing court charges. His position is that abortion is within the reproductive rights of women and should not be criminalized.

CHAPTER THREE

METHODOLOGY

Included in the methodology, are the description of the study site, research design, methods of data collection and analysis, sampling and the study population, ethical considerations, and the limitations of the study.

3.1. Study site

The study was carried out in Nyang'oma Division of Bondo District, Western Kenya. Bondo District is a recent creation having been carved out of the formerly expansive Siaya District. It is located in Nyanza Province of Western Kenya region. The District is bordered by Siaya District to the North, Kisumu District to the Southeast and Homa-Bay District across the Winam Gulf to the South.

The District has five administrative Divisions, which are Bondo, Nyang'oma, Madiany, Rarieda and Usigu. The District covers an area of 1977 square kilometers with a total water mass of 1005 square kilometers, which are Lakes Victoria, Sare and Kanyiboli. The number of Sub-Locations is forty-five (45) with nineteen (19) Locations.

The health facilities in Nyang'oma Division include the Nyang'oma Mission Dispensary, Uyawi/Nango Government dispensary, Anyuongi Government dispensary, Nyaguda Government dispensary and Ouya Community dispensary. The health facilities are sparsely dispersed and most of them are low in supplies and most frequently lack essential medicine.

The Luo ethnic group occupies the area. The agricultural potential here is rather low and only drought resistant crops such as sorghum, millet and cotton can do well. The area is also ideal for livestock production and irrigation can also be possible using the various water masses found here. Bondo Division and the upper parts of Rarieda are however, classified under low-midland zones and have reliable rainfall. This area can support crops such as maize, cotton, sugarcane, sorghum, millet, cassava and potatoes.

Fishing is a major activity from the various water masses mainly, Lake Victoria. The District has twenty-eight gazetted fish landing beaches, which have great potential for the production of popular fish species such as Nile perch, Tilapia, "*Omena*" (dagaa). The beaches are also a

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hub of business activities and a meeting place for all sorts of transactions. There are a number of private health care providers closer to the beaches such as Wagusu and Sirongo.

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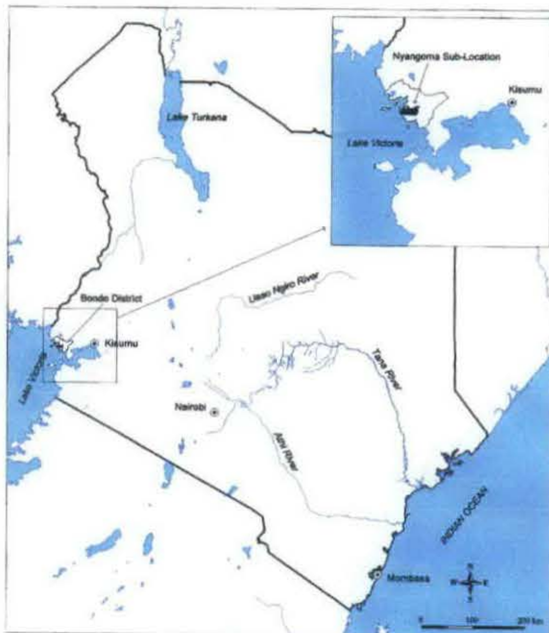
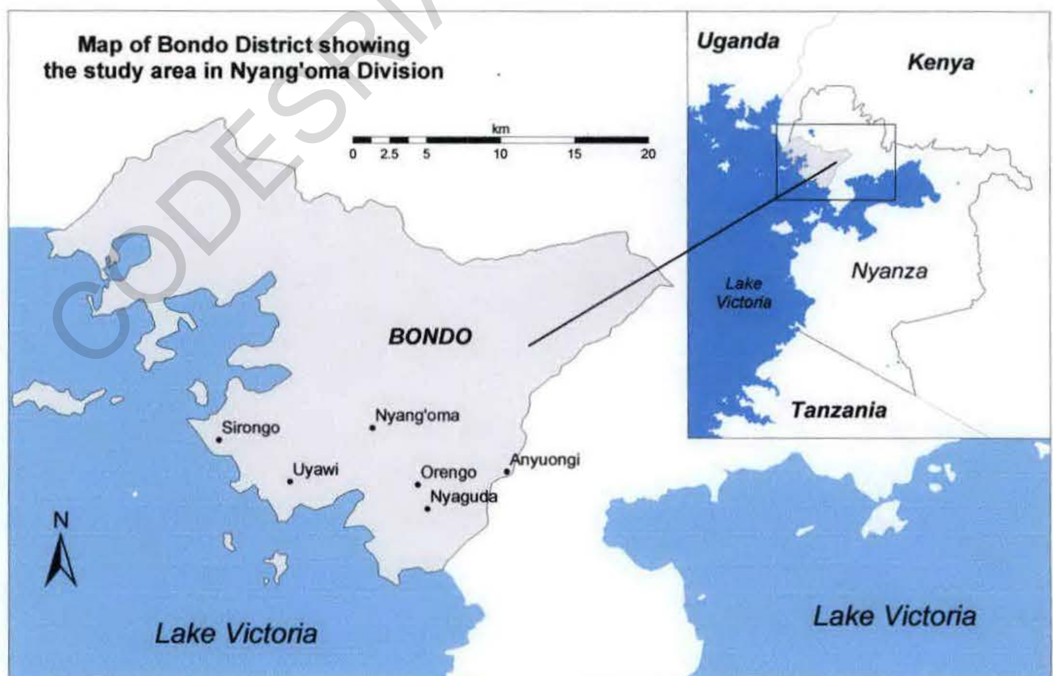
Maps of the study area showing the health care facilities





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Every day Life at the Site

The research concentrated in three villages in Nyang'oma Division where the maternal cohorts were drawn. These villages were Nyang'oma, Orengo and Sirongo in Central Sakwa Location. Those from Sirongo were living in a peri-urban environment with men engaged in predominantly fishing economy and the women were engaged in petty fish trading and retail shopping. The other women were predominantly housewives helping their spouses with domestic chores.

The women around Nyang'oma came from different backgrounds. Some were professionals (teachers, tailors) as in the Focus Group Discussions and those who answered the community survey questionnaires, some were petty traders while some were housewives.

The mothers from Orengo village were living in their ancestral homes. Most of the mothers were living with their spouses while others were living with their parents-in-law and their children since their spouses were either engaged in wage labour in the urban areas or fishing away from home and living, in the islands within Lake Victoria. Others were living at Nyamnwa beach very close to the village.

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The residents of these villages derived their livelihood from a variety of activities besides farming and livestock rearing. Some of the activities include formal employment in the government institutions (Schools, dispensaries, extension workers) and the missionary institution (Catholic Mission), which has several schools, health centre, vocational training facilities, and the church among others. People in these institutions worked as primary and secondary school teachers, nurses, medical assistants, artisans, craftsmen. secretaries and civil servants. There are also petty traders at the Nyang'oma market centre where there are facilities such as posho mill for grinding grain, small hotels for fast foods, a bar for leisure, several kiosks selling a variety of foodstuffs and other exotic goods, open air market where hawkers trade their wares and one butchery. Market days here are on Sundays, which takes advantage of the Sabbath day. The Nyang'oma complex owes its vibrant life and infrastructure to the existence of several institutions that include the Catholic mission, the dispensary, the technical institute, the primary and secondary schools and a special school for the deaf. The centre has electricity and running water.

Besides, there is a local chicken feeds processing plant owned by a local investor that employs a large number of local people and uses the left over from processed fish to manufacture chicken feeds. People are employed here as technicians, drivers, machine

operators and watchmen. The villagers however. complain that the factory emits pungent smell that is a health risk to the locals. They also attribute some ailments resulting from environmental pollution to the effluents from the factory.

The two villages (Sirongo and Orengo) were very far away from the existing health facilities. Sirongo village was almost 10 kilometers away from Uyawi health centre. Mothers had to walk this distance to or from the clinic in a very rough terrain. The way to the clinic is very hilly and not easy to walk up and down. Orengo Village presented other challenges. The closest facility was the Nyang'oma Mission Dispensary, which was besides being far away, was a private clinic whose charges were higher than the villagers could afford. The village was also separated from the dispensary by a small river that was impassable during the rainy season as a result of flooding.

3.2.Research Design

This study was designed to last for three years with one year for fieldwork. During the fieldwork period that started in July 2002 to July 2003, in-depth analysis of issues around pregnancy and maternal health care were explored. The research explored the socio-cultural issues regarding the utilization of maternal health care services in Bondo District. The aim of this exploration was to understand more clearly from a cultural perspective how pregnancy is carried to term in the community and to come up with culturally sensitive intervention mechanisms for safe motherhood.

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As a basis for locating the sources of information, the existing social network and presence of experienced field assistants in this area who have worked for a considerable period of time in the Kenya Danish Health Research Project (KEDAHR) was a great asset.

The known Traditional Birth Attendants (TBAs) and Community Health Workers (CHWs) assisted the research team in identifying other informal maternal health care providers through the snowball method. Contact was also made with the official health care providers at the local facilities who assisted in identifying other TBAs and CHWs in the community. They also assisted in locating and recruiting the pregnant women attending antenatal services in their facilities.

These pregnant women recruited from the health facilities assisted in directing the researcher to others known to them but had not yet visited the clinics. This group formed the maternal cohort in the longitudinal follow-up. This was followed by a cross-sectional community survey in the sub-locations among women with children below one year of age. This was to determine the level of awareness of the maternal health care services and whether they delivered at home or in a health care facility.

The core of the study was the longitudinal follow-up on the selected women and their households. From the point of anchorage in the community (which was the KEDAHR guest house in Nyang'oma Catholic Mission), the research longitudinally followed the respondents closely monitoring and observing their day today activities. There were family visits weekly at the beginning and fortnightly thereafter during the study period. The women's workload, those they consulted, and their feeding patterns were all observed and other information concerning them and their pregnancy were generated through informal chats. The women were at times accompanied to the facilities where they went for help during pregnancy so as to observe the process of services delivery besides observing their health seeking behaviours. During the facility visits, the length of time taken in attending to one patient at different occasion in the two facilities in the study area was observed. The research also observed the examination process, client care and the entire health delivery environment besides the homes where the care seekers came from. The study 'lost' two women to what it has termed 'feigning Pregnancy' which is discussed at length in chapter four. The loss was only with respect to the fact that they had not delivered by the time the study ended. They however, provided vital information and clue to how women undergo socio-physiological stress in the process of proving their womanhood.

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Besides official health care providers, the research followed two of its clients to legion Maria mother (*Madha*) who was one of the health care providers and observations were done on how she performed the consultations and the arrangements in her 'maternity'. During the visit to *madha*, the study had a good informal chat with other clients in her clinic other than the respondents in the longitudinal follow up.

Maternal health care services providers in a variety of facilities were part of the key informants who provided rich accounts of their work environments and their view of the clients they attend to. Nurses in the private, mission and government facilities (Owens,

Nyang'oma, Nango, and Bondo district hospital) provided vital information on their working conditions, patient attitudes, and their own understanding of their services and this was compared to the community's view.

Particular cases for further analysis were chosen by use of local informants and personnel in the health care system. Two of the cases were multiparas who had lost many children in their previous births. Purposefully selected cases based on the individual interest in the research and the previous experiences in childbirth were selected to narrate their experiences and provide their case histories regarding the entire birthing process and the networks that exist for a pregnant woman at the village level. They also narrated their encounters with both the formal and the informal health care delivery systems.

The research conducted ten Focus Group Discussions (FGDs) in the three different locations. Three of these were done in Sirongo, three in Orengo Village and four at Nyang'oma. All the FGDs had between eight to ten participants except for two in Nyang'oma that had twelve participants.

3.2.1. Sampling population and strategy

The study had different study populations. The core of the study and unit of analysis was the twenty-five pregnant women and their households. Other members of the homestead where these households were such as the mother-in-law were also informally interviewed in order to find out the importance of the therapy-managing group.

The second category was the 100 lactating mothers who had given birth in the previous year preceding the study. Other categories of respondents included in the sample were the health care providers both professional and folk practitioners, Community based Health Workers, informed (mature or old) women who have given birth before and were knowledgeable in the birthing process as it relates to the Luo culture.

The research adopted both purposive and snowball sampling techniques in identifying the respondents. Attempts were made to recruit respondents from diverse geographical locations (both those from around health facilities as well as those far away to see whether distance was a major problem in health facilities utilization).

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Methods of recruitment

The mothers in the longitudinal follow-up were initially recruited at the health facilities (Nyang'oma and Uyawi dispensaries). From Nyang'oma, only one pregnant mother in her 4th month of pregnancy was recruited. She was used as the entrance point and in a snowball method; she directed the study to other pregnant women in her village in Orengo who had not gone to the clinic. The recruited ones further directed the research to other pregnant women until we had ten mothers from the village. As for the recruitment at Uyawi dispensary, since there were difficulties in getting pregnant women in their 4th months of pregnancy as most women attend their first antenatal care visit late in pregnancy, we decided to include those in their 5th month of pregnancy and widened the catchment area beyond the facilities. At Uyawi, we recruited five pregnant mothers who later assisted us in locating other pregnant women in Sirongo village. This was done till we had a total of thirteen respondents from Sirongo village. The snowball and purposive sampling strategy was flexible enough to allow for the inclusion in the study of other women who were not interested in the facilities care, in the first place other than only having the 'converted'.

For the 100 women in the community survey, they were initially recruited at the facilities where they had gone for postnatal care. However, since PNC is not a common practice in the village, the research only managed to get 15 women at Nyang'oma mission clinic after three days and 18 women at Uyawi after four days. This therefore required that we use snowball method to locate other lactating mothers so as to reach the desired sample. This also gave us an opportunity to locate mothers who had never attended clinic during their previous pregnancy.

Focus Group Discussions involved some of the respondents in the Community survey and others were mothers in the neighbourhoods where the FGDs were conducted. The total number of participants in the FGDs was 99 respondents distributed as follows in the three villages (Orengo village had three with 9,10 and 10 participants respectively; Sirongo village had three with 8,10 and 10 respectively and Nyang'oma village had four with 8,10,12 and 12 respectively).

Other categories of respondents were the key informants who included the nurses, Legio maria *mudha* and two of her clients, TBAs, CHWs, District Medical Officer of Health, five elderly women in the community and two other informal maternal health providers.

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3.3. Methods of data collection

The research adopted the qualitative techniques of data collection with minimal application of the quantitative methods. Since the study is social and cultural in nature, its aim was to provide the necessary contextual information and rich ethnographic materials.

3.3.1. Direct Observation

Direct observation was used as the primary approach of generating qualitative data. What was directly observed were the different activities performed by pregnant women in and around the household. The research was able to participate only in activities that are appropriate to the situation (Spradley 1980:55). Such activities had to be those culturally acceptable since not all situations offered the possibility for involvement with the people and activities. Some of these situations were direct witnesses in the clinic environment and helping pregnant mothers in accessing the clinics in our bicycles. Other activities observed were the domestic chores and work pattern, triple demand for female time, gardening activities, child rearing practiçes, food getting patterns, health seeking patterns, self treatment in pregnancy, discussions of pregnancy and the female worries, male expectations and spousal care in pregnancy and feeding patterns in pregnancy among others.

In some cases, a more moderate and even passive participation were employed. Part of the strategy was to closely monitor a group of expectant mothers till delivery. This enabled the researcher to explore how pregnancy is perceived, handled and how the health care system responds to maternal needs in a number of specific cases. The actions of pregnant women with specific regards to their practical demands, health awareness, taboos and rituals observances were observed. This approach helped in getting to the bottom of the socio-cultural issues at play with regard to maternal health care services. It also identified precisely the health seeking behaviour and the therapy-managing group in the community in matters of pregnancy. Observations were then made on how these affect the utilization of maternal health care services. The knowledge of the native language was very handy in this regard.

In some situations, it was inappropriate for the male researcher or research assistants to do a follow-up. This was the case in two instances involving two teenage pregnancies that the research followed up. It was very difficult to have the young teenagers talk to us freely. We instead got to them via the female assistants. In some situations, the husbands of our

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respondents were not comfortable with the male assistant conducting the follow-up in their absence or that all visits had to have the female assistants.

The participant approach was relevant since it encouraged local research and continuous dialogue with villagers, health officials, local people and the bearers of the pregnancies. Over time, the husbands of respondents came to accept the whole process and viewed all the research assistants as harmless.

As earlier expressed by Swantz (1974 and 1978) this approach can achieve desirable results as it emphasises local participation of the researcher and places him/her at the centre of enquiry. The close observation accords the researcher an opportunity to compare the ideals with real life situations. There are instances where interviews alone may give inappropriate information about actual practices. To achieve the desirable goals, the research had four field assistants, three of whom were females and one male. This arrangement was very handy in situations where participation,may not have been possible as a man.

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3.3.2. Interviews

The study employed a variety of interviewing techniques as a supplementary method to direct observation. The interviews enabled the researcher to explore the views of the villagers on maternal issues within their socio-cultural context. Some of the interviews were tape-recorded and notes taken by the researcher and the field assistants. There were both formal and informal interviews.

a) Key informant interviews

In depth interviews with key informants were conducted. It covered issues of maternal health, pregnancy practices, perception of pregnancy, value of pregnancy, the place of the pregnant woman in society, the network around the pregnant woman, health-seeking behaviour in pregnancy and health care delivery. Issues of avoidance, cultural prescriptions and proscriptions, taboos and related practices in the community were all explored. Those who were included in the interviews were the pregnant women in the longitudinal follow-up, their spouses where possible, official health care providers, TBAs, CHWs, five older women, informal health care providers and two other women found at the legion maria clinic.

b) Narratives and Case Histories

Eight members of the cohort who showed greater interest in the research (those who were good informants) were requested to narrate their relevant experiences with regard to pregnancy and their health seeking behaviour during the process, their encounter with the health care providers, their position and value in the community during this period, workload, spousal expectation and the final birthing process.

Two women also from the Legion Maria clinic were of great interest and were followed further to enrich the study with their experience in childbirth and marital conditions. Their cases provide a view of the role of religion and culture in determining the utilization pattern of official health care facilities.

A personal life history of some of the informants chosen as a result of their deeper knowledge, proper recall and interest in the research was considered relevant. This included the period from conception to birth and even beyond in the postnatal period.

c) Questionnaire

A very basic short questionnaire was administered to 100 women who had given birth in the last one year. The questionnaire was used to generate basic demographic and socio-economic information as well as quantitative data on the place of education, poverty or wealth in maternal health care seeking behaviour in the study area. The questionnaire was also used to get information on where mothers seek help and how they rank services within the folk, popular and the professional sector. The questionnaire acted as the basic entrance point to the community.

3.3.3. Focus Group Discussions

Focus Group Discussions (FGDs) were conducted in the community involving women of childbearing age. A total of ten FGDs were held in different villages within the study area. The women who participated in each of the FGDs had similar characteristics.

One field assistant facilitated each focus group and the proceedings were tape recorded and later transcribed. The two other field assistants and the researcher took notes during all the FGDs for later comparison.

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3.3.4. Secondary data

The research also relied on secondary data from authored books, journals, world organizations' reports, newspaper reports and a variety of Internet reports on maternal health care and reproductive health in general.

3.4. Data Analysis

Data were analyzed using both qualitative and quantitative methods. The results of the questionnaire survey were coded and simple frequency tables and bar charts generated to summarize the data.

The bulk of the data from the interviews, and the longitudinal follow–up have been analyzed qualitatively. Qualitative analysis emphasizes how data fit together as a whole, bringing together context and meaning (Ulin et al. 2002).

A particular more in-depth and inductive approach to analysis was adopted and a sequence of interrelated steps in data analysis followed i.e. reading, coding, displaying, reducing and interpreting. The process began with an immersion, that is, reading and rereading texts and reviewing field notes after the process of transcription. As the notes were read, one listened to the emerging themes and labels were attached to the chunks of data that represented those themes. A thematic content analysis followed along the main themes of the study and also focusing on the issues and patterns that pervade the data.

Data were then coded and grouped according to the thematic issues. This was followed by the systematic summary of the data. Some of the data have been summarized in a narrative form and key quotations from the data using respondent's own words have been incorporated to illustrate the main ideas and to give a detailed picture of the circumstances and consequences of maternal health situation and the overall interaction in the community and with health care providers.

Finally, the research provided an overall interpretation of the findings, showing how thematic areas relate to one another, exploring how the network of concepts respond to the original study questions and suggestions made on what the findings mean beyond the specific context of the study.

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3.5. Ethical considerations

The research received all the necessary approvals from the relevant authorities. Research permit had earlier been granted under the auspices of KEDAHR that supported the study. The Ministry of Health as well as the local health division in Nyanza Province was a collaborating partner in the research. The Bondo District Health Management Team (DHMT) approved the research. The local health institutions willingly consented to the research. The Institute of African Studies, University of Nairobi, also approved the research proposal.

Members of the local community where the study was done were informed in advance about the research, the purpose of the research was adequately explained to them and participation was as a result of informed consent. The recruitment process was elaborate and each member of the maternal cohort and those in the community survey were given an opportunity to decide whether or not they were willing to participate in the study. The study included only the respondents who willingly gave their informed consent. In the longitudinal follow-up sample, even the spouses had to consent besides the pregnant mothers.

During the research period, respondents who had adverse health problems and required medication were referred to clinics or encouraged to seek care from the various health care providers in the community. Some of the mothers were also assisted in transportation to access facilities by the use of the bicycles by the research assistants or by providing the transport money for the vehicles or bicycle taxies. At the end of the research, each member in the maternal cohort was given a treated bed net for purposes of preventing mosquitoes from transmitting malaria to the lactating mothers and their young born. Confidentiality was strictly observed and all the information gathered about a particular respondent was strictly for the research purpose and not shared either among respondents or in the community at large or shared with the health care providers.

After the completion of the one-year research period, the enduring relationship created with the families in which the fieldwork was anchored has persisted. Equally, in a bid to give back to the community what we found, there have been community feedback sessions to explain to the local community the findings of the research and in liaison with the official health care system to use the findings to enrich their services. KEDAHR has been able to bring together the community and the health care providers in feedback sessions where they were able to

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get feedback from the research that should assist in mapping out joint strategies for safe motherhood.

In the write up, in a confidential way, all the names of respondents have not been included and instead, pseudonyms have been used. In situations where the description of a particular episode is too obvious that the person in question can easily be recognized and the description could have adverse effects on the respondent, sites have been strategically altered to bring out the point, but to at the same time protect the identity of the respondent. The final copy of the thesis will be submitted to the District Health Management Team in Bondo district and if possible, to the two local health facilities where the study was based. A summary of the key findings and their implications will also be handed over to the local community representatives in the study area for their future reference.

3.6. Limitations of the study

My role as an 'outsider insider' was ambivalent. As a man from the same ethnic group, I was expected to, on the one hand, be aware of the traditional practices in the community as a shared experience handed down through generations and on the other hand, not to be closely linked with the birthing process. Birthing was seen as a female domain. The male link to this process could only be understood if I was a medical doctor and therefore, playing a different role as a biomedical expert. If this was the case, it therefore, meant that I was more knowledgeable on some aspects of modernity.

When I asked certain questions, I was always reminded that at my age and the fact that I was married with two children, I ought to have known all that I needed to know about pregnancy and more so, about hospital based care and familial dialogue. This initially meant that I was given answers that the respondents thought fitted my role and their definition of who I was to them.

The entry into the community during the initial recruitment of respondents was facility based. This created a dilemma as most of the providers and the respondents looked at the team with a biomedical lens. We were seen more as quality monitors in the beginning and not as 'flies on the wall' that were too harmless and ignorant. The fact that I was introduced as a member of the university community enhanced our image that did not blend well with my simple approach and need for immersion into the community. It also created too much

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expectation where members of the community were expecting assistance and the rural respondents expected that I would either find immediate solution to their problems or influence the way the health care was organized and being offered.

Being a man studying women's issues and more specifically reproductive health, created initial suspicion in the spouses of some respondents who even refused to have their wives enroll in the longitudinal follow-up. We however, overcame this but after a whole month of rapport creation and by which time, two women had been discouraged from taking part in the study by their husbands. Again, we tried as much as possible to be participants in most of the activities of pregnant women (such as taking them to the clinic, assisting in the self treatment advice, observing them doing domestic duties e.t.c.) but some of the activities could only be accessed by my female assistants (such as accessing their private domains, being able to see them naked when being massaged by the TBAs, and bathing in protective medicine from the traditionalists among others). This therefore, meant that there could be possibilities that being women and coming from the same community, they could have assumed and failed to record important activities as they viewed them as routine and not of interest.

The research did not investigate further the role of some cultural practices such as bride wealth and girl child socialization and how that affects their relationships with their husbands and the implications that they have on reproductive freedom. Rather, concentration was on the observed aspects of gender relations and on interviews as per the time.

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CHAPTER FOUR

THE SOCIO-CULTURAL CONTEXT OF PREGNANCY

4.1. Community views on pregnancy

Pregnancy in the Luo context is perceived as a normal condition that requires minimal intervention particularly from the point of view of medical care. The reason for this is the perception that pregnancy is not a sickness.

During the research, women reported the following as what they considered to be how people perceived pregnancy in the Luo community:

Table 4.1. Community perceptions of pregnancy

Perception	N	%
Normal condition	50	50.0
Between normal and sickness	31	31.0
Sickness	15	15.0
Just there	4	4.0
Total	**100**	**100.0**

Source: Primary data (Community Survey)

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Table 4.1 shows that half of the women in the community survey reported that pregnancy is a normal condition. Pregnant women reportedly went on with their daily chores un-interrupted. A similar pattern was observed in the longitudinal follow-up where thirteen of the twenty-five mothers perceived pregnancy as normal. The general feeling of fatigues, which is common during pregnancy, was seen as a normal experience brought about by the growing child that only required proper management but not hospitalization. Those who reported that pregnancy was a condition in between normalcy and sickness were of the view that only certain pregnancies are problematic and not all. They expressed that most pregnancies were normal unless the mother had other conditions that required attention, which is not always the case. Only 15% of the respondents in the community survey defined pregnancy as an illness and this could be because they themselves had sought treatment and attended clinic as a result of being unwell during pregnancy. However, only six (24%) of those in the longitudinal follow up viewed pregnancy as sickness. The six were those who were constantly sick and included one respondent who ultimately died and

one who lost her husband just before delivery. Others were the respondents discussed elsewhere in the thesis as having 'feigned' pregnancies.

Those who considered pregnancy as a normal experience also thought of it as a curse from God. Auma who has four children commented:

> "You know, only women can give birth and this process came about after the Garden of Eden sin where Eve drove Adam to sin. This condition is therefore. God's punishment to female kind and the more we appreciate and live with it as a normal condition, the better"

One of the key informants felt that the best way to deal with pregnancy is to define it as normal in order to deal with the anxieties and fears women have in their first pregnancy. She commented thus:

> "The best way to deal with the pregnancy condition is to normalize an abnormal situation. This process gives strength to the bearers of the pregnancy and instills in them the will to carry it to term without necessarily assuming a sick role that only complicates the process. Do you see how children behave when they are sick?, who will give a pregnant woman who assumes a sick role that close attention in Luoland here where women must toil to survive?" (Trained TBA who has also worked as a nurse in Kisii District).

Most of the other key informants particularly the aged TBAs reported that pregnancy is a normal condition. One of the older and more influential TBA commented as follows:

> "*Nyuol, mon ema tinde odhialore. Ok onyal bedo tuo to mon duto dwaro nyithindo kendo gimor go malich*" (this meant that with respect to birth, women are nowadays the problem as childbirth cannot be an illness yet every woman covets it and wants children whom they are very happy to get).
>
> The perception of pregnancy as a normal condition was more common among the elderly health care providers than the younger generation.

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Respondents who believed that pregnancy is an illness were concerned with the strains it places on the individual woman. They were concerned that the body changes and demands in pregnancy far exceeds normalcy. This concern was expressed by one respondent in the FGD:

> "Those who have been pregnant know the burden of the process and the weakness of the body that comes with it. You cannot be normal if you continue vomiting, experiencing stomach pains, general body fatigue and craving for certain foods that your 'sick' condition imposes on you. You also become moody that people around you may not be able to understand unless they also consider your condition as sickness" (A 25 year old primary school teacher and a mother of two).

However, some of the respondents in the follow up, survey and participants in the FGDs were of the opinion that pregnancy is a condition that falls in between normalcy and sickness and that it would be more appropriate to pathologies it as a means of creating greater attention. They saw pregnancy as a time of extreme physical, social and emotional instability and stress that individuals needed maximum care and love. One participant in the FGD summarized the feelings as follows:

> "One big problem in our community that explains the high maternal morbidity and mortality rate is our overall definition of pregnancy and the idea of honourable birth. Every woman is forced by cultural circumstances to act 'tough' since pregnancy is not a condition that requires closer monitoring or regular facility based check-up. For us to talk about safe motherhood, we must define our pregnancy as a special condition that requires a change of approach in relationship from those around the woman" (A 30 year old school teacher and mother of three).

Some of the respondents reported that pregnancies differ in their presentations. Whereas certain pregnancies would make a woman too weak and sick, others are less problematic and women may continue with their daily chores and lives in a normal way. This view was summarized by a mother of three who said:

> "In all my pregnancies, the worst one was my second born, the only son. I was always sick and weak. I went to the clinic several times and even decided to deliver at Nyang'oma dispensary because we were all worried that something may go wrong. I did not have a problem with my first born daughter nor my third born daughter. The boy has continued to be very problematic even after birth and falls sick frequently"

Some respondents however, reported that girl child presented more problems to the mother in pregnancy than the male children.

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In the in-depth interviews, one elderly TBA compared the past and the present times. She said that traditionally, pregnancy was seen as a normal condition since most of the complications that were likely to occur were taken care of by personal *nyamrerwas* that each and every woman had access to. She was of the opinion that the traditional 'pot medicine' (*yadh agulu/nyaluo)* which was administered in accordance with their respective therapeutic strengths was so good for the mother and the foetus. The medicine enabled both child and mother to be of good health. They equally ensured that the mothers were very light and able to perform their respective duties. Locally prepared medicines were taken and they triggered excessive urination or diarrhoea that not only cleaned the stomach but

also offered the body some immunity. She laments that today's women have been cheated to disregard anything traditional;

> "Today, everybody is struggling to be modern and conform to present living. Some people rush to the churches; others just buy medicine from shops that in reality just complicates their conditions. The foods people eat today also make the foetus grow too big for normal deliveries, whenever you advise them against greed, they do not listen. I hope that one day, we will realize how important our cultural belief system and values are" (An elderly TBA).

The closest view to defining pregnancy as an illness among other aged TBAs was that it may be a '**necessary disease**' which people cannot avoid and has to be endured at all costs. However, there is convergence among the old informants that the condition should not be pathologised and that pot (traditional Luo) medicine is the most effective therapy as it is readily available and women can be taught to prepare it themselves and save their skins from the extensive medical intrusion common in health facilities today.

The definition of pregnancy becomes the first arena where the female powerlessness determines the patterns of care and maternal health care behaviour. Old women seen as custodians of the community values try to influence the young mothers to see things from their perspective and to conform to the societal norms.

Talking about pregnancy with family members

There is poor communication between spouses during pregnancy and this is reinforced by culture through the socialization process in the community. It is considered a taboo in the Luo culture to prepare or to talk about the unborn child.

Most respondents in the longitudinal follow-up indicated that they rarely discussed their pregnancies and birth preparedness with their spouses. Those who did had their discussions limited to question-answer sessions more particularly after clinic attendance. Most men felt the need to know how the money they provide for clinic is utilized and as to whether the women really attended clinics. Women on the other hand, felt that it was not very appropriate to regularly discuss their pregnancies. Discussions were mostly limited to whenever there existed health complications during pregnancy. The overall view can be summed up in the words of one respondent;

> "It is not necessary that you continuously discuss your pregnancy with your husband. Most pregnancies make people develop negative attitude towards their spouses and this hampers any meaningful

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communication. Most of the time, it is the husband who has to initiate the discussion by asking you how you feel or whether you attended clinic and how much the cost was. As long as you are moody, delicate and attitudinal, most men shy away and communication channels are cut. At times, women feel so bothered that the discussions are just amongst themselves other than with their spouses"[26]

Other women cited shame and embarrassment as the main reason for their lack of verbal communication with their spouses. One respondent commented thus:

"I even feel embarrassed to tell my husband that I am pregnant. I try to hide the pregnancy as much as possible until I cannot hide it any more. I would feel really ashamed to go to him that I am now pregnant" (Angeline in her third month of pregnancy).

Angeline was recruited in the study through the snowball method and was the only respondent who was less than four months into her pregnancy at the time of recruitment. By this time, she had not informed her husband that she was pregnant. When we visited her for the first time and found her husband, he was curious to know more about the study. After a thorough explanation and even confirming to him that his wife was expecting, he wanted to know how we knew that she was expecting. It was after this that Angeline retorted, "Is it a must that you know everything?" This was a friendly comment and he did not take offence.

Men on their part felt that discussions were not likely to be fruitful in the event that women were never interested in them. Some men reported that whenever they were in the mood for any discussion, their gestures were always misconstrued to mean meddling in female affairs and private concerns and the women's moods were not conducive for any fruitful and meaningful dialogue. One man commented thus:

"How do you expect us to discuss anything if any time I ask her how she is feeling or how the pregnancy is progressing the answer I receive is that '*in to obadhie ang'o*?'(How does it concern you?)" (A 30-year-old husband to a respondent).

The other man on the same issue commented:

"It is very difficult to discuss anything sensible with a pregnant woman as they are too moody and extremely unpredictable. It is in my best interest never to disturb the 'bees' unless I want to be stung". (A 32 year old husband to a respondent).

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[26] The Focused ANC package advocated for by WHO requires that there has to be an elaborate birth plan with the assistance of the so called "birth partners"

Noted on the issue of familial discussion is the fact that the absence of communication at the family level is one of the most crucial cultural obstacles to women's maternal health care seeking behaviours. When women cite shame and embarrassment with their spouses, it is difficult to open up. At an overall level, women in the community reported that they feel ashamed from the very beginning of people around her finding out that she is pregnant unless it was the first child in a stable marriage or the first child in a marriage that was turbulent as a result of lack of a child where the child confers identity to the women and stabilizes her marriage. During the pregnancy, most women will only discuss with their husbands as a last resort when she is faced with a problem whose solution she alone cannot manage such as material, financial or health related complications that require hospitalization.

One respondent commented

> "I only talk to my husband during pregnancy if I am asking for something or permission to go for antenatal care, for the rest of the things and the progress of the pregnancy, he can see it for himself as my tummy grows big and bigger each day. Why bother somebody with something that is obvious and visible for all to see?" (A 28- year old mother of three and in her 4th pregnancy).

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However, as has been noted, some men were always open for discussion and believed in it as part of the emotional support. The lack of discussion at the household level about pregnancy bars information sharing between primary stakeholders in the process about the risks involved and how to deal with them. It can also curtail the informed decision-making process necessary for the allocation of family resources and adoption of behaviours beneficial to maternal health and supportive of safe motherhood.

Gender, avoidance behaviour and pregnancy risks

Other than the definition of pregnancy, the Luo also have avoidance relationships that may be harmful to the safe pregnancy outcome. The father-in-law, daughter-in-law avoidance make it impossible to assist a daughter-in-law in distress. Cases were reported during the research where women were not able to receive care since those who were present within the homesteads were not in a position to come into direct contact with them. One such case was of a woman who was delivering twins and she developed complications in the process, but was unable to get instant assistance as would be expected.

Mary[27] was a 27-year-old mother of four whose husband was in town employed in the informal sector. She was staying in their rural home with her step mother-in-law who was also aging. Mary had been pregnant but only consulted a *Nyamrerwa* and therefore, did not know that she was expecting twins. On this material day, Mary managed to successfully deliver the first bouncing baby boy named Opiyo at dawn with the help of her *Nyamrerwa*. Her pain did not stop and the after birth also did not come out. This continued with those present hoping that things would work out. By 4 p.m., nothing was forthcoming and they were now getting worried and she was getting too tired and frail. The only men in the extended kin network available were related to Mary in a way that the avoidances relationship had to be observed. They were in a relational position of her fathers-in-law and could therefore, not in any way get in direct bodily contact with her to take her to clinic/dispensary on a bicycle which was the only available means of transport or a wheelbarrow. They claimed that relationally, they could not hold or get into bodily contact with Mary in her condition and that she was also 'dirty and impure' and their actions would be a taboo that would lead to '*Chira*'. The others who could have helped insisted that Mary's husband is normally indifferent to them and they could therefore, not be of any help to her. The research team intervened and by the use of their bicycles, took Mary to the dispensary where Mary successfully delivered her second baby boy at around 7.30 p.m.

The TBAs on their side rationalized this position by reporting that birth as a process among the Luo at the communal level is the concern of women and it is where women derive their power and strength. Rarely are men involved in the process unless complications arise requiring spiritual and ancestral intervention.

The pressure to have children and fake pregnancy[28]

Two of the clients in the longitudinal follow-up had not delivered by the end of the study more than one year after having 'conceived'. The conclusion made was that these were 'feigned' pregnancies that resulted from the societal and cultural pressure imposed on women to deliver. This in our opinion was the female attempt to deal with the construction

[27] Note that all names in the thesis are pseudonyms and are not the true reflections of the bearers as indicated in the ethical concerns.

[28] In my childhood, there was a woman in the village who had not delivered for a long time though she had her first-born son born out of wedlock before marriage. When she 'conceived', the husband was happy as well as the mother in-law. But on the day of delivery, it was discovered that she had never been pregnant but was stalking pieces of cloth in her tummy. When this was discovered, she ran away and had never been seen to date, almost twenty years later. It is rumoured that she crossed the border to Tanzania.

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of womanhood and the pressure of reproduction in a community where birth completes a marriage and the birth of a son as the most cherished sex for the continuity and inheritance purposes in the lineage system. It also indicated how motherhood defines the status of a woman in marriage, the family, community and society at large and how that definition is a site for individual discrimination and socio-psychological struggle.

The two cases are as follows:

Case 1

Nyalego was a 35-year-old mother of two daughters and her husband was a primary school headmaster. She was a businesswoman running a family shop that dealt in a variety of exotic goods and was well stocked. She was recruited for the study at Nango dispensary on the 11th of July 2002 and by this time; she was three months pregnant and had come for treatment as she was experiencing stomach pains. She said that she had been bleeding a lot but on and off for about a month. With the assistance of the husband, she went for proper check up in Bondo at a private clinic when the problem persisted. Here, she was diagnosed and told that she was pregnant but the baby was in the wrong position. She was informed to go to Kisumu for a corrective surgery.

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When she went to Kisumu, she was diagnosed to be having an abnormal growth in the stomach. In between, she got worried and started visiting her parents who assisted her in getting a traditional medicine practitioner without informing her husband. In the process, the husband decided that she goes for proper check up and treatment in Nairobi. In Nairobi, she went to a private missionary hospital and they confirmed that she had a tumour. They recommended surgery but could not be operated as other diagnosis revealed that she was suffering from high blood pressure and more so, the husband who was supposed to sign for the operation was at home in Bondo. She was therefore, given medication and an appointment for the operation. The husband however, refused to sign for the operation in fear of the negative consequences of the surgery. Nyalego came back to Bondo and explored several options including the Makini herbal clinic which required 60,000 shillings for her treatment.

On the whole, Nyalego still maintained and believed that she was pregnant but was worried that the child was not moving nor was there any physical sign of the baby's growth. By the end of the study in July 2003, almost fifteen months after 'conception', Nyalego had

stopped attending clinic and was planning to consult a traditional herbalist to expel the foetus as she believed that it could be dead. She knew about the herbalist from a fellow woman who had a similar experience before and was planning to see her without her husband's knowledge. The husband was already disillusioned and never wanted any discussion on the pregnancy nor was he willing to spend any more money on it. Nyalego herself told us that the husband was complaining that he had spent a lot of money on the pregnancy and the whole treatment saga was creating tension in the household.

Meanwhile, there were rumours in the neighbourhood that she was actually not pregnant but had a growth and was trying to make it up since the husband was threatening to marry a second wife so that he could have a son. We therefore, concluded that part of Nyalego's problem resulted from social pressure from her family and society at large to give birth, particularly to a son. Being a school headmaster, her husband had the need for an "heir" to the throne as an assurance of the lineage continuity and for inheritance purposes.

Case 2.

Achungo was a 33-year-old mother of two (a son and a daughter) and a widow. She was, however, cohabiting with a young man of 22 years who was engaged in fishing in one of the beaches. Achungo herself was running a hotel business at the local market centre where she had moved after the death of her husband.

At the time of her recruitment on the 11th of July 2002 at Nango clinic, she was five months pregnant and was attending antenatal clinic because she was experiencing such problems as stomach pains, bleeding, vomiting, diarrhoea and fatigue. During our home visits, we found out that Achungo was engaged in self-treatment and was taking traditional herbs which she said were intended to expel the bad winds (*yamo*) from her stomach. We also had a chance of meeting her man friend who expressed his eagerness to have a baby as people were telling him that he has been bewitched since he was cohabiting with an old widow who can never give birth.

By the 24th of October, though Achungo had never gone back to the clinic, she was worried that the baby was not growing though she insisted that she could feel it play in the stomach. When she later went back to Nango, she says that the nurse told her to wait outside as from 10 a.m. to 4 p.m. in the afternoon and was finally given only pain killers and told by the nurse to be seeing her in private at her home.

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By the 7th of November, she had gone to another health centre and was advised to go for an x-ray in Bondo which she never did. On the 14th of April 2003, almost 14 months into the pregnancy, there was still no physical sign of the baby growing, so, we decided to talk to her at length to get her birth history and what she considered to be the problem. She narrated how her first pregnancy was problematic and had to travel from Nakuru to come back home for it to be corrected by a traditional medicine woman. She later delivered the baby prematurely at seven months and had to be put in an incubator in a hospital in Nakuru. The second born was also problematic but she managed by constantly going to hospital. She confessed that the present pregnancy had drained her of energy and had really bothered her. She believed that there was *yamo* in the stomach that was interfering with the growth of the child and that one day, she would ultimately deliver though she could not tell when that would be. The rumour around the village however, was that the man friend wanted a baby to prove his critics wrong including his mother who had made two trips from their place in Gem, Siaya District to 'rescue' her son from the custody of a widow who cannot give her a grandchild. On the other hand, Achungo who did not want to loose him was under extreme socio-psychological pressure to measure up to the expectations of the 'husband' and be able to retain him.

Further enquiries from the providers on what would be the explanation on the delayed or prolonged pregnancy elicited divergent views. The nurse at Nango attributed it to miscarriage resulting from a long history of venereal disease which they were now treating and hoped that all would be well. The Legion Maria mother on the other hand brought in traditional elements on how Achungo had bad winds in her which are inherited or rather "*juok ka kwaro*" (spirits of the clan) that had to be exorcised and could only be assisted through prayers at her church. One traditional birth attendant from the neighbourhood of Achungo's marital home explained that she had refused to be inherited after the death of her husband and she also did not complete all the required rituals as expected of her and she would always experience problems in her life.

Talking to two elderly men in the community, they accepted that such cases were normally common in Luoland and that women who are the responsible sex for the safe delivery of children could be involved in activities that prolonged the pregnancy to more than the nine months. One man even said that he himself took more than 11 months before birth. To him, this was a positive attribute as he took the additional two months in his mother's stomach

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to grow up and by the time he was born, he was more active and brighter than the rest and continued to excel in his activities compared to his age mates. The second man however, gave several interpretations to it. He said:

> "Issues of prolonged pregnancies used to be very common in the past as compared to today. Women, who for some reasons did not conceive when they were expected to, resorted to tactics to maintain their status and to avoid scorn by neighbours and relatives. Sometimes, when the ancestors were unhappy, a pregnancy would be constantly problematic with a lot of bleeding until sacrifices were made. At times, black magic would be used by jealous people to scuttle the progress of a family" (Community elder at Nyang'oma village).

Other explanations were simple as one woman said "*gima ogen jabare*" (whatever is highly expected does not always happen), that women, whose expectations and wellbeing depended on particular births, were more likely to experience prolonged pregnancy and may even lose the baby in the process.

Besides the social, psychological and cultural pressure on women, respondents and the key informants identified other problems that women in the community face during pregnancy. These factors included poverty which is associated with poor diet leading to anaemia and malnutrition and inadequate access to quality health care; Domestic violence and inadequate care and support from family members, particularly the husbands; sexual infidelity among spouses exposing women to STIs and STDs and at worst HIV/AIDS; Illiteracy among most women hampering their access to useful health information and their ability to adequately interact with the hospital bureaucracies and poor infrastructure that makes it difficult for women to access health care facilities during the rainy seasons.

Other factors identified were lack of adequate and satisfying treatment in the few health care facilities; Single parenthood and widowhood in the community resulting from the high death rates occasioned by the dreaded HIV/AIDS; Heavy workload that include gardening, mining and other domestic chores; High temperatures in the region and the high malaria burden; Lack of clean water for domestic consumption and the long distances women must travel to fetch water from the lake and the high birth rate in the community leading to the birth of many children that deplete maternal strength. Since most families are poor, they cannot adequately feed, cloth and educate the many children. This leads to a cyclic poverty episode with little hope of getting out of the poverty web.

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4.2. Pregnancy and Domestic workload

Although the last three months of pregnancy should be a time when the mother rests and gains weight, the truth on the ground in this community is that women continue with their full workload right up until the time of labour, and resume work immediately after delivery. This can have an extremely detrimental effect on their health.

There is a great necessity for assistance during this period to enable women go through their pregnancies in an atmosphere of peace and reduced stress. The heavy workload is further complicated by reported cases of poverty and poor nutrition in the community where the pregnant woman's diet is heavily controlled. Additionally, the male expectation and the societal enculturation process encourage women to be 'beasts of burden unto death' as hard work is seen as a virtue and a means of retaining one's husband to ones-self and striking good relationship with the in-laws.

As mentioned earlier, a childless marriage among the Luo is considered to be socially incomplete. In most cases, the birth of a baby boy is much more celebrated than that of a girl since this is seen as the only way through which the lineage is maintained and sustained. In spite of the high value placed on children by the community, pregnancy itself is seen traditionally as a normal condition and therefore, not expected in any way to alter the daily routine of a woman. It is a condition that is seen not to be requiring any additional attention. The above definition determines the health seeking patterns of women and by extension, the level of assistance they expect and receive from those around them. As long as a condition is deemed normal, it is not seen to require any break from the normal daily routine or closer monitoring and improved nutrition.

Respondents in the study were involved in a variety of income generating activities with most of them reporting that they were housewives. The responses are shown below

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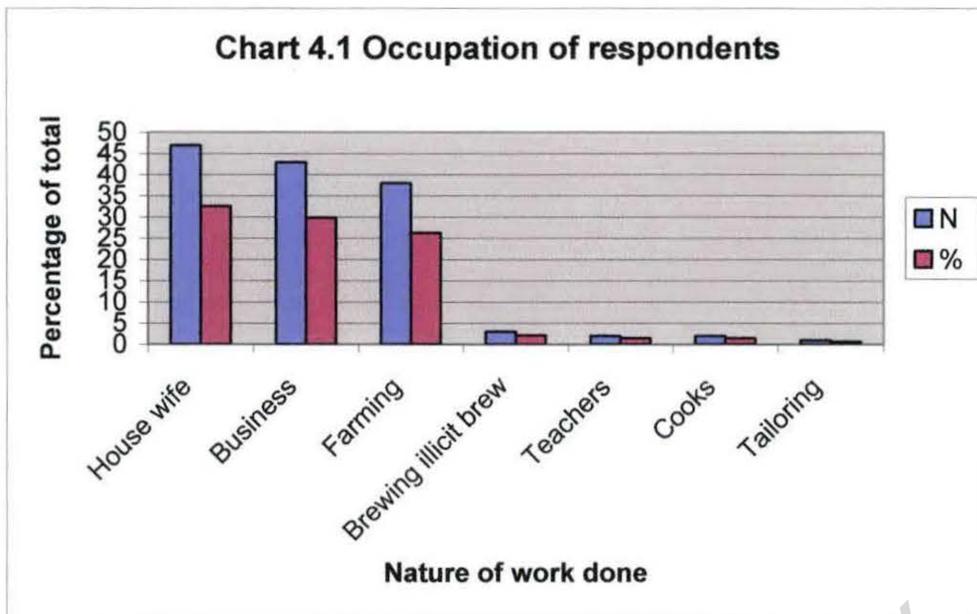

Source: Primary Data (Community Survey)

As shown in chart 4.1 above, most women in the community survey as well as the longitudinal follow-up were engaged in a variety of domestic work and other productive activities outside the house. Those in the beach areas were engaged in petty trade such as selling *omena*. Other income generating activities included hawking fish, selling paraffin, tomatoes, selling groundnuts, second-hand clothes dealers, selling maize, vegetables vending, selling of firewood, selling mandazis, hotel business and shop keeping, among others. Besides being in their businesses, most women were also engaged in subsistence farming. Only four women mentioned that they were involved in vegetables farming for sale. Women who engaged in petty trading still referred to themselves as housewives since according to them, they were not salaried or in formal employment. The process of nurturing, feeding, taking care and socializing children were not mentioned as work by any of the respondents though; these activities take a good part of their time on a daily basis.

In the longitudinal follow-up, it was observed that the respondents' daily routines were not compatible with their pregnancy status. Most of them lacked helping hands. Among the domestic chores mentioned included washing utensils, washing clothes for all the family members, ironing clothes, cooking, mopping and sweeping of the house, smearing the houses, and fetching firewood among others. In the process of fetching water, they went to the lake barefoot thereby endangering their own lives and increasing the chances of contracting waterborne diseases such as bilharzias. Those from Orengo village, who were in their own homes, also did routine gardening and overseeing the general welfare of the

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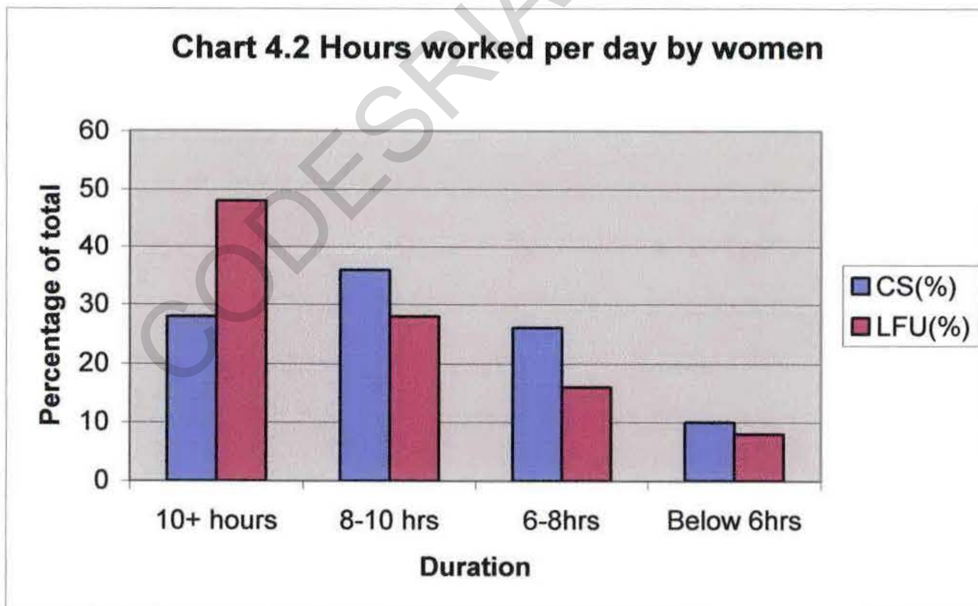
homestead. They performed tasks that rarely gave them time to rest. Most of the tasks performed required too much bending that was not only tiresome, but also injurious to the women. One key informant (TBA) reported how one of her clients miscarried as a result of being attacked by one of her bulls as she was tethering them. She said:

> "Nyaimbo was recently brought here in a pathetic state after she had been knocked down by this big bull in her compound. I have always reminded her to avoid grazing cattle whenever she is pregnant but she has insisted that she has to do it since the husband had given her the cattle and each wife had hers. She unfortunately miscarried after this encounter with the bull"

The brewing of illicit brew for example was not only illegal but also highly labour intensive. The amount of heat involved is too much and can be hazardous to the health of a pregnant woman. One of the women involved in illicit brewing had this to say:

> "It is not that we like it given a choice, but you either brew or die of hunger and when you are pregnant, you even have more needs for money, If you stop, you go hungry since the lands are shrinking and less productive" (A pregnant 28 year old mother of four).

Related to the employment and low earning was the duration each woman worked in a day. The chart below show the hours worked per day as reported by women in the community survey and the longitudinal follow-up:



Source: Primary Data (Community Survey & Longitudinal follow-up)

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As indicated on chart 4.2 above, women worked for long hours with the least reported duration at five hours and the highest was seventeen hours by a hotel owner who had to wake up by 4 a.m. and go to bed after 10 p.m. every day. The average hours worked per day in the community survey were eleven and at a closer analysis, women worked more hours than they reported. The chart showing the longitudinal follow-up results provides the best picture of how much women worked in a day. In the follow up, over 70% of the women worked for more than eight hours daily with the highest percentage (48%) working more than ten hours a day. Respondents had a tendency of trying to quantify the hours in terms of the duration in which they were engaged in activities outside the house. Take for example Awuor in the sample who was a quasi businesswoman, her typical day is too crowded. She works for almost eighteen hours though she reported to be working for only twelve hours. Her typical day is as follows:

> "I wake up early to prepare children to go to school say at around 5.30 a.m., after preparing breakfast for the whole family, I go gardening till around 10 am. I at times have to come back home to get the cattle out of their kraal if the herds boy is not around after that I start the process of fetching water, firewood and food for lunch, prepare the lunch. after lunch, make adequate arrangements for super and go to the market to sell my vegetables so as to buy some of the things I need. I get back home by 7p.m. and start the process of preparing super as the children have to sleep early, By 9 p.m., I am done and when the children are asleep, I prepare for the next day before retiring to bed at around 10 or 10.30 p.m.."

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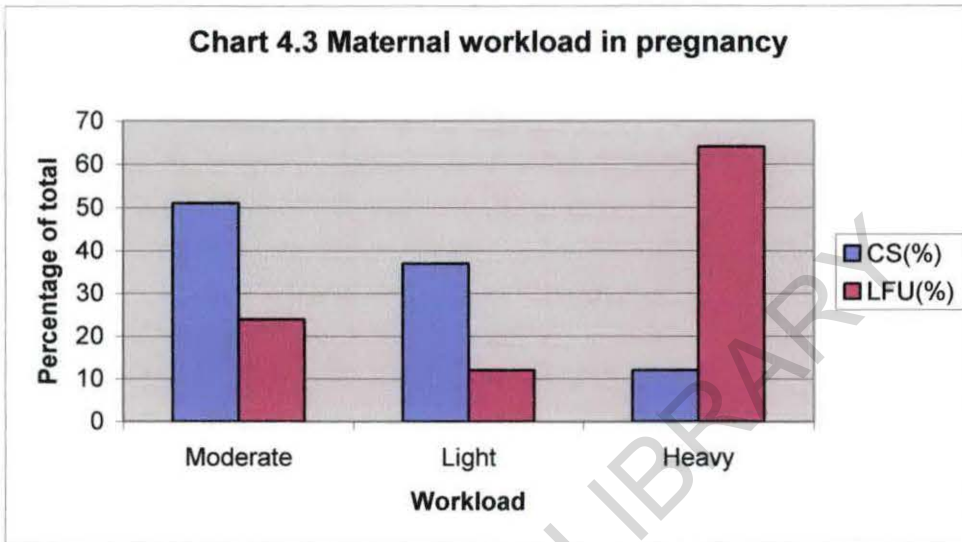
The second mother who talked about her daily work routine was one who was not engaged in business and was staying at the beach with her husband. She also worked for longer hours than reported. Her day was spent as follows:

> "I usually wake up at around 6.30 a.m. daily to make breakfast for my husband and my little girl and my brother in-law who stays with us and goes to school. After breakfast, I do laundry for everybody, sweep and mop the house, fetch water and look for fuel, either paraffin or firewood or charcoal for cooking, I then take time with my young daughter teaching her how to walk and talk. At around 11 a.m., I go to dry *omena* for my husband and then come back to the house to prepare lunch since the schoolboy comes back for lunch. After lunch, I go fetching water again and start preparing food to be cooked for super. I prepare super at around 6 p.m. and retire to bed at around 9 p.m. after making sure that everything for breakfast is ready for the next morning"

The overall work pattern in the community conforms to the public-private dichotomy. Women have learnt through the world system to only quantify activities that they regard as income generating as work and tend to leave activities within the domestic sphere unaccounted for. Overall, the chart indicates the advantages of community follow-ups

where one can verify information provided in a survey where reliance is on the respondents other than the researcher's own observations.

Some women did not, however, recognize the fact that they were overworked. When they were asked how they perceived their workload compared to other times when they are not expectant, the responses were as shown on chart 4.3 below:



Source: Primary Data (Community Survey & Longitudinal follow-up)

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The study findings have shown that pregnant women work hard until they deliver. Though from the community survey, it is shown that the majority have moderate workload, the true picture can be seen from the longitudinal follow-up data where 64 % of the respondents reported that their duties are heavy. This is true from the direct daily observations in the community. Women wake up very early in the morning whether pregnant or not to prepare everything for everyone else in the family, before going gardening and from here, they embark on other household chores such as fetching water, firewood, looking for food, and preparing the food for lunch. Immediately after lunch, they again start the process of arranging for the food or looking for food for super besides preparing it. This is a typical daily routine for every woman in every rural household. Women have to wake up earlier than the rest and go to bed later than the rest. They are the 'engines' that drive the homes without which, the homes cannot function. In one situation, the woman prepared breakfast and left to go gardening leaving the husband asleep, when he woke up, instead of taking the prepared '*uji*', he sent their little daughter to call the mother to come from the garden to serve him the porridge.

The perceived value of hard work

The long working hours and the heavy workload involved all tied well with the overall cultural idea of being 'hardy' and enduring to the end of the pregnancy period.

One respondent commented thus:

"Whenever I am pregnant, I have to prove myself; I have to be strong and to provide for my husband or else I loose him permanently to my core-wife" (A 24 year old 2nd wife).

The socialization process in the community instills in women virtues of hard work and teaches women to be servants. It is common to find a woman who instead of worrying about her pregnancy and labour, is more concerned with her other children and the welfare of her home, garden, husband and livestock. An example of this was a woman who gave birth at the Nyang'oma dispensary and when visited the following morning, she asked her sister who was standing in for her the following questions:

"Did Otieno's father take super or you left him without food? How about Otieno and the sister? Are the livestock out of the kraal, how about the chicken?"

The lady was more concerned with getting briefs about responsibilities she thought were not being attended to and lagging behind as a result of her one day in the maternity. When I asked her why she was not concerned about her health, she said:

" ("*Nyuol anyuola gi gin gik mawang'iyogo wuod wegi. Ngima nyaka dhi mbele kata ituo seche duto kendo dhako e wuon ot kata entie kata oonge* (She reminded me that giving birth is something they are used to and life has to continue whether one is sick or not and that women are the custodians of their household and must ensure that everyone is cared for whether they are physically present or not).

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The second example is a 32 years old woman and a mother of eight children who reported that she continues to work till delivery. She reported that she burns charcoal, makes sisal for sale, and does routine gardening and other mandatory domestic chores till delivery. She only takes two weeks off after delivery and she is back to her routine work. She says that they are advised at the clinics never to be lazy and to just continue with work for the proper growth of the baby and they have also been socialized to be endurant and providers for their families. This is also the advice given by the TBAs who added that the poverty in the community could not allow someone to relax, as that would imply starving. The 32-year-old mother summarized the maternal burden thus:

"We have traditionally been socialized to believe in hard work and men prefer hardworking women who can provide for their families at all times and in all situations. Moreover, since pregnancy is not a

recognized illness, one has to struggle to continue providing for the family since poverty does not know pregnancy"

The cultural requirement and the need for a woman to show her strength and might imposes certain burden on the female shoulders in the Luo community that they end up being too exhausted at the end of the pregnancy. For the professional women, for instance teachers, the work requirement is that they are accorded maternity leave. There is no equivalent of a maternity leave in the community and if anything, sometimes pregnancy brings with it jealousy among co-wives which in certain cases makes the workload even heavier. The terrain in the community and the shortage of water means that most people get their supplies from the lake which is a very long distance from most villages. If a pregnant woman has to walk long hours carrying water on her head and continue the routine till delivery, this can be very tiring.

Previous researches (World Bank, 1994a; Neema, 1994; Moore et al., 2002) had also found out that women are over burdened in the domestic front during pregnancy. They spend more time in their multiple responsibilities such as care of children, fetching water or fuel, cooking, cleaning, gardening and petty trading than they do in seeking for health care.

Additionally, past studies have reported that in most Kenyan communities, pregnancy is not expected to interfere with the woman's daily chores (KMMBS, 1994; Trangsrud & Thairu, 1998). The long working hours leave women with no time of their own to take good care of their health. The report by World Bank (1994a) clearly summarises the work pattern facing pregnant women in the rural settings and how that pattern compete with their time for clinic attendance. It says that the availability of women's time is an important factor in the utilization pattern of health facilities since women in developing countries spend more time on their multiple responsibilities for care of children, collecting water, or fuel, cooking, cleaning, growing food and trade than on their own health.[29]

To show how women are dedicated to their duties at the expense of their health, Smith et al. (1985) in their study in Zaire, found out that 13 out of 20 maternal deaths occurred

[29] Women in Urban centres and those who are slightly affluent have an indirect assistance by their spouses brought about by technology. Examples are when a man buys cooking gas himself (Equivalent to collecting firewood), gets water whenever there is shortage in the house from elsewhere in the boot of his car (fetching water), employs a baby sitter, goes to the supermarket to buy food, takes children to hospital in his car other than carrying them on the back by women common in the rural areas etc.

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during the first 5 months of planting and harvesting seasons when the need for women's work in the field can make them reluctant to go to hospital.

Exceptions to the working rule

There is a category of women who carry less workload than the rest. In the follow-up, those who reported light and moderate work were mostly the teenage pregnant women and those who are recently married and pregnant for the first time. The teenage mothers are normally believed to be very emotional and weak and may even commit suicide if not observed closely as they are still emotionally unstable and may face a hostile environment resulting from their becoming pregnant out of wedlock. This view is held by the mothers and grandmothers. They are therefore, cushioned from heavy workload. This exemption however, increases conflict between siblings with those who are not pregnant hating the pregnant ones since they are favoured by the exemption from some of the daily domestic chores and hard labour. One of the teenage pregnancy cases had this to say on workload and exemption:

> "Since I became pregnant, I have been advised by my mother not to perform certain tasks such as gardening, fetching water from the lake and engaging in too much bending while washing clothes. My younger sister who is 15 years is not happy about this and she has threatened mother that she will go away soon to stay with grandmother because she cannot work for me as if she sent me to get pregnant" (17 year old pregnant girl).

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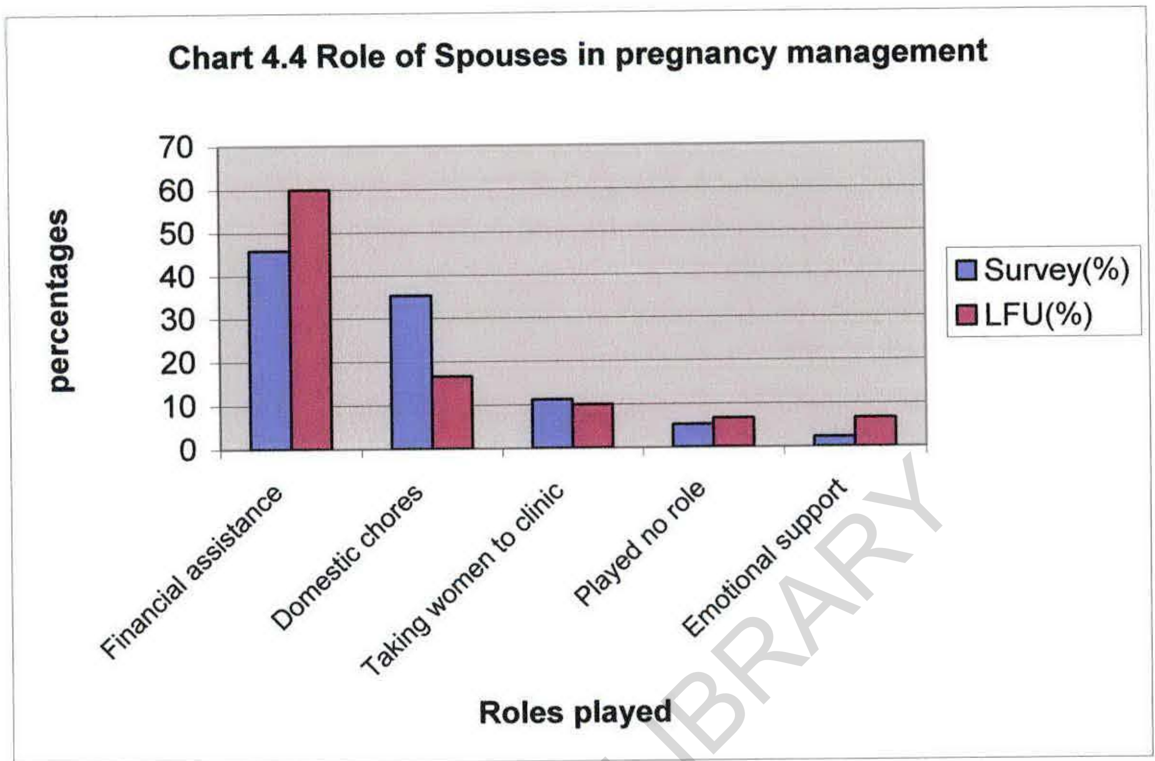
Among those who are recently married and pregnant for the first time, there are great expectations and men go an extra mile to either assist in domestic chores or have one of their female kin assisting the women. However, as observed and as the women confess, the situation changes for the worse in subsequent pregnancies. Achieng', a mother of two and pregnant for the third time summarized the feelings thus:

> "Women are normally cheated and lied to when they are newly married. As for me, my husband stayed home and helped me a lot during my first pregnancy. By then, I was 18 years old and he was about 26 years old and the expectations of his people was very high and everybody was looking forward to the day the child would be born. Since then, things have changed for the worse and I am now always on my own and must learn to survive like any other woman in this village"

Male role during Pregnancy

There were limited instances where the respondents mentioned that they received help with domestic chores from other members of the family.

The chart 4.4 below shows areas where the respondents mentioned as having received some form of assistance from their spouses and men generally:



Source: Primary Data (Community Survey & Longitudinal follow-up)

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As indicated on chart 4.4, 35% of women in the community survey reported that they received assistance on the domestic front from their spouses. However, as shown from the longitudinal follow-up data, only 17% of the respondents got assistance with domestic chores. This was the case after observations over a long period of time in the community. Among the domestic chores mentioned by women included gardening, washing/looking after babies, cooking, fetching water, looking for/buying food, helping with heavy tasks and other household chores. However, the majority in this category just mentioned buying of food as the only way their spouses assisted. It is interesting to note that women believed that they were assisted by men in gardening work instead of regarding this as part of the male responsibility that contributes to the household food security. As can be noted, 5% of women in the community survey and 10% of the respondents in the longitudinal follow-up received no form of assistance from their spouses. They reported that since men do not believe or define pregnancy as a disease, the condition was not meant to interfere with the female work routine and therefore, no need for any helping hand. They reported that men were more concerned and interested in the outcome (interested in the child to be born) than

the mothers themselves. The women wondered how men expected quality product from a process that they invested little time and resources.

The greatest form of assistance reported in the community survey was financial (48.5%) where women said that they received financial support from their spouses and other male friends to go to clinic, to buy baby clothes, to buy maternity dress, to prepare for deliveries where possible though rare, and the money needed for the overall maintenance of the household. Though 60% of the respondents in the follow-up mentioned financial support, it was not uncommon to find women failing to attend clinic or being unable to purchase drugs for lack of money. However, most women believed that men can do more than just providing the money as most of them reported that they got the money after a long spell of persuasion and at times abuses that did not augur well with their pride and dignity. The situation can be summed up by one respondent who said:

> "Getting money out of my husband is like squeezing water out of a rock. You have to beg and beg and you may even be on your death bed, you could be very lucky to receive the money" (A 24 year old mother of two complaining about her husband in his presence). To these accusations, the husband responded by addressing me, he said:
>
> "Wuod Ugenya, these women always think that we men always have money, when you say that you do not have, it is like you are a joke and not worth being the husband or you do not care about their pregnancies and their welfare in general"

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A small fraction of women reported that they were taken to the clinic on bicycles by their spouses. This was more common in the first pregnancies than the subsequent ones. Other women reported that their spouses encouraged them to attend clinic and ensured that they did so through constant reminders and checking on return dates on the ANC cards. An example of this was Adek's husband who reported that she fears medicine and has to be constantly reminded to take them. She also does not like going to clinic and he has to ensure that she does so because, in the event of a problem, he will be the person to suffer. This statement is a testimony of the male view over their spouses, all the assistance are geared towards serving their male interests other than helping their wives as women.

In some instances, the women reported that their spouses allowed them to use 'their bicycles' to be taken to clinic by some other good Samaritans or brothers in-law. This is a clear indication that women regard themselves as external to the ownership of some of the

family assets like bicycles. Two women informed us how the family bicycles were out of their bounds and whenever they requested to be taught how to ride, the men reminded them of how they suffered before buying their bicycles.

There were however, other women who reported that they had very good husbands who were very helpful particularly during pregnancy. They were not only available during this period but also ensured that they reduced the maternal workload. They were at hand to provide all that the mothers required and the women cherished their pregnancy periods since during this time, they were really loved. Only three out of the twenty-five mothers in the longitudinal follow up reported this. One of them, a 21-year-old form four school leaver whose husband was a young high school teacher had this to say;

> "Although this is my first pregnancy. I must confess that my husband has been very helpful in ensuring that all the domestic duties are attended to. At the beginning, he encouraged me to suspend my small-scale business and relax at home. He made sure that he not only bought the food but prepared it too. When the workload became too much, he engaged a maid to assist me in the household chores. I owe a lot of gratitude to him and I hope he will remain helpful in future"

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A female neighbour who is a trained birth attendant working as a nurse in the local dispensary attended to her in her house. She was concerned that the lady was receiving too much assistance from the husband to an extent that she was becoming lazy. She commented thus; "*Nyar Kano to chwore odhialo marach ahinya*" (the daughter of Kano is being baby sat by the husband). The husband on the other hand believed that maternal health care could only improve with the express involvement of men in all spheres where possible. He commented:

> "Pregnancy should be shared and it should be a time of extreme happiness and since women are the sole physical bearers of the burden, the emotional part is the responsibility of all and I try my best to make her feel wanted. That is my contribution besides making available what she needs"

The second respondent was a 20-year-old mother of two and a businesswoman who was engaged in small-scale fish vending at the local market. She said:

> "My husband and I usually get home in the evening. On market days, he returns home earlier than me. Whenever he gets home early, he does not wait for me to arrive; he assists in fetching water for the family and even prepares food for us all. Since the onset of my pregnancy or whenever I have been pregnant, he has been so helpful that I have been sympathising with him".

The third respondent was of the view that the husband's ability to help and his assistance is based on his background and how they have been living as from the time of marriage; she had this to say:

> "My husband and I were both orphans when we married each other. We derived a lot of consolation from each other to an extent that some people were accusing him of being too lenient and that I was 'sitting on him' as a wife. He has remained the same man all this ten years we have been married and he has been too helpful to me at all times. During all my pregnancies (4 children and the fifth one presently), he has gone out of his way to be the family cook and has done any other work that can be done in the household. He has been exemplary and I thank him a lot for that"

Overall, women did not receive adequate support from their spouses during pregnancy and had to work extra hard to be able to provide for their families. The heavy workload and the lack of assistance at the family level becomes another site for female burden making pregnancy and childbirth a risky process.

Why men do not help

Although some women reportedly received assistance from their spouses, most of them preferred getting help from other female relatives. This can be interpreted to result from the construction of social reality as imposed by the socialization process in the community where gender roles are clearly demarcated with women being the 'beasts of burden'. Three of the respondents who reported that they received no assistance from their spouses had this to say:

> "How do you expect a husband to assist you in the domestic front, my husband believes that all the household chores belong to the woman and he cannot offer any help, in fact, he comes home and demands for food irrespective of your condition reminding you that you came to 'cook' and anything to do with cooking falls in the female docket" (Atieno, a 26year old mother of three).

The 2nd respondent said:

> "Husbands are husbands and they need their respect, proper planning requires that you envisage your situation and needs in advance and prepare adequately for the process and this includes inviting your sister or any other female relative during the process of pregnancy or else you have yourself to blame if you cannot make it through the pregnancy period. If you expect your husband to do the domestic chores, you are expecting too much that may not be realised" (A 32 year old mother of five).

The third respondent who shared the same view said:

> "My husband was only available in the home in the initial stages of our marriage. During my first pregnancy, he could even cook for me and ensured that I had everything I felt like. During this period, we were only the two of us staying at Bondo town, since we came back to our rural home, he married a

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second wife and it is now evident that everyone is left to fend for herself even in pregnancy. I have learnt it the hard way and I don't even bother him" (A 26 year old mother of four and who has a co-wife with two children).

Women in the study justified low male involvement in domestic chores. This is as a result of their socialization. As noted, those men who assisted their spouses were branded 'weak, feminine, sat on' and other descriptions that were not encouraging. In situation where they did not receive a helping hand, they justified and even excused the men for not being of help. This proves that socialization process imposes deeper meaning and constrains behaviour in a way that mere prescriptive therapies based on survey data may not bring out clearly the envisaged change in behaviour at the familial level.

Women's work burden has also been compounded by an increase in their responsibilities at home resulting from the schooling of their children (Trangsrud & Thairu, 1998). The traditional support they received from their grown up children is also no more since most of the children go to formal schooling and others are fending for themselves either in urban centres having migrated or in the local informal sector such as fishing in the lake, looking after livestock and other activities that take them away from home. With the advent of 'free primary education' under the present regime (NARC Government after the 2002 general elections), even children who may have stayed home assisting their mothers as a result of lack of school fees can now afford to attend schools thereby increasing the maternal burden in the domestic sphere.

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In addition, the diminishing role of the extended family and changing family relational patterns that makes even fostering difficult compared to what existed traditionally has compounded the situation further increasing the maternal burden. Women generally do the most work and are however, the least recognised since they are powerless and subordinate.

Mood swings and male interpretations

Emotionally, only 2% of the respondents in the community survey and two women in the follow-up reported that their spouses emotionally supported them during pregnancy. Some of the support included being patient and understanding, sympathetic and being around to offer a hand in all minor details of life. Women reported that very few men understood and appreciated the hormonal changes that women undergo in pregnancy. They rarely come to

terms with the mood swings and become additional burden in the process. Out of a sample of twenty-five women, twenty of them reported that during their pregnancy, they had a changed attitude towards a family member with twelve of them mentioning their husbands.

These mood swings that are always misconstrued to mean hatred require a deeper understanding and a positive emotional response from the spouses during pregnancy. The explanation women gave about the hate was that it was a condition brought about by the demands of the unborn child and there was absolutely nothing they could do about it. This condition is believed to differ from child to child and not all children imposed this condition on their mothers. Ayugi who was in her third pregnancy reports that her first pregnancy did not turn her away or against anybody. However, her second one turned her against her brother-in-law who was staying with them at Sirongo beach. She says:

> "In my second pregnancy, I hated my brother-in-law to an extent that whenever he was in the house, I ended up vomiting but I could not explain what was happening to me. This started when I was around four months pregnant and my husband did not understand this, so, they ganged up with the brother and took me back home to their mother. My mother-in-law also saw me as a bad woman who does not welcome people in her house and she treated me very badly. I was not sure that I would deliver safely as I was not attending clinic"

When I asked the husband his side of the story and his understanding of the changes that women undergo in pregnancy, he responded by dismissing his wife and women in general. He said:

> "*Mon wuondore* (women are pretentious), whenever they are pregnant, they take advantage of their condition to make demands on their spouses in the name of the unborn child"

This statement was a direct attack on Ayugi whose pregnancy had turned her against the husband. There was hostility between them that she had to control, as she did not wish to be taken back home to the mother-in-law again. This misunderstanding meant that they did not have any meaningful discussion about the pregnancy and her clinic attendance was very irregular. She had to constantly frustrate her feelings and attitude lest she be taken back to the rural home to live with the mother-in-law once more.

The other respondent with similar experience was Awuor who was expecting her second baby. The pregnancy had turned her against her husband. She says that whenever he is in the house, she prefers sleeping or staying outside with her neighbours or else she becomes breathless. According to her, the condition was worsening as the pregnancy progressed and

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she had opted to change her sleeping pattern. She left the bed for him and was sleeping on the floor. She said:

> "I have tried all I can but I have been defeated, I just cannot withstand him. Anything about him irritates me including his clothings. What annoys me further is that whenever he responds to my behaviour and leaves the house for me for a long spell of time, I feel so lonely and unwanted, I wish he could understand that it is not me, but the child"

Women tended to rationalise these behaviour pattern by invoking the Oedipus complex. They explained that the sex of the unborn child determined who to be disliked. When you are expecting a baby boy, you are likely to turn against the father as the child competes for your attention and love with the father. When I asked women what should be done to avert this tension, women in the FGDs believed that proper health education that takes into account hormonal changes should be given to men to enable them understand that the changes are temporary and that women are delicate and short tempered in pregnancy. They were of the view that it is men to give way in such situations, and when one shows his unending love to the woman, she probably changes.

4.3. Food Taboo and Nutrition in Pregnancy

One of the most important sites where culture has tremendous influence on the pregnancy outcome is on diet and nutrition. Throughout history, strong suggestions about changing food habits during pregnancy have been transmitted from generation to generation. In part, the nature of those suggestions may reflect physiological changes that appear to increase appetite during pregnancy (Taggert, 1961) and cause some alterations in taste sensitivity (Brown and Toma, 1986). However, of all the periods in the life cycle, pregnancy is considered one of the most critical and unique. During this period, food is very essential to health and growth of the mother and the unborn baby. Changes that occur during pregnancy have a great influence on nutritional needs and have a bearing on the reproductive performance. Proper nutrition in pregnancy is a necessary prerequisite to carrying the pregnancy to term and the subsequent healthy delivery. However, proper nutrition and food prescriptions are all culturally based and more often than not, women are denied the opportunity to consume food rich in nutrients necessary for their good health.

In the study, the following foods were frequently mentioned as worth avoiding: Fruits (mangoes, oranges, paw-paw, lemons, bananas, and avocado), too much of the following foodstuffs: Mandazi, chapati, groundnuts, *sim sim*, peanut, finger millet porridge, sugar

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cane and other sugary drinks, milk and other fatty foodstuffs, eggs, too much salt, coconuts, Irish potatoes, pepper, wild game, and the consumption of alcohol.

One of the reasons for avoiding starchy and fatty food was that they cause the baby to grow too big and difficult to deliver and this could lead to the death of the mother and the foetus. Sugar cane is believed to lead to the birth of a baby whose body has strange marks (cuttings/segments) and has a salivating problem. Most of these beliefs are based on empiricism rather than scientific studies.

Related to the food avoidances were the food taboos mentioned by respondents. The taboos included not eating on the same plate with the husband, avoiding meat from an animal hit by lightening, or killed by hyena, python, leopard or one that died on its own in the bush or an animal that is pregnant. Additionally, pregnant women are not allowed to share a dish/food with a sister or mother-in-law if both are expecting among others.

The reason for avoiding meat from animals that die in pregnancy is that similar fate may befall the pregnant women during delivery. Other beliefs associated with the consumption of the above food items included difficulty in delivery resulting from the consumption of porcupine meat, scars on the child's body resulting from the consumption of meat killed by python, lightening and leopard, difficulty in speech or 'heavy mouth' or a child who takes too long to develop speech abilities resulting from the consumption of eggs among others.

The food beliefs limit the range of foods that can be consumed by pregnant women who in real sense are very much in need of a balanced diet and energy giving foods. An important observation here is that most of the fruits are classified under foodstuffs that should be avoided. During pregnancy, a woman needs a balanced diet and energy giving foods. Most of the fruits are locally available and would be of great help to the woman if consumed regularly. The availability of the fruits is advantageous since they are less costly and most women can afford them. At times, the fruits are available free of charge as some of them like mangoes and guavas grow in the wild and the Luo do not believe in selling fruits to fellow villagers and even when they are sold, they are still very cheap.
The food beliefs were seen to be both restrictive and prescriptive. They were restrictive in the sense that certain food items such as eggs were associated with the reproductive functions and discouraged all together whereas others were allowed in advisable quantities.

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It was equally observed that women were not really worried about gaining weight themselves during pregnancy, but were only concerned of the weight of the baby and the difficulty in delivery.

Food dislikes during pregnancy

Some mothers reported dislike for certain foods such as fish (unfortunately the most common source of protein in this area), dagaa (*omena*), tea, milk, *sukuma wiki* and other vegetables. One respondent summarized the feelings of most women who expressed dislike for certain foodstuffs during pregnancy particularly fish. She said:

> "Whenever I am pregnant, it is always common to develop negative feelings towards most foodstuffs that I am ordinarily used to. The most common in the list is fish and more particularly fresh fish from the lake and *omena*" (A 24 year old mother of two and wife of a fisherman).

Other respondents felt that though they did not like certain types of food, they were too poor to choose what to eat. A respondent reported that even though she does not like *omena* during pregnancy, it was the only source of protein available to her. She said:

> "I really do not like *omena* very much when I am pregnant, however, it is the only 'sweet thing' cheaply available other than the bitter vegetables. If anything, it is the only way to change my diet from the daily consumption of vegetables. We are also advised in clinics to eat a lot of it" (A 20 year old mother of two staying in Nyang'oma village).

Two key informants reported that some foods are highly recommended during pregnancy. These were flowy vegetables (*Apoth*), beans, milk, eggs, fruits such as paw-paw and oranges. These foods were seen to provide additional protein, vitamins and iron necessary for the proper development of the foetus.

The observation revealed that most of the taboos associated with food were male driven. In most places in the Luo Community, women were not allowed to eat chicken and its by products such as eggs or gizzards. Women were socialised to believe that eating chicken was 'un-feminine'. A lot of bad omen were associated with the eating of foodstuffs that men found delicious. One old TBA made it look criminal to eat chicken. She said:

> "I have never seen a situation where women also sit down with their husbands to eat chicken; you youngsters of today are making our work very difficult. Women are competing for chicken parts with men thereby challenging our culture, no wonder they have difficulty in birth because of their diet"

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From the above pattern, it is clear that most food taboos traditionally kept women away from eating nutritious foods and foods that would provide them with the highest protection and boost their body immunity. From the TBA's statement, some foodstuffs were traditionally labeled male foods (such as chicken or certain parts of the chicken) and were not to be consumed by women. Such perceptions have persisted and in some instances, some sections of the chicken have been named 'male parts' (Gizzard, thighs and the back) and others 'female parts' (the wings, the neck and intestines) to show a clear division on what can be consumed by either gender. These avoidances and proscriptions have been observed for generations and they result from the conservative nature of the old women in the community who are responsible for defining the needs of the younger generation and frowning upon those who show elements of independence in their food consumption patterns. Those young women who show some degree of independence in their food behaviour are most likely to be defined as 'greedy' and disrespectful to customs.

Food craves and preferences

Most women expressed the desire for independence and the need to have the ability to eat what they craved for and what they wanted without the cultural or economic hindrance. They feel that poverty and the constraints of cultural adherence prevent them from proper nutrition. Most women talked about the tendency to crave for certain types of food during pregnancy as shown in table 4.2 below.

Table 4.2 Food crave and preferences during pregnancy

Food type	N	%
Fruits	12	48.0
Vegetables	8	32.0
Protein	3	12.0
Grains (starch)	2	8.0
TOTAL	**25**	**100.0**

Source: Primary data (Longitudinal follow-up)

As shown in table 4.2 above, twelve out of twenty five women in the follow-up mentioned Fruits (mangoes, oranges, paw-paw, bananas, avocado). eight women mentioned vegetables such as *sukuma wiki* (kales), cabbages, cowpeas, traditional vegetables such as *dek* and *apoth*. Other foodstuffs mentioned included meat, chicken, rice and beans, *nyoyo*

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(mixture of maize and beans), fish, tea with milk, cooked bananas, mandazi, chapati and sorghum porridge among others.

It was observed that the food preferences differed with some women hating what others were craving for. Most women tended to hate what was easily available in their immediate environment and that pregnancy tended to draw women away from their daily diet. Most women whose husbands were engaged in fishing and ate fish regularly mentioned fish as one of the food they hated. The other observation was that women tended to crave for foodstuffs that were also branded as those to be avoided in the belief that they led to an overgrown foetus and could result in difficulty in delivery. The other observation was that those who could not afford to purchase foodstuffs rich in protein were more likely to mention such foods as what they craved for. This is an indication that their bodies were responding to certain deficiencies.

Women reported that the frequently reported aversions and cravings are tangentially related to physiological changes in taste sensitivity and are behaviours that are unique to pregnancy and are not practiced at other times in the life cycle. The reported likes, dislikes, aversions and craves were only observed during pregnancy with one child imposing this and that condition on the mother and the other child imposing different set of conditions. Overall, the food belief and practices could be classified as practices that positively or negatively affect the foetus; belief related to promoting the health of the baby and above all, geared towards easier and safe delivery.

There is an existing belief system among many women in the community that seems to support the consumption of soil (geophagy) during pregnancy. This can be interpreted to indicate the body's response to lack of iron and proper nourishment in pregnancy.

Nutrition is key to safe motherhood and it is normally said that no subsequent treatment after a baby is born can make up for lack of healthy prenatal environment. Healthy women can lead more fulfilling lives, and good nutrition benefits families, the communities and the world as a whole (Wynn and Wynn, 1993).

Overall, food insecurity, micronutrient deficiencies, infections, parasites and gender inequities and heavy physical labour threaten women's nutritional status throughout life.

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Adolescence and the reproductive years are periods of heightened nutritional stress. Women need additional food and micronutrient intake to support adolescent growth, foetal growth during pregnancy and milk production during lactation. Improved energy intake, a diversified diet and increased micronutrient intake can help to improve women's health and nutrition, as well as birth outcomes.

Maternal nutrition is therefore, seen as a key factor in pregnancy outcome (WHO, 1986, Allen 2002, Wynn and Wynn, 1993). Though a balanced diet is necessary during this period, protein is the most important ingredient in pregnancy. Most of the foods rich in protein are however, proscribed, disliked or unavailable to the majority of women in the community. It is also evident that the facilities women attend whether traditional or biomedical rarely advise them on proper nutrition and in situations where they do, poverty limits the individual choices. When women attended clinics, some of them lamented that the providers directed them to eat certain food that were unavailable to them. This was mostly taken by the women as a sign of boastfulness and despise by the providers.

The other crucial food element is calcium and vitamins found in fruits and vegetables. Most of the fruits are seen to be responsible for an overgrown foetus and therefore, difficulty in delivery. In situations where families must make choices on what food to purchase, rarely do fruits feature anywhere. There is also low maternal knowledge on the importance of fruits and their nutritional value to a pregnant woman.

Also required is the increased supply of iron for haemoglobin, the oxygen carrying substance of the red blood cells that oxygenates the baby. Iron is needed in larger doses, especially in the later stages of pregnancy. Anaemia results from inadequate iron supplies, which can cause loss of appetite, extreme fatigue in the mother as well as decreased oxygen supply to the baby. Anaemia can also make the mother less able to fight off infections and unable to handle haemorrhaging during birth. Since it is difficult for a woman to consume enough of iron from foods to maintain an adequate supply, it is often recommended that pregnant women get iron supplements that are given in tablet forms.

It has been noted that problems such as low birth weight are linked to inadequate maternal nutrition. There are other hormonal effects resulting from improper nutrition such as the retarded brain development, and neurological defects (Wynn and Wynn, 1993).

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Besides the beliefs that bar women from proper diet, the eating patterns in most rural communities where patriarchy reigns supreme also dictates that women eat last. In many families, men/husbands are served first; then the children and women are left to eat the left over regardless of her pregnancy or health status. It is not uncommon to find women going without food in situations of scarcity while men and children are fed on the little available.

Although good nutrition before and during pregnancy provides no guarantees, it reduces potential risks. Wynn and Wynn (1993) assert that how well we feed our girls, both in school and at home, not only affects their health but influences their food choices and habits in their child-bearing years. They further assert that if future mothers are not well fed, through choice or because of the stresses of life and income, or because of cultural proscription, the next generation will have ill health and disabilities that could have been avoided. Most of the feeding patterns and food avoidances result from the gender differences and the overall position of women in the community. The resulting malnutrition leaves the women more susceptible to disease, and subsequently, vulnerable to complications during pregnancy as well as at delivery. The frequently reported cases of extensive bleeding after delivery could be resulting from the maternal diet during pregnancy.

4.4. Social support system during pregnancy

In the Luo Community, pregnant women are often not the decision-makers regarding care seeking during pregnancy, birth or the post-partum period. There is a group of people who offer assistance and are the determinants of the care seeking patterns and the wellbeing of the pregnant woman. This group has been referred to by Janzen (1978) as the 'therapy managing group' or 'important others' and as 'birth partners' by the focused ANC approach advocated for by WHO. These groups form the support network during pregnancy. The network consists of the following; the in-laws (mother in-law, father in-law, brother in-law, sister in-law), husband/spouse/partner, co-wives, older children, servants, peers, neighbours, grandparents, parents, aunties and fellow siblings (common among the teenage pregnancies) and other relatives among others.

The above network not only provides the day today comfort for the mother but also determines where and when she attends clinic, what she consumes and controls even the

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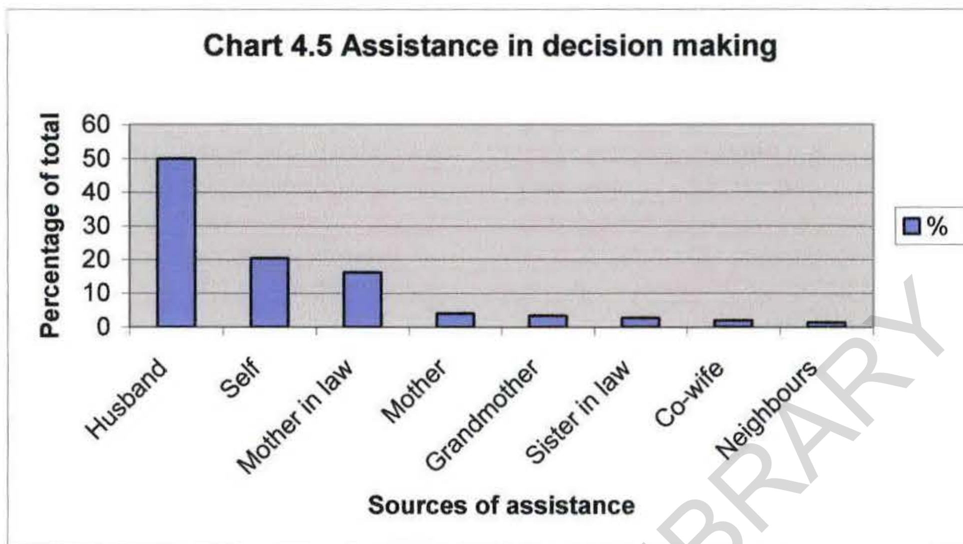
available information to her. It is a network that can break or make a particular pregnancy. Central to the concept of support is the whole question of dialogue and advice in pregnancy.

The table below shows those who support the women in their daily chores and in decisions affecting their daily operations and wellbeing:



Source: Primary data (Community Survey)

Note: Multiple responses allowed where more than a single source influenced decisions.

As shown in chart 4.5, many women are not the sole decision makers. Almost 80% of women are assisted by an array of therapy managing group in their health care seeking behaviour and in making decisions affecting them in everyday life. Only 20% of women reported that they determine their own destiny. Included in this group were the widows or those whose husbands were away in search of employment or waged labour or in other Islands on fishing expeditions. In most cases, even in widowhood, the power shifts to the mothers-in-law and/or brothers-in-law.

The process of decision-making and the power to do so has net negative effects on women's health. In some situations, women cannot take advantage of the knowledge they have to attend to emergencies or go to antenatal clinics as they need permission from their spouses to do so or from other male affines or the mothers-in-law.

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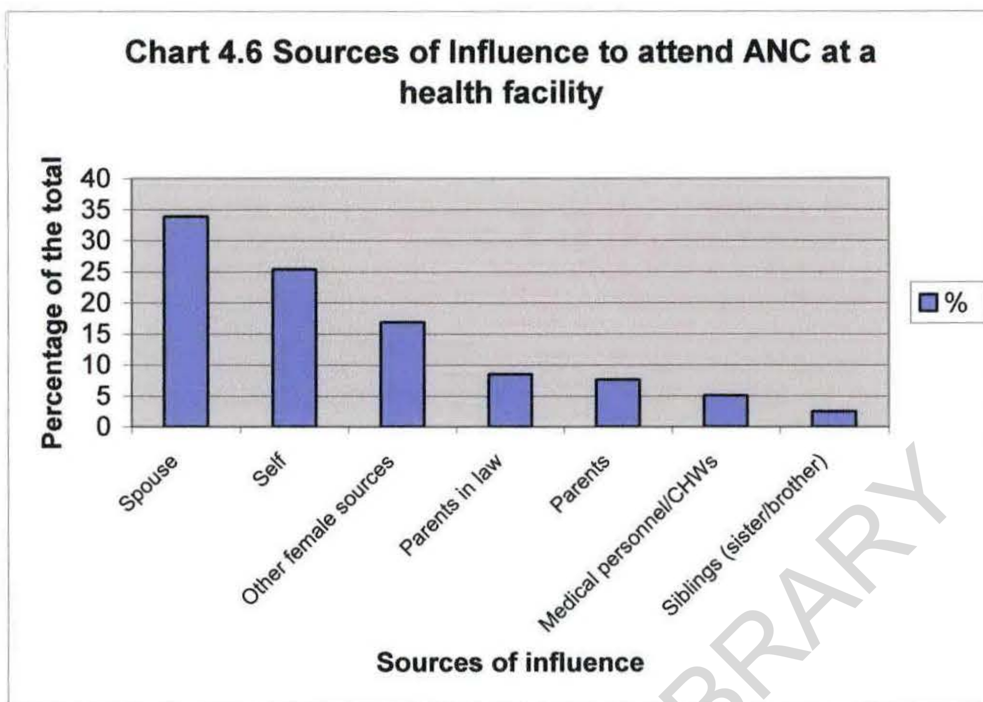
With respect to the initial influence to attend ANC, there is a slight change in the source of the information as compared to the percentage of people who influence the women on daily basis as shown in chart 4.6:



Source: Primary data (Community survey)

As shown in chart 4.6, spouses were the most common source of influence and advised women to seek facility-based health care. A good proportion (25 %) of the women reportedly decided on their own to attend ANC since they were aware of its importance and benefits in safe delivery. A number of them mentioned that they had been taught the importance of ANC at school. The other sources of influence were the peers and other female friends and relatives including aunties, sisters-in-law, co-wives and neighbours.

Parents, particularly the mothers, were found to be more influential in advising the teenage girls whereas parents-in-law also advised their daughters-in-law. In only one case was the father-in-law the source of influence in antenatal information and this could be attributed to the communal avoidance relationship. This particular case involved a married woman whose husband was working away from home and she was staying with her father in-law at home in the village. Besides the above, health personnel and siblings were also reported to have influenced the women to seek antenatal care at a health facility. This shows that women's health seeking behaviour is influenced by a variety of people in and out of their immediate environment.

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An important observation that makes ethnographic follow-up an important methodological tool is the ability to find fault in some casual survey responses. Whereas the survey indicates that a good number of women made their own decisions, closer scrutiny in the follow-up revealed that this was not always the case. This was always done in consultation with and in most instances, through the influence of others. Two respondents who had initially reported that they had made their own decisions to attend clinic later talked of variety of influences. Take for assistance Achungo already discussed in feigned pregnancy, she said:

> "My initial clinic attendance was as a result of my own decision having seen women attend antenatal care throughout my youth and having been taught at school during home science lessons. Though my husband also advised me to go, I cannot say that he is the one who made me to go to the clinic"

The second respondent in the longitudinal follow-up commented thus:

> "Going to clinic is a matter of personal choice. Even if somebody wants you to go and you do not have money or you do not feel like going, nobody can force you. However, men can bar you from going even if you wish to go since as wives, we have to obey them. In this regard therefore, I can say that my husband allowed me to go though I was aware of the importance of antenatal clinic in pregnancy from my school days" (22 year old mother of two).

The above observations clearly indicate that in terms of gender relations, the female agency is not accorded the respect it deserves in society. Women are denied the enjoyment of their reproductive freedom and rights. Their reproductive choices are submerged while the male authority is clearly visible even in reproductive concerns that were traditionally a female domain.

Female based maternal assistance

Among the female relatives who were helpful with domestic chores included sisters-in-law, mothers-in-law, grown up daughters and to a limited extent co-wives. They assisted in the preparation of food, washing of clothes and utensils, fetching water and firewood and taking care of the children whenever the mother was not able.

Other women reported that they received assistance from their grown up daughters and unmarried sisters-in-law. *Nyagem* who had a 14 year old daughter said that she prefers getting assistance in performing domestic chores from her own daughter as this does not create a lot of indebtedness and expectations in the community. During the research, we

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observed that she occassionally interfered with her daughter's schooling so that she could assist her. She commented:

> "I would rather get assistance from my own blood than beg people to do so in a way that makes me indebted to them. I know I at times interfere with her schooling, but just a week cannot make much difference, after all, I am simply teaching her a head of time to be a good and responsible mother in future"

Co-wives as a resource in pregnancy

Respondents were divided on the role of the co-wife as a support network. Three (two in the longitudinal follow-up and one in the survey) women reported getting full attention and maximum assistance from their co-wives in pregnancy while others saw them as sources of jealousy and potential threats to their wellbeing. Those who were positive about their co-wives reported that they not only ensured their husband was well taken care of, but also assisted them with domestic work. In families where 'love' existed, polygyny was seen as a mutually supportive institution and a cultural strength that could be exploited for the benefit of the pregnant woman.

The following two cases (3 and 4) illustrate mutual understanding and support among co-wives

Case 3

Aluoch and Achieng' are co-wives. Aluoch is the first wife (*Mikayi)* and has three daughters. Their husband married Achieng' almost three years ago who already had a son and she was pregnant for the second time during the study. When Aluoch was pregnant with her last-born child who is now two years old, Achieng' was of great help. She assisted her with all the domestic work, cooked for her, worked on the farm together and even made their food from the same pot for quite sometime after the marriage. According to Achieng' who is the younger of the two, Aluoch has been like a mother to her. During her first and present pregnancies, Aluoch was quite supportive of her. She advised her on antenatal care and also massaged her at home whenever she felt tired. She has been helping with domestic chores and has done more for her than their own husband. Achieng' narrated her story as follows:

> "Our husband is most of the time out of the home trying to make ends meet. Although we both have our pieces of land and at the moment everyone cooks independently in their houses, we have always maintained a common eating pattern. We take all our children as same and we have shared practically everything. We have been assisting each other all the time and more so while pregnant. Aluoch is

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responsible for all my traditional medication, my clinic attendance and above all, she named my first child. I always hear of rivalry among co-wives and I thank God for my condition as I have experienced the reverse".

Case 4

Awuor and Adhiambo are co-wives to a 40-year-old man called Owino. Awuor is the first wife (*mikayi*) of the home and has had six children with Owino and they have been married for over 13 years. Over the years, they have had four daughters and two sons. All the first four children were daughters and the last two are sons. Owino married his second wife (Adhiambo) six years ago and they already have two children with the current pregnancy being the third. Her two children are almost the age mates of Awuor's two sons. Adhiambo confesses that since her marriage to Owino, they have had a very successful relationship with her husband and her co-wife. During pregnancy, they ensure that they assist each other as they understand the period to be a very stressful one. They prepare meals for each other and take care of each other's children. During the longitudinal visits, the research always found the mothers together. Their understanding is in such a way that the younger wife who was initially a catholic converted to Anglican Church of Kenya (ACK) to join the husband and the first wife. Adhiambo pointed out that;

"I have been blessed by a very understanding co-wife. She has been very helpful and we share a lot of things including our faith. Even the villagers really wonder whether we are sisters or co-wives. Whenever I am sick, my co-wife has been the person who accompanies me to hospital and even during this pregnancy; my first antenatal visit was courtesy of her. We even have one *nyamrerwa* who come visiting often. We have instilled this love and understanding in the children and they regard each other as true brothers and not as "*nyithi nyiego*" (literally meaning, children of jealousy)".

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Hostility among Co-wives as a burden in pregnancy

Not all the respondents with co-wives were happy about them nor were all of them helpful. Three of the respondents reported that the co-wives were a source of stress. They were always competing and whenever one was pregnant, she was always afraid that the co-wife would do something harmful to her. One of the co-wives had this to say;

"*Nyieka* (my co-wife) is always against me and since I became pregnant, we stopped cooking together as we used to do before. She has even left for their home claiming that I have given our husband love portion as he does not attend to her needs. Of late, whenever I am bought something like I was bought a mattress recently, she also demanded for her own and she was bought one, when our husband bought me rubber shoes, she again wanted a pair for herself. When this was not done, she became very moody and started threatening me with dire consequences. Recently, she came home very late from the market and

they quarrelled with mzee and she decided to leave. It has been two years of tension. When I was married to this man, they had been married for nine years with our husband. They had been blessed with two daughters but one died. When I gave birth to my first child (daughter) she became abusive telling our husband that he thought I would bear him sons. Little did I know that the reason this guy married me was because my co-wife could not bear him sons. During this second pregnancy, she would always sarcastically joke telling me that I was pregnant with 'the King'; she had a habit of always annoying me. When I finally gave birth to my son, she was very unhappy and we do not see eye to eye" (22 year old second wife and mother of two).

The second respondent with a co-wife reported that both her co-wife and stepmother in-law did not like her pregnancy. She said;

"I do not discuss my pregnancy with any other person apart from my husband. My co-wife and my step mother-in-law are both not happy with my pregnancy and since they are the only people I am with at home, I do not bother them. My husband stays in Sirongo where he runs a business and I cannot see him on a daily basis. I have never received any help from any of them and I did all my domestic chores alone and even went gardening besides taking care of the chicken of my deceased mother-in-law. On the day of delivery, labour pain started when we were just the two of us at home with my co-wife, I could not inform her and since we had quarrelled the previous day, I was only relieved when my husband arrived and took me to a *nyamrerwa's* home from where I delivered. After delivery, I took three more days there since no body would assist me at home. On the fourth day, I joined my husband at Sirongo and here is where we now stay" (Report of a 20 year old second wife and mother of one).

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As the name implies, *nyiego* (co-wife) means jealousy and in many instances, it is an institution that most women consider too conflictual to be enjoyable. There is always a lot of mistrust, misunderstanding, tension, and in some extreme cases, accusations of witchcraft. This denies women the confidence and comfort they need to live and enjoy their pregnancy as they always believe that somebody is after their lives.

Case 5 below illustrates the negative aspect of being in a polygynous marriage

Case 5

An extreme case of co-wife rivalry that was intense and had the potential of leading to miscarriage involved a lady who was married as a third wife to a man who was around 50 years of age. During her pregnancy, the two co-wives ganged up against her and raided her residence.This lady and her husband were staying in the local market in a rented house closer to the beach where the husband was engaged in fishing. When she became pregnant, the rest of the two wives became so hostile to her that she decided to migrate from home together

with her husband to the market centre. The other women accused her of exploiting their husband and that he no longer cared for them. On one evening, they raided her house injuring her in the process when she was four months pregnant. She confessed that she was informed that the co-wives had planned to harm her through black magic. She however, believed that God would be able to save her from their evil designs. In her own words during an interview, she had this to say:

> "At the beginning, I thought my co-wives were just jealous and trying to scare me to leave. This thinking changed immediately I conceived because they became violent and unreasonable. All they were interested in is that I go and leave them in peace. They accused me of everything including being a prostitute, practicing black magic, witchcraft and administering love portion to our husband. The hostility was too much and when they made good their threat and attacked me, I had no option but to leave home. They even followed me to the market centre where I had migrated and promised to teach me a lesson that I would never forget in life. Neighbours informed me that they were planning to make me blind through witchcraft"

Co-wife rivalry can be too intense that it reverses any gain achieved through proper antenatal care. It brings with it extreme suspicion and fear that women are always in a constant look out whenever they are pregnant. This adds additional burden to women in this critical period when their mental stability is necessary. As shown in case five, rivalry also increased the economic burden on the man who had to rent a separate house to ensure that his third pregnant wife was safe from the other two wives. This also divided his attention and had the potential of making him neglect the other two wives. All these increase the female dependency syndrome and further insubordinates women making it difficult for them to make independent life choices.

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The social stigma associated with Teenage pregnancy

Grandparents and mothers were seen during the study as the bedrock of hope and the centre of assistance to the youngsters who had become pregnant (**teenage pregnancies**). Among the respondents in the longitudinal follow-up, two of them were cases of teenage pregnancies who had dropped out of school. They all carried their pregnancies to term with the help and guidance from their mothers. The mothers advised them to go to the clinic, encouraged them that there was nothing wrong with giving birth and literally made them confident besides negotiating with their husbands to be understanding.

Cases 6 and 7 below illustrate the support network available to pregnant teenagers

Case 6

Awiti who was 16 years old got pregnant when she was in class seven in a local primary school. The responsible man was a shop attendant in the village market who was 22 years old and single. Awiti dropped out after discovering that she was pregnant. When her father learnt of her pregnancy, he was outraged and Awiti had to run away from home for her safety. She went to stay with her paternal aunt. The father followed her there quarrelling and chased her away. She later went to her maternal grandmother who welcomed her. After staying there for two months, her mother talked to the father and convinced him that it was not in the best interest of their daughter to stay away from home and far away from the clinic. The father cooled down and let Awiti come back home. The mother was then able to take care of her daughter till delivery. They promised to take her back to school after delivery as they took care of their grandchild. According to Awiti herself, her fears were based on her belief that her father would be angry with her. She however, believes strongly that she brought shame to her family by getting pregnant. She has vowed to reciprocate the maternal love and care she was accorded by going back to school and performing well in the exams to please her parents and prepare for her future. She said:

> "I know I have disappointed my parents and I have been a bad example to my sisters. I however, must thank my mother for her understanding and support. I promise to go back to school and make them proud. After all, I have had to experience things the hard way"

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Case 7

Amollo was 17 years old and preparing to sit for her class eight examinations (Kenya Certificate of Primary Education-KCPE) at the end of the year. She became sickly and complained a lot every morning not knowing that she was pregnant. When her mother became interested in her condition, she discovered that the daughter was expectant. Since Amollo's father was a harsh man, the wife did not know how to break the news to him. The mother and daughter later arranged privately for the daughter to go and stay with her sister where she could still be able to attend school, but away from the father. Amollo after moving to her aunt's place got ashamed and did not attend school as a result of fear of both her peers and teachers. One day, the school headmaster informed the father that his daughter was not attending school though she was a candidate. This perplexed the father to an extent that he went demanding for an explanation from the wife. When the wife told him the truth, he chased her away telling her that she was responsible for her daughter's

pregnancy and that he could not tolerate such kind of shame in his family. It took the intervention of neighbours and his local church to re-unite them.

Thereafter, the mother continued helping the daughter with the money for clinic and bought her the needed food till delivery. She believed that the daughter would learn from her own mistake and that whatever had happened could only be countered by love and care and not irresponsible denial. Amollo later gave birth to her son and was staying with her maternal grandmother. Amollo named her son *Taabu* (meaning problems) as a reminder to what she calls "the most difficult phase of her life".

The above cases illustrate the social stigma associated with teenage pregnancy and how being a pregnant teenager traumatizes the girl and her family. The idea of a girl who gets pregnant out of wedlock bringing shame to herself and her family is still strong in the Luo community. This perception leads to the denial on the part of the fathers and strains family relations. Mothers are always seen to be more sympathetic with their daughters as they are more realistic acknowledging that once the girls become pregnant, there is little that can change that situation whereas the men remain idealists and in constant state of denial. This tension has negative effects to the maternal wellbeing. Men also blame their wives if the daughters get pregnant as they are expected to be the socializing agents in the cultural division of roles. The blame on women for the failure of children in life extends beyond pregnancy and transcends the gender role divides. During the research, a father was overheard blaming the son who had failed his exams to be as thick as the mother and her lineage. He refused to go for his report form and instead sent the wife saying:

> "Go and collect the report form of your thick son, I think he must have inherited the thickness of his uncles in Yimbo, since in our lineage here, we do not have this kind of brains".

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Importance of social support in pregnancy

In the longitudinal cohort as already indicated, few women reported that they discussed health issues, particularly their pregnancies with their husbands. This group reported that whenever one knew that the husband and all those in the homestead such as parents-in-law were supportive, it became very comfortable to carry one's pregnancy to term with a lot of confidence and in an environment of appreciation. One respondent summed up the feeling thus;

> "Every pregnant woman is not an island but part and parcel of a network of friends and relatives who can make or break her. She is not only a stranger in the midst of consanguineally related kin, but only an

affine who may be a member or non-member depending on the wishes of those in the majority. The wishes, demands and attitude of parents-in-law, brothers and sisters-in-law besides one's own husband are crucial for safe delivery and generally, safe motherhood. An environment of love, care and passion is all a woman needs to be comfortable and to bring forth a happy baby to continue the lineage" (Confession of a 24 year old mother of three).

Most women acknowledged that strong family ties, friendships and involvement in social activities could offer psychological buffer against stress, anxiety and depression. The social support system can also protect an individual from developing an illness and cope better with the burden of pregnancy and other medical problems. People in one's social network may subtly or indirectly encourage one to change unhealthy lifestyle habits or may urge one to visit a doctor or antenatal clinics to prevent problems from escalating or for just routine check-ups.[30]

Social networks can also increase one's sense of belonging, purpose and self-worth, promoting positive mental health. Just knowing that the network is available can reduce negative emotional and behavioural responses to stressful events. Social connections provide a sense of belonging, security and a welcoming forum in which to share your concerns and needs. Confessions from women indicate that they feel more comfortable in the midst of concerned kin. Two of the respondents reported that they truly cherished their first pregnancies as the level of concern from kin was good. One commented:

"In my first pregnancy, I thought I was the centre of attraction to everybody in the family. I had just been married for three months when I became pregnant and everybody from my mother in-law, brothers-in-law, sisters-in-law to my own parents were concerned. There was no single day that I felt lonely or in need of something and was not provided. I wish all pregnancies would receive similar attention" (26 year old mother of three).

The second respondent reported that if motherhood is to be a cherishable role in society, then the social support system must be party to all happenings and responsible to the maternal health in all aspects as pregnancy places both physical and psychological strains on the bearers. She said;

"A pregnant woman is like a basket of delicate eggs that must be handled with care. She needs love, considerate care, and support in all spheres and above all, emotional wellbeing. She needs an assurance that her life and that of the unborn are protected and that her pregnancy role is for the welfare and

[30] The focused antenatal package recommends that a pregnant woman be accompanied to the health facility during the four visits as part of the social support system.

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continuity of the entire community" (A 24 year old mother of two and established business woman).

The TBAs and two nurses reported that people with strong support systems have many health advantages. For example, people with caring family and friends generally are seen to cope better with chronic pain, are less likely to become depressed, are more independent, recover faster from illness, have lower blood pressure and are believed to live longer. The most important arena where proper understanding should exist as a basic foundation is within the family and this should be exemplified through the family dialogue. Two TBAs reported that even the return to normal life and back to their homes after delivery by women depended to a great extent on the loving environment that existed. Some women preferred recovering at the homes of the *nyamrerwas* instead of going back to uncaring partners. One *nyamrerwa* summarized this thus:

> "We face a lot of problems with women who refuse to go back to their homes after delivery for fear of being scolded by their partners. I have had to live here in my home with a woman who had delivered for more than two months as she felt that by going back home, she would not get the required support or be able to have adequate food since her husband was a drunkard and the rest of his family members did not care" (A 53 year old *nyamrerwa*).

Supportive environment is something that every woman needs and it requires minimal investments to achieve. As long as men and the 'important others' are made aware of their roles and expectations, through a community educative approach, women can be able to carry their pregnancies to term in a happy way.

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4.5. Gender-power imbalance and pregnancy

Most respondents reported that they feel powerless and unable to make informed choices about their reproductive lives. As shown in chart 4.6, the process of decision making on a daily basis or on whether to attend a health care facility did not lie with the woman alone. In only 25% of the cases in the longitudinal survey were women the decision makers to attend ANC. In the follow-up, only five out of twenty five women reported that they were the sole determinants of their health care seeking patterns. Some in the longitudinal follow-up could fail to attend clinics because they had been waiting for permission from their husbands who were away on fishing expeditions in far away beaches. Others believed that their fates were now tied with those of their husbands to an extent that they behaved as if attending the clinics would be in the best interest of their spouses other than themselves. One respondent had this to say:

"I cannot go to the clinic now though the days have passed. I have to wait for my husband or else he may be very mad with me, he will demand to know where I got the money and by the way, even if I were to die in pregnancy, it is upon him. He married me and he has to take great care of me" (A 22 year old mother of two).

The decision to attend antenatal clinic depends on several people besides the woman and her husband. This decision lies with a larger network of therapy managing group as shown in chart 4.6. Important in this group is the mother-in-law. She is not only a reservoir of knowledge on reproduction issues who must be consulted, but also a powerful force whose authority is necessary and must be sought before a decision is made. This makes the pregnant woman a mere spectator in her own pregnancy. Achieng' (A 20 year old mother of one and expecting the second child) had this to say:

"My mother-in-law determines where and when I go for check up. When I recently spent two days indoors, she came and quarrelled me telling me to be strong and to stop being too weak. She reminded me of how in the olden days, they would work till delivery and that the clinics were never there and that they were still able to deliver successfully. She instead recommended a massage and pot medicine for my pain"

Men on the other hand think of clinics as places where their spouses are taught family planning methods; others see it as excuses to extort money from them. One of my respondent's spouse complained bitterly how his wife conned him of Kshs 500 (about 6.7 dollars) lying that the money was needed in the dispensary and when he followed up, he found out that only kshs. 50 was required. He also suspected the wife of potential infidelity;

"Women lie to us about the cost of services just to get money from us; they also take the opportunity to roam around in groups and even try to see other people behind our backs in the name of going to clinic. When you insist that you want to accompany her, she changes the dates" (said a 25 year old man and father of two).

There is always tension between the young women in the village and the elderly mothers-in-law with regards to what should be done and what used to be done. The elderly are in most cases living in the past which they romanticize and see traditional medicine and care as the way forward in safe motherhood initiatives.

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Women, however, believe that some of their spouses are very mean and unwilling to financially assist them during their pregnancies. They revealed that they had also devised methods of ensuring that they got their rightful share of family resources. Some women admitted deceiving their spouses so as to get more money to spend on things they badly needed but which their spouses were not willing to spend money on. They reported that men did not fully understand the needs of pregnant women and the process of preparing for the newborn. They were therefore, left on their own to devise survival tactics against all odds. One respondent commented:

> "Pregnancy lasts nine months and in that period, the mother has many demands that require resources. Men rarely if ever understand our needs. To them, as long as you are walking, cooking for him and your stomach grows big, he thinks all is well. We have to devise ways and means of fulfilling our demands and at the same time keeping the men happy. If you nag him too much for resources, he may even run away and into the arms of another woman. It is a balancing act that requires tact" (A 26 year old business woman and mother of three).

On the fear of family planning, the male views can be summed up by the husband to one of the respondents who asked:

> "How is family planning related to these antenatal clinics? As far as we are concerned, family planning is for the rich who can afford to have only one or two children because they can afford food and health care and ensure that the two survive. With us in this malaria prone place, we have to deal with nature. God gave us the power to procreate and why should somebody want to interfere with that? As long as we associate clinics with contraception, I will not allow my wife to waste her time"

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Men were accused of waiting for the final product without being actively involved in the process of quality assurance. Most women reported that their spouses think that beyond 'implanting the seed, they had to wait for the harvest'. One respondent was told by the husband to be a true African woman and to be enduring and to devise methods of ensuring that she delivered safely without bothering him. She said:

> "When I asked my husband for money to go to the clinic one day, he told me that his job was done since I was already pregnant and the remaining phase was for me to accomplish. He referred me to his mother. This annoyed me and I also reminded him that even a '*shamba*' (garden) has to be cultivated; crops planted, weeded twice or thrice before one can finally harvest the product" (26 year old mother of three and a primary school teacher during the FGDs).

The implication of the above is that men are less concerned about the welfare of their spouses during pregnancy but very interested in the outcome. There is a paradoxical view

in this regard. Men tend to place much hope in the unborn child as a true reflection of themselves and as perpetuators of their lineage and heir apparent but at the same time, seeing the women as external to this arrangement.

Women also complained that they at times faced very hostile home environment resulting from the sex of their previous children. A pregnant woman who has for instance given birth several times before to daughters faces the risk of her pregnancy being rejected and scorned resulting from societal socialization and the love for male children.

Case 8 below illustrate the frustrations women go through resulting from the sex(es) of their previous children.

Case 8

During the follow up, there was a 32-year-old mother of four daughters and was pregnant for the fifth time. When she reported her pregnancy to the husband after four months, he retorted that he was fed up with her since his peers kept abusing him of being '**childless**'. The woman narrated her ordeal and the difficulty she went through in her pregnancy. This is what she said:

> "When I became pregnant, I was so worried since I had been warned before of filling the homestead with *Ogwange* (mongoose), I tried to conceal the pregnancy until I could not do it any more. I decided to let my husband know that I was expecting. He did not respond when I revealed this to him. This worried me a lot and I kept to myself all the times praying to God so that the pregnancy could turn out 'positively' meaning, a baby boy. At one point, for the first time in our twelve years of marriage, my husband left home on a fishing expedition and took more than three weeks before coming back. Previously, he had never been away for more than a week. This even worried me further. When he came back after one month, I requested to know where he had been. His response was more worrying; he said that he had gone to look for a woman who could bear him a son. This depressed me even more. When my delivery approached, I was so tired, fatigued and worried about my future and the future of my daughters to an extent that I kept praying to God to give me strength. When I finally delivered, it was a baby boy. On the day of delivery, I went to a *Nyamrerwa's* place, as I feared delivering at home because the environment was very hostile, I could not predict my husband's reactions in the event that I gave birth to a baby girl. My husband went drinking and only came the following day, almost twelve hours after my delivery after being informed of the sex of the baby, this was the most horrifying period of my life"

There was also a case of a lady who had to endure a very hostile environment and was living in constant fear of the unknown for giving birth to daughters. There was always tension in the home with the mother in-law, her sons and their other wives who had sons

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looking down upon her. This was done despite the fact that she only had three children. This was the only reason that drove her husband to marry a second wife with the express support of his kin. By the time of the study, she was pregnant again but in her late pregnancy (8th month) and was not therefore, recruited for the longitudinal follow-up. After her delivery, she was sent away to her paternal home and accused of all manners of things by the husband supported by the mother-in-law.

Related to the above was a conversation with a man whose wife was in the longitudinal follow-up. She had two daughters and was pregnant with her third child. When we visited and were talking to the wife and observing her in her daily chores, we picked up a discussion with the husband that went like this:

Husband: My wife is pregnant again and I am worried she could give birth to a daughter, what can we do to get a son?

Researcher: She is already pregnant and you may not be able to do something now.

Husband: You know, I believe that women are responsible for the sex of the child and it is her responsibility to ensure that we get a son.

Researcher: How is this possible from your knowledge?

Husband: This can be done before conception where the woman times her periods and conceives at the right time, but with these *odhiangabuk* (corrupted word to mean dunderhead) of ours, they cannot time anything?

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At this point, the wife interjected and commented that children are God given and they should appreciate the fact that God had given them daughters. The husband interjected in a hush voice and said:

Husband: *Sama awuoyo gi dichwo wadwa ok adwa ni dhako bende loso!! Ne ibedi ni idhi sikul maber diwuonyo ing'eyo gik mawawacho gi kendo lingthi*! (when I am speaking with a fellow man, I do not want a woman to comment, if you had gone to school properly you would know all we are saying, so you better keep quiet).

When this exchange got personal, the wife backed off and things cooled down. This is a reflection of male attitude in the study community where the women are not supposed to make any comments that are likely to challenge the male position. This could equally explain why there are limited discussions on pregnancy since women know that by

bringing out all they know in the way they know it, there is likelihood that this would lead them into trouble with their men.

Another case of power game involved a young lady of 18 years of age who was married as a second wife to a man who was engaged in long distance cattle trade. When she visited antenatal clinic, she was diagnosed to be suffering from a sexually transmitted infection (STI) and requested to come along with her husband. When she reported back this to her husband, she was beaten and accused of being unfaithful and a disgrace to the family. She was reminded that her co-wife was not complaining and was well. When she went back to the clinic, the providers opted to accompany her to her home since she had indicated that the husband kept demanding for sex and she could not deny him. They believed that treating her in isolation was a waste of time as she still faced the risk of re-infection. When the providers arrived with her at her matrimonial home, the husband was not in. They only met the co-wife who was requested to go for treatment and promised to do so after consulting their husband. When he came back, the co-wife narrated to him the whole story. Instead of seeking treatment or allowing his wives to go for treatment and thanking her, he became more violent accusing the wife of disgracing him and bringing shame to his family. He later sent her away back to her parents as a punishment for exposing the family to ridicule.[31]

During the recruitment process of the respondents in the longitudinal follow-up, we visited villages where we already had respondents from the clinic. We were able to get several pregnant women through this process. However, we lost three of them who had initially accepted to be part of the study since their spouses refused to allow them to participate in the follow-up. In our discussion with two of the men, they categorically told us that they did not want family planning in their homes and there was no way we could claim to talk to their wives without their permission and without discussing family planning issues. When we reminded them that the women were willing to participate and we were not doctors or family planning counsellors, one of them commented:

> " *Mon to ong'eyo ang'o, ok ubiro mana wuondogi ka to umiyo gi yien mag panga uzazi, koneno ni nyaka otim kamano to odogi korgi mondi*" (women know nothing and we will simply cheat them and give them family planning pills and if they must participate in the research, then they better go back to their parents.

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[31] It is interesting that the man did not even understand that the first wife could also be infected but had not been tested. Instead of going for the test, he chose to blame his second wife and sent her away in her delicate condition.

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insinuating a separation or divorce). (Young man of about 22 years and a husband to a lady who was in her first pregnancy and aged 17 years).

The other man became violent when he was told that we were seen in the vicinity. We had two respondents in the neighbourhood. This man besides refusing to have his wife enrolled in the study, when he was told by his sister who was staying with them that the research team were at Nyakano's house (one of our respondents whose husband truly welcomed us), he accused the wife of not heeding his advice not to participate in the study, he insulted her and decided to sent her to their rural home to stay with the mother in-law to ensure that she was not influenced 'negatively'. Later, Nyakano informed us that the wife almost died in pregnancy, as she did not attend clinic on the advice of the husband and mother-in-law. She had twins but was not diagnosed in time, as she did not attend any professionalized care apart from the massage by the mother-in-law and a TBA in their village. She had a stillbirth, as there were complications at delivery. The woman told her neighbours that she was so upset but there was nothing she could do as she did not want to annoy the husband who was known to be very violent and could harm her. She however, confessed that when she sees Nyakano's beautiful daughter, she imagines what hers would be if she had listened to her own voice other than the influence from the husband and his kin.

Overall, most women in the study area were unable to make independent choices regarding their health and had to struggle with the cultural constraints and power play in their marital lives. A lot of obstacles stood on the path of women and pregnancy did not help in reducing these obstacles. It was evident that in some instances, pregnancy became the arena for men and the rest of his kin to stamp their authority on their spouses and to control their movements and freedom.

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CHAPTER FIVE

DEMAND AND SUPPLY FACTORS INFLUENCING THE UTILIZATION OF MATERNAL HEALTH CARE FACILITIES AND THE HEALTH SEEKING BEHAVIOUR IN PREGNANCY

5.0. Introduction

Demand for antenatal care services can be influenced by other service factors (such as accessibility, affordability and acceptability of services), patient and environmental factors such as personal characteristics (age, education, parity) and the cultural attitude as already documented. The supply side which includes the availability of facilities, availability of supplies and equipment, availability of qualified personnel and the quality of care all act in concert to determine the level of official health care patronage.

The emerging pattern from the research indicates that most women prefer to be attended to in a friendly environment and that they are not as ignorant as popularly thought by the health care providers. Nyang'oma as a Division does not have adequate health care infrastructure to satisfactorily serve its growing population. Pragmatism is therefore, the guiding principle in the health care seeking behaviour where women oscillate between the biomedical and ethnomedical options available in the community.

For example, picture a pregnant woman arriving for the first time for antenatal care at the district hospital. There are no signs showing her where the maternity clinics are located. She however, sees other pregnant women going in a certain direction and she follows them. On reaching the clinic, she sits on the wrong queue since the services are not integrated and there are several NGOs and CDC conducting research on HIV and IPT (Intermittent Presumptive Treatment for malaria) respectively as part of the focused ANC. Each of the groupings provides just a component of the focused ANC. After one hour's waiting and when she is almost seeing the provider, she is told that she is on the wrong line and has to see the records clerk in the room at the far end for history taking and basic measurements, after which she has to see the NGO counselor for HIV/AIDS counseling and be told about PMTCT and then to the CDC staff to be tested for malaria and for the administration of IPT before going to the nurse for the physical and gynaecological examinations.

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She has to go back and begin the queue afresh. When she finally makes it to the main provider, it is almost 12 noon and lunch is approaching. If she is lucky, she may be seen and if not, she has to cope with the long waiting hours or even go away unattended. The nurse finally sees her and after examination, refers her to the laboratory for HIV, VDRL and other tests. She gets to the lab and finds the technician just closing for lunch, she hands him the papers and the money for lab tests and is told to come back at 2 p.m. in the afternoon for the results. Since she has no money for lunch and home is far away and having walked to the clinic, she stays around the hospital sleeping on the unkempt lawns.

At 2 p.m. sharp, she is back at the lab window in the company of other women in her condition. The lab technician comes back or opens his window at 2.45 p.m. and she is given her results at 3.10 p.m. After getting her results, she has to go back to the nurse for interpretation and treatment. She comes back to the nurse who has just arrived back from lunch and the queue is long. She opts to wait. By 4.30 p.m., the nurse has not yet seen her but orders everybody to come the next day early enough as she is too tired and has to attend a meeting with the hospital superintendent to plan for the next day. The woman leaves for home dejected and vows never to come back[32].

The above scenario is a common experience in most health facilities and most women opt to go to smaller dispensaries where the bureaucracy is low and services integrated or to other health care options available in the community.

5.1. Sources of Maternal Health care in Nyang'oma Division

Nyang'oma Division has a very poor coverage of biomedical health facilities. It was made a Division recently as it was previously a Location (South Sakwa Location).

Among the health facilities that are within the Division are Nyang'oma Mission dispensary, Nango/Uyawi, Ouya, Anyuongi and Nyaguda government dispensaries. There are also minor maternal and child health clinics run by the private providers in the semi-urban settlements within the fish landing beaches such as Wagusu, Uyawi, Nyamnwa and Sirongo among others. Some of the clinics here offer all manners of services depending on the need. They fill the void that exists as a result of low biomedical coverage in the region.

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[32] True observation at a district hospital during the study period where women had to cope with the bureaucracy and long waiting hours for the services in an intimidating environment.

Within the District but outside the Division are referral maternity facilities such as Bondo District Hospital, Madiany sub-district hospital and the private Owens Maternity in Bondo Town. Most Women are referred to Bondo District Hospital in the event of any complication from all the other facilities in the District. Owen Maternity is a private clinic whose charges are slightly higher than the Government facilities and it is only patronized by those with financial ability.

Besides the above facilities, there are also all sorts of trained and untrained Traditional Birth Attendants and other Community Health Workers (CHWs) who are also sources of maternal healthcare. Most of them operate from the precincts of their own homes and at times within the facility framework. They are flexible enough to visit the mothers in the comfort of their own homes. There are also respected elderly women whose opinions are respected and sought in times of distress caused by pregnancy or illnesses defined in traditional terms.

Within the Division, the area around Sirongo Beach at a place known as '*Ka John*', there is a well-established and respected Legio Maria Mother (locally referred to as *Madha*) who is an expert in maternal health care issues. She has quite a number of clients who regard her as their prime source of care. Within the same area, there is also an Anglican Church of Kenya (ACK) mother who is a member of the mother's union who also offered antenatal services to clients in the village (See Appendix 3 on religious therapy).

Other forms of healthcare involve self treatment by the women from over the counter drugs bought from shopkeepers in the market centre and the neighbourhood. The most common drugs purchased over the counter include panadol, fansidar, malariaquin, comaquin, chloroquine, piritons, hedex, and action among others. The mothers reported that at times, this is the only option available to them. They however, confessed that they only depended on the shopkeepers to tell them how to administer the drugs. There was also a pharmacy at Nango from where some women got their supplies. The problem was that the sellers were not really trained pharmacists since the owner of the pharmacy had several of them and could not be found in it all the times.

5.2. Patterns of care seeking behaviour during pregnancy

Care seeking decision-making is usually uninformed, slow and in many instances, sought from multiple unskilled sources before considering skilled care.

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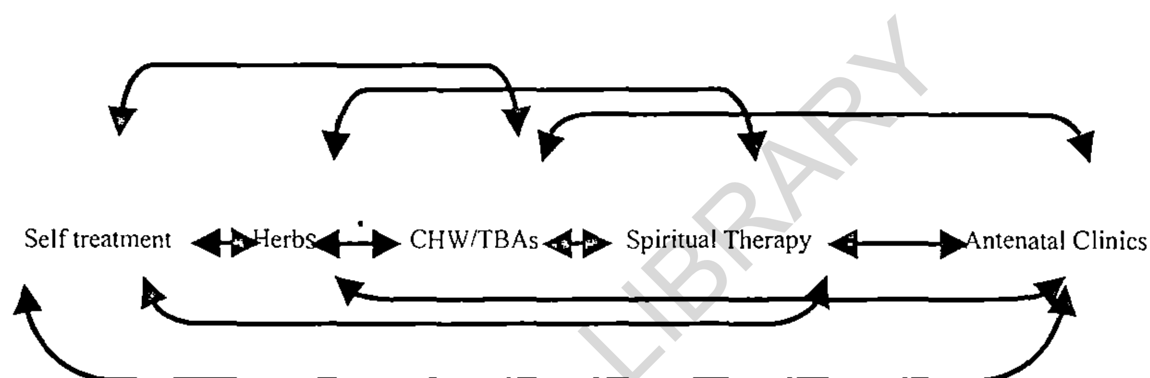
Pregnant women often oscillate between the various existing options within the community. Some women are totally opposed to the idea of attending facility based ANC while others rely primarily on TBAs for ANC as well as for delivery. Others rely on spiritual therapy for their wellbeing. Other women simply believe in fate and share the common perception that pregnancy is not an illness. This means that they do not plan ahead of time to visit any of the available antenatal health care options.

The utilization pattern of health care clearly responds to the multi-health systems locally available. Traditional, modern and religious therapies are combined during pregnancy and delivery. The following utilization pattern emerges:

Figure 1 Health care utilization pattern



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The above model has been developed as a result of the observations in the community over the one-year period.

Individuals begin the process by self-treatment whenever they feel any fever during the formative stages of the pregnancy. Self treatment involves the purchase of over the counter drugs from the shops in the local market place, preparation of pot medicine if they are aware of any for bathing and oral taking as protective devises, changing their eating patterns and habits and consulting widely for advice from those around them. Thereafter, they resort to seeking for help from the Traditional Birth Attendants and the Community Health Workers, others consult Religious experts for prayers and the Antenatal clinics. The process continues in an oscillatory and zigzag way as mothers move back and forth in their care seeking approach without any clearly defined pattern as shown in the above model. Whereas one woman may begin by going to ANC clinic after defining her condition, others may begin by consulting community experts or going for prayers by the spirituals experts

or praying themselves for heavenly intervention. Auma for example reports that when she is pregnant, anything that can lead to her wellbeing is welcome. She says;

> "I try whatever is available. After all, traditional medicine, prayers, massage and antenatal clinics all respond to different needs in the pregnancy process and one does not replace the other. You need all of them for an all round health" (24 year old mother of two).

Community Health Workers in most cases provide the initial point of contact with the health care system in most rural areas. They contribute to the facility based care. On the other hand, Traditional Birth Attendants and other community based care play important roles in rural communities. They tend to be more active among the poor and in poor locations than they are among the affluent. They are considered to play more crucial roles as they pay more personalised attention to their clients. Since most of the TBAs and the CHWs are local people personally known to the mothers, they at times have relaxed payment terms for their services and are very personal and affectionate in their approaches compared to the facility based providers. Most TBAs interviewed in the community reported that they believed in the importance of traditional medicine and its ability to expel all stomach winds (*yamo*). One old TBA had very good praises for traditional herbs, she said:

> "Herbs are the best during pregnancy, labour and postpartum period. We use herbs to expel bad winds from the womb of a pregnant woman and to massage her body in pregnancy and to protect her from evil eyes, to induce and quicken labour, after delivery, herbs are used to stop the pains and excessive bleeding, for massaging the mother to remove blood clots and quicken healing, wash both the mother and the baby for protection and to treat diseases which the baby may have contracted in the mother's womb"

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Most of them however, acknowledged that it would be good if women could have a combination of both clinic and pot medicine as the two respond to two different therapeutic regimens. The TBAs work in the village involved both curative and preventive therapies. They massaged women using traditional medicine which was made out of a mixture of traditional oil and herbs, they prepared herbal concoctions that they administered orally and at times had herbal mixtures that women used for bathing to protect them and their unborn babies. They were also responsible for helping women in delivery and assisting with the domestic chores. Overall, they fill the void created by the inability of most women to come to terms with the new construction of reality imposed by the pharmaceuticals and International programmes that have enhanced the medicalization of pregnancy and childbirth.

When the TBAs were asked what they thought is responsible for the high maternal mortality rate in Nyanza Province, they gave the following reasons:

- Lack of proper adherence to clinic/hospital care
- Refusal on the part of young women to consult the old village experts in maternal health care
- Low prestige and lack of recognition of the Nyamrerwa by the official health care providers making people loose faith in them
- Widespread poverty and lack of proper nutrition during pregnancy

The above problems according to the TBAs are occasioned by the conflicting information women are exposed to. On the one hand, they are aware of the importance of the Nyamrerwas and their traditional herbal medicines and on the other; they are told that they need to be attended to by trained experts. In the confusion, they end up not attending to any of the providers. Sarah, one of the retired nurses and now a TBA in the village said:

> "Having been a nurse, I must admit that we are part of the problem. As a nurse, we despised the TBAs and clustered them all as ignorant and the cause of delay in attending to official ANC. I look back today and realize that the work we do as TBAs in the village requires support and recognition. Women need warmth and personalized care. We offer that in the village"

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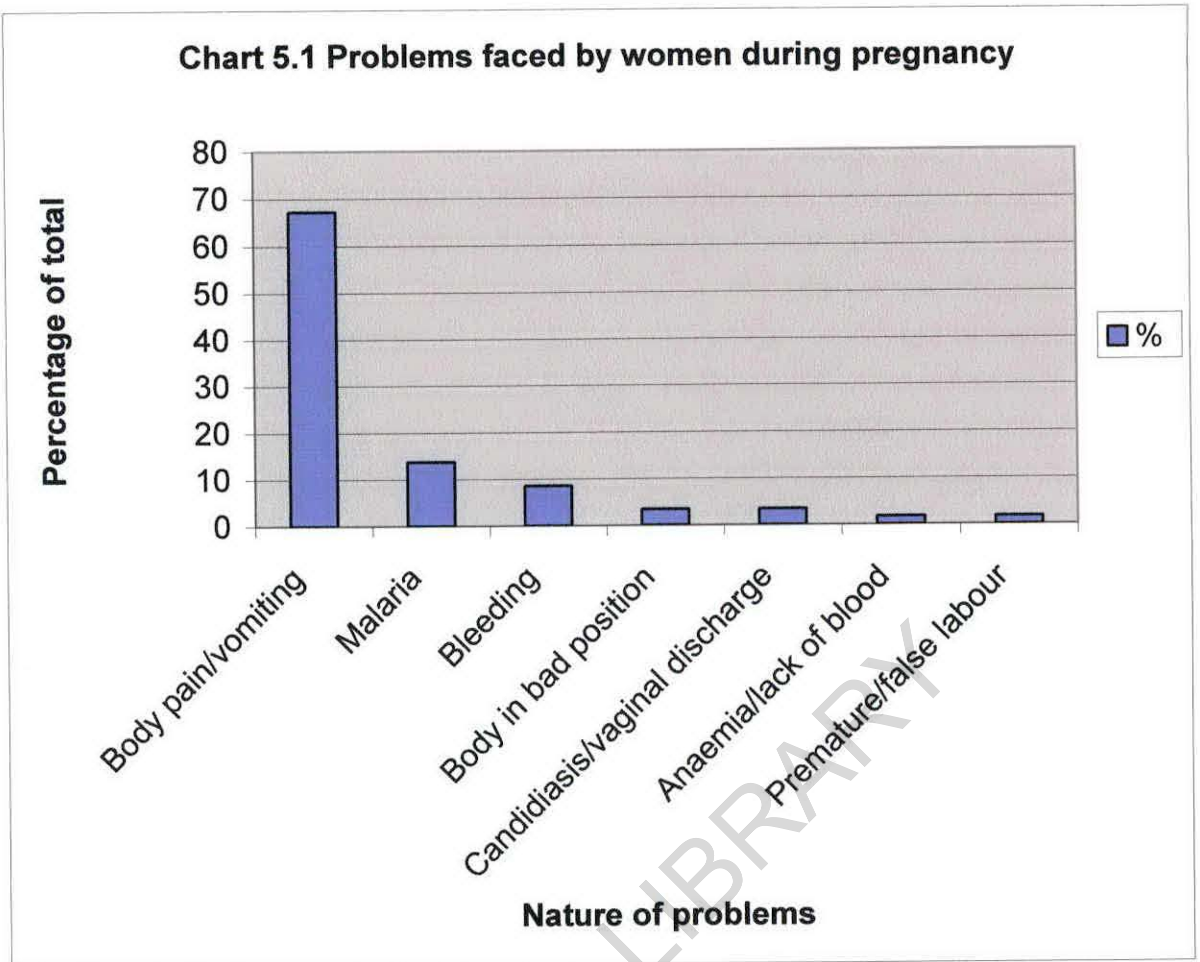
The TBAs gave cases where they have had a chance to save women's lives in pregnancy and during deliveries and believed that the way forward is to have them incorporated and recognised by the official health care system. This they said would help since they are already working with women in the villages, their services have been accepted and are culturally compatible with the women's needs and their charges are reasonable. Further therapy from the spiritual providers can be seen in appendix 3.

In most cases, women reported that their choice of therapy was determined by the etiology and the feelings at the time. Education, economic ability, the level of awareness and exposure, and one's social network were all seen to determine the options women resorted to in pregnancy. The following are some of the biomedical problems the women reported to be facing during pregnancy and that required attention:



Source: Primary data (Community survey)

Note: Only 58 out of 100 women mentioned that they face problems in their pregnancies. Among them were those who gave multiple responses.

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Some of the problems mentioned by women included as part of the body pain are abdominal pain, headache, blurred vision, dizziness, cough, chest pains, body fatigue, morning sickness, heartburn, watery eyes, back pain, groin pain, pains in the thighs, difficulty in breathing, and heavy and rumbling stomach, and swollen legs, hands and face, among others. One woman in the longitudinal follow up mentioned that she had tumour. What is even more interesting is how they dealt with the problems. Although most of these problems are medically classified as danger signs in pregnancy and require medication, women defined them in their own local terms and resorted to therapeutic options that were available, affordable and cheap, but those that lent well with their cultural understandings. Take the position/presentation of the baby for instance, we were informed that this may require prayers or sacrifice to the ancestors who may be annoyed with the living and punishing them through the problems they face. A respondent said:

"You know, we are only vessels through which God does his miracles. He may be pleased with us or unhappy depending on our relationship with him. We must always appease him directly or through the ancestral spirits that guarantees our wellbeing"

Vaginal discharge for instance was reported to be shameful and women wanted to be very succinct about it. The association of the discharge with venereal diseases even makes it more difficult for women to be open about it and seek medical attention. Bleeding was associated with attempted abortion and this also created suspicion in the community. Women therefore, tried to go to friendly sources where their conditions would remain secret and health care provided without the abuses and degradation. The case of Anyango who later died illustrates this:

"When I went to Nango dispensary and told them of the discharges from my private parts and accompanied by my emaciated body, I was immediately asked where I had contracted HIV/AIDS and why I was sleeping around with men. It reminded me of the abuses from my own people at home and hated myself as well as going back to that clinic again"

For most of the above noted ailments, women resorted to different therapeutic options. For the body pains, the majority massaged themselves or were massaged by the TBAs, malaria was treated by over the counter drugs, drinking of herbs and by going to the dispensary. Traditional 'experts' who are well known in the villages could stop bleeding and vaginal discharge. Some TBAs were known to be experts in putting the baby in the right position. However, most respondents reported that the best way was to attend antenatal clinic so that any bad presentation would be detected in time.

Cases 9 and 10 below illustrate the oscillatory nature of health seeking behaviour patterns during pregnancy:

Case 9

Akinyi is 29 years old and a mother of eight children. She narrated how she had used multi-health systems in her first pregnancy and how she oscillated back and forth in several health care points from conception to delivery and after. She said;

"I was 15 years old in my first pregnancy. During this period, my husband and I were staying at Wichlum Beach where he was working as a fisherman. I never felt sick during this period and I was attending clinic at Bondo District Hospital. I also used some pot/herbal medicine brought to me by my mother-in-law from home insisting that all pregnant mothers must take it to make them lighter. I was shown how to administer the pot medicine so I did so on my own for two weeks. One day when I was experiencing headache and fever, my husband bought some malaria drugs from the shops, which I took. When I was in labour, I was taken to Bondo Hospital where I took a day before delivery. The nurses

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harassed me and left me to deliver on my own despite the fact that it was my first delivery. After giving birth in Bondo, I came back home and after three days, the baby stopped suckling and started crying, my breasts became painful and I sought treatment at the Bondo District Hospital but did not get well, I later decided to use traditional herbs which also never worked well. I was later advised to look for a skull of a dog, warm it in a glowing fire and massage the breast with it. I did exactly this and I recovered so well. I still keep the skull up to date. The child later continued feeling unwell and I decided to go to my parent's place to seek further help. When I asked my husband for money for transport, he refused saying that he had spent too much money on the child already and did not mind even if the child died. I got annoyed and sneaked out one morning and went back to my home in Asembo where a woman who is a traditional healer discovered that the baby was suffering from '*Chira*' (resulting from a taboo). The explanation was that my husband got married before his elder brother and we were eating together with the brother and this should not have happened traditionally. She administered traditional herbs known as *manyasi* (herbal concoctions to undo the effects of *Chira*) and the baby got well and I then came back to my husband. The child took one and a half years before being able to sit down. However, the child is now doing well at the moment"

The case above reflects the complexity of decision-making and health seeking patterns and shows how this process is dependent on many factors, including the perceptions and abilities of women and their family networks. It also spells out the male attitude towards post partum care, which in most cases is a neglected area. Most men in the longitudinal follow up did not support their women to attend postnatal clinics. Only five women in the maternal cohort had taken their children for immunization six weeks after birth when the follow up stopped. Most of them saw completely no need for doing so. They argued that the children were not sick and therefore, there was no need for them to be taken to hospital. Although most men knew the advantages of immunization and postnatal care, they did not encourage their spouses to seek medical attention as they did while they were still pregnant. Additionally, the case brings out clearly the prestige in the respondents' voice in being able to be an 'expert' in her health. Being able to make her own herbal medicine and being able to treat herself using the dog's skull and the fact that she can still do so in the event of a similar tragedy places her destiny in her hands and empowers her in a special way. These are realities that have been neglected or downplayed in reproductive health care and are some of the sites of misunderstandings.

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Case 10

This second case also illustrates women's multiple use of therapy. It was narrated by a mother of two who had different experiences, one in Kisumu and the other one in the rural area.

Nyamalo had her first pregnancy when she was just 16years of age and was staying with her aunt in Kisumu and attended antenatal clinic but also used other non-facility based care. She said;

> "When I became pregnant for the first time at the age of 16years, I was young, fearful and confused. Since I was staying with my maternal aunt in Kisumu, I attended antenatal clinic at New Nyanza Provincial Hospital (Popularly known as Russia). At the clinic, we were given lectures on breastfeeding, childcare and required feeding patterns. Besides the clinic, my aunt who was a 'church mother' and elder made a concoction, which was made by boiling a combination of a lemon, a candle and a plant with pink leaves. The plant with pink leaves was believed to be increasing blood in the body, the lemon was to control abdominal pain but I was not told the part played by the candle. I guessed that the candle might have been for spiritual guidance. I also practiced self-medication occasionally whenever I thought I had malaria (fever). In my second pregnancy (the present one), I had already been married and now staying here in Sirongo. I attended clinic at Nango though the services were not as good as they were in Kisumu. Here, there are no lessons on how to deal with the pregnancy and for this reason together with the fact that I had no money for transport, the distance to the clinic, poor state of the roads, excessive fee without service and my general low opinion over their services, I did not attend as I should have done. During this period, I also had lower abdominal pain and headache and decided to seek assistance from a Legio Maria mother who massaged me with Deepak oil. I also bought some painkillers from a shop here in Sirongo. I intended to use pot medicine but did not have money to buy it nor did I know how to prepare it. I delivered successfully at a nyamrerwa's place who is also a relative of my husband where he took me when I was in labour". (A 19-year-old mother of two).

In most cases, mothers use several available options in a way that makes it difficult to point out the options that are considered more appropriate than the others. This oscillatory care seeking pattern gives false hope in therapies whose efficacies are un-testable and unproven. Most herbal remedies are seen as having the potential to prevent the umbilical cord from wrapping around the baby, relieves abdominal pains, cause expulsion of a retained placenta, reduce pain and fever, relieve obstructed labour, prevent bleeding and augment labour. It is noted that although some of the herbs may be effective in achieving the above, their use and over reliance may sometimes lead to delays in seeking more appropriate care. The hope created through spiritual and herbal therapies have been noted as being responsible for late referrals to professional obstetricians in cases of complicated births.

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It should be noted that all the above therapeutic options respond to different fears and worldview of their seekers. Village maternity care for instance is a personalized care, concerned with social interaction and culturally defined needs. It also responds to the 'risk TO motherhood other than risk OF motherhood'.[33] Whereas, the official antenatal care responds to risks of motherhood and it is concerned with the bodies of the technical training of practitioners and the providers are strangers to the woman. TBAs and CHWs were seen to go beyond the patient-provider relationship. They became personal family friends, workload relievers, participants in the household and family rituals and operated more as members of the kin network. The TBAs were at times responsible for the conception by assisting the woman in identifying problems and linking them to the exorcists if they themselves were not in a position to do it. Most of them were also knowledgeable in traditional medicine for other ailments other than pregnancy and assisted in solving cases of barrenness and infertility. They assisted beyond delivery and ensured that the woman was reintegrated back to societal life after the short period of exclusion. They even provided shelter and food to needy cases.

5.3. Demand factors influencing antenatal care

The economic and socio-cultural characteristics of respondents had some contribution to their health care seeking behaviour as discussed in this chapter.

Respondent ages

The ages of respondents in the study had some influence on their health seeking behaviour. The table below shows the age of respondents:

Table 5.1 Ages of Respondents

Age	N	%
15-20	32	32.0
21-25	28	28.0
30-34	17	17.0
26-29	16	16.0
35-39	6	6.0
40+	1	1.0
Total	100	100.0

Source: Primary data (Community survey)

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[33] Risk OF motherhood refers to situations as articulated in the governments' safe motherhood strategies and risks TO motherhood is as articulated in the healing strategies adopted by women in the community. (For details, see Allen 2002)

The youngest respondent was 16 years and the oldest 43 years. The mean age was 29.5 years. Majority of the respondents were between 15-20 years indicating very young age at marriage. This has effects on maternal welfare. Age is one of the factors mentioned as posing reproductive risks. Any age less than 20 or more than 35 years are regarded as high risks and replete with problems in pregnancy and childbirth. The majority of the 32% in the community survey in the 15-20 age range were aged 18 years or below and were in the age bracket where they may be too young still and their bodies have not yet matured fully to be able to give birth without difficulties. In the longitudinal follow-up, 11 (44%) respondents were also in this age category and this indicated a very young age at marriage in the community. An example here is Abila who at 16 years was already married and a mother. The age also determined whether one would attend maternal health care clinics or not since most of them were not yet socially mature and able to deal with the hospital bureaucracies. They had also just dropped out of schools to get married and still could not face their peers who were still schooling. They spent most of their time indoors and with minimal interactions. It was this group that had the highest number of those who waited at home to be attended to by the Legio Maria care provider otherwise known as *madha* in the community. Through the 'hawking' process, she was able to reach many clients who otherwise would not be reached by any maternal health care provider. Details on her services are in the appendix 3. When asked why she opted to visit women in their homes, she replied:

> "Most of these girls are very young and they fear being seen in public while pregnant particularly the first pregnancy. My experience is that though they would wish to go for antenatal care, they fear facing the public. I therefore, decide to reach them in their homes and even encourage them to be brave and bold"

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It can be noted that more than 7% of the mothers were 35 years and above. Chances of facing problems were therefore, higher. Such women were also more likely to have given birth to too many children and therefore, endangering their lives even further according to the WHO (1986) risks factors. They also were not likely to go to clinics because of their belief in the previous experiences. Some of them reported that they were thought of by the providers as being too mature and old to conceive. These feelings made them feel awkward and they therefore, avoided the clinics altogether. One respondent reported how she heard a woman being scorned for having conceived at an advanced age of 42 years. She said that the nurse made a comment like "*In mama maduong' aduong'a ni to koro imako ich ñango?*" (Why should you as old as you are get pregnant?). This she said was in full view of every body who had

gone for antenatal care that day and the woman felt very embarrassed and left before being attended to. This embarrassment is compounded by the fact that issues of sexuality and sexual health are considered very private and are rarely discussed in public in the community. This questioning in simple language means that she was wondering why the mother still engaged in procreative sex.

The number of children each respondent has was also found to be a factor in seeking care and the level of threat that each additional pregnancy was expected to pose.
Most women had more than three children as can be shown in table 5.2.

Table 5.2. Number of Children per respondent

No of children	N	%
One	24	24.0
Three	19	19.0
Four	18	18.0
Two	17	17.0
Five	9	9.0
Six	5	5.0
Ten	3	3.0
Seven	2	2.0
Nine	2	2.0
Eleven	1	1.0
Total	100	100.0

Source: Primary data (Community survey)

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Those who had four children and above constituted 40% and those with six children and above constituted 13%. Women with three children or more accounted for 59% of the respondents. According to WHO (1986), previous pregnancy poses major risks to women. They concluded that the safest pregnancies are the second and third and women who have had more than six births are at three times more risks than those who have had only two births.

From the foregoing, it can be deduced that most of the respondents had high-risk pregnancies as 24% in the community survey and 32% in the longitudinal follow-up were first pregnancies and almost 13% were in their sixth pregnancies and beyond. Some of the cases of multi-paras in the research are worth mentioning here.

The first respondent was Akodhe;

Akodhe who was 33years of age had given birth eleven times losing five children in the process with two miscarriages at the 4th and 5th months respectively. She says that she has always had problems from her fifth pregnancy. The other three children died before the age of one year from a variety of complications such as malaria and measles. She reported that she did not take them for childhood immunization as all the deliveries were home births and she does not believe in postpartum facility based care. She says that when she went for antenatal clinic for her last pregnancy, the nurse asked her whether she wanted family planning. When she refused, she made a comment to the effect that "these many children, where do you want to take them?" this was not a welcome comment as according to Akodhe, her children were being counted and this could expose them to danger, after all, she said "I have not asked her for food for my many children or any help in life"

The second respondent was Adongo;

Adongo who was 43 years old had given birth ten times and had lost three children. One child died during birth as a result of being overweight and the inability of the mother to sustain the pushing at delivery. She said that this was home delivery and she was alone as she assumed that her past experience made her an expert and did not bother to go for help either in a facility or from a nyamrerwa. Her last born was three months at the time of the study and she reported that she had been pregnant for one year and three months and it all started with a miscarriage which was rectified at Bondo district hospital for which she was scorned and belittled on her age and number of children by the nurses. During delivery for this baby, she went to a different hospital where she delivered the baby as she had been warned that her delivery might be difficult.

The third in the series was Nyakoi;

She was 34 years old and had given birth eight times losing two children. During her last pregnancy, she was frequently sick and after delivery, her afterbirth split into two with one piece refusing to come out. She was however; assisted by a nyamrerwa in whose home she was delivering.

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The last in the series was of a mother of twenty years who had given birth six times losing two children in the process through miscarriage. She also had problems with the providers on the number of children she had and the rate at which she was conceiving. Most of the women who have experienced childbirth several times before tend to believe that they are experts and see minimal need to attend to antenatal clinics. They normally fail to notice that each pregnancy is unique and different from the previous ones.

The above cases illustrate the high fertility rate in the community and the young age at which women start producing thus endangering their reproductive lives and health. Related to the number of children is the rate at which some women lost their children in avoidable instances in the community and the reasons they advanced to explain their deaths. The women who were at highest risks as noted also feared going for professionalized care for fear of being scorned by the providers in a way that did not please them. Although age and parity are seen as factors that lie with the patient, their major influence on antenatal care attendance is intertwined with the view of the providers.

The table below shows the number of women who have lost their children and the reasons behind the loss:

Table 5.3 Number of women who have lost a child and reasons for the loss

Cause of death	N	%
Measles	20	48.8
Miscarriage	8	19.5
Malaria and meningitis	6	14.6
Premature/death at birth	3	7.3
Diarrhoea	2	4.9
Bewitched/Chira	2	4.9
Total	41	100.0

Source: Primary data (Community Survey)

It is important to note that out of a sample of 100 respondents in the community survey, 41 have at least at one time lost a child in childbirth or during the postpartum period or in less than one year after birth. Half of the respondents in the longitudinal follow-up have also lost a child. This is a clear indication of the disease burden and the dangers facing women

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in their reproductive well-being. Some of the reasons women gave for losing their children in childbirth included: Failure to push as the child was too big and died during home birth, born with eyes closed and died the day the eyes opened, giving birth to twins who refused to come out and the nyamrerwa did not know what to do and the baby was in an upright position and could not descend in time. Those who lost their babies sometimes after birth but in less than one year gave reasons such as the baby was dehydrated as a result of diarrhoea and could not respond to treatment, severe malaria, baby had measles but the elders said that it was *chira* because her mother was not inherited and they used the same utensils to feed the baby among others. Measles was reported to be the biggest cause of child mortality postpartum, whereas miscarriage was the biggest problem in pregnancy and at delivery.

The above reasons lead one to a conclusion that several factors determine the women's health seeking behaviour and make it difficult for them to access proper antenatal and postnatal care that could have enabled them to save the lives of their children before and after delivery. However, at a general level, most respondents reported having attended clinic at least once in their pregnancy as shown in the table below:

Table 5.4. Antenatal care attendance at least once

Attendance	N	%
Yes	94	94.0
No	6	6.0
Total	100	100.0

Source: Primary data (Community survey)

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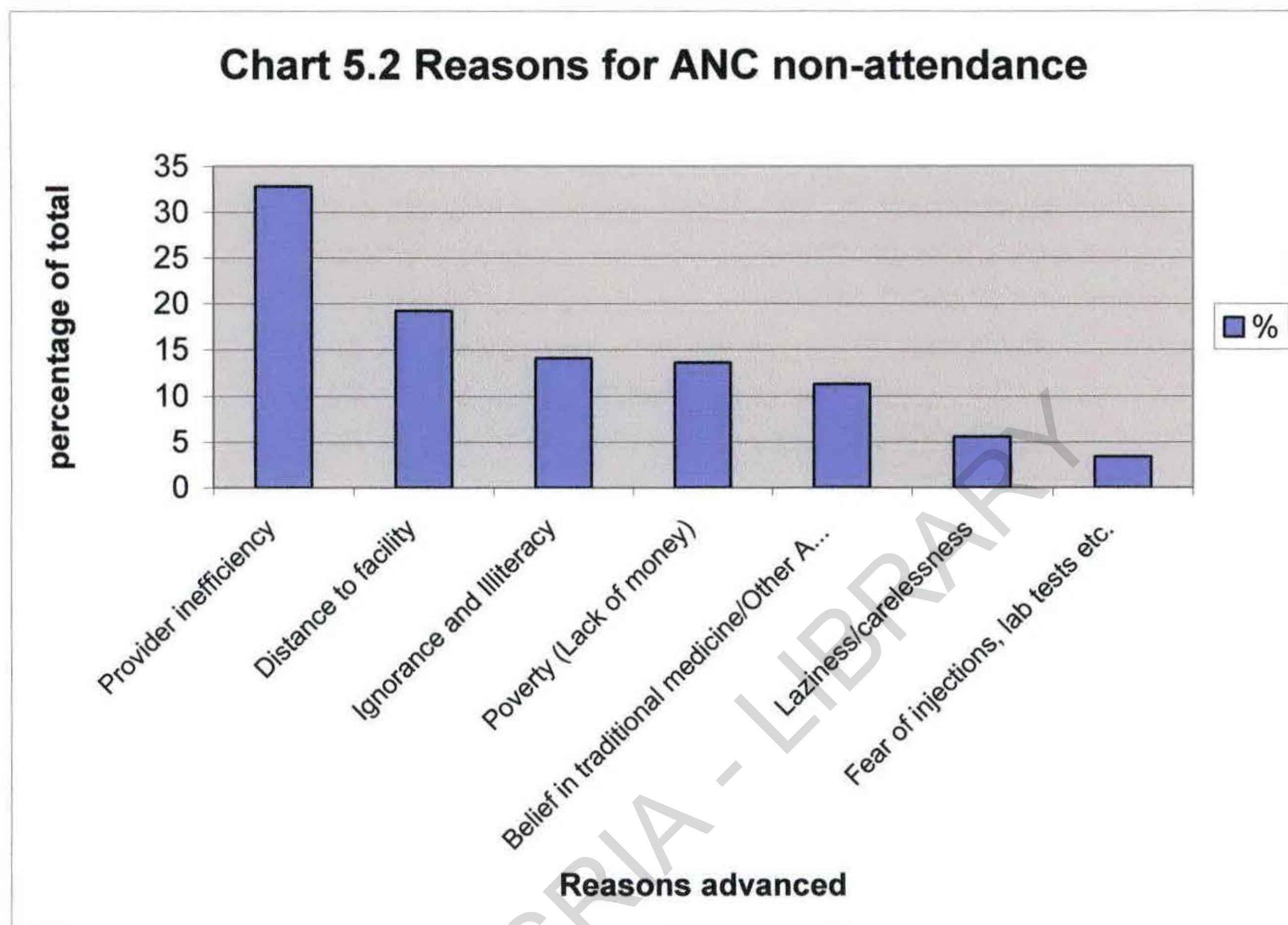
As shown in table 5.4, 94% of the respondents in the community survey indicated that they had attended a facility at least once in their pregnancy for antenatal care. The sample in the longitudinal follow-up had all attended antenatal care during their latest pregnancy. However, it should be noted that 6% of the respondents in the survey indicated that they had not attended clinic at all in their last pregnancy. Most respondents however, indicated that the reason for their attendance was to get an antenatal card.

There were some barriers that the respondents considered to be important and barred them from adequately attending to antenatal care in the available biomedical health facilities beyond the first visit for antenatal card. Chart 5.2 below shows the reasons.



Source: Primary data (Community survey)

Note: Multi responses allowed as women mentioned a multiplicity of reasons.

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As shown in chart 5.2, many respondents (33%) in the community survey cited provider inefficiency as the reason for their lack of proper attendance. Although provider inefficiency is a supply side factor, its effects overlap to affect the demand for services. Distance to the facility was second highest with 19%. Maternal ignorance and illiteracy accounted for 14% with poverty at 14% as well. Availability of alternatives included belief in traditional medicine, spiritual therapy, traditional massagers and all the village professionals who complimented or competed with the official antenatal care providers. This group accounted for 11%. Maternal laziness and carelessness accounted for 6% and in this lot, we included the mothers who could not offer any adequate explanation as to why they did not attend to professional care. Some said that the competing workload and other engagements in the community left women with no time to attend properly to their

wellbeing. Fear for injections, laboratory tests and the array of questions posed by the providers within the clinic accounted for 4%. Bondo Division is a malaria holoendemic region and laboratory tests for malaria should be mandatory. The present ANC guideline also requires that in addition to the VDRL tests, one has to undergo HIV/AIDS counseling and test. This is also an area of greater contention since most women fear going for this test (There is still a lot of stigma associated with HIV/AIDS in this community though the prevalence rate is quite high along the beaches on Lake Victoria).

From the above chart, over 67% of the reasons advanced by the respondents for non clinic attendance can be attributed to patient based demand constraints such as poverty, distance to facility, belief in traditions, laziness, ignorance and fears of injections and laboratory investigations. Other than poverty, the other reasons could imply that women are trying to communicate that they are responsible people who are well aware of their actions and are pragmatic about their health care. In this regards therefore, it is the task of the health care providers and the other concerned parties to understand the women other than the other way round.

The cases of women who had never attended clinic in their pregnancy would probably provide a clearer picture of what women go through in their daily interactions during pregnancy in the villages and what they think about the official antenatal health care.

The three cases below are illustrations of women who did not attend antenatal clinics at all and their reasons:

Case 1

Agunda who was 20 years old and a mother of two was one of the respondents who had never attended antenatal clinic for her last child. This she says resulted from her past experience during the first pregnancy, the means of transport to the facility and the reduced love between her and her husband and finally declares that she was just tired and did not see the need of going to clinic. She adds that even her first born was still too small to be left alone since he was just 8 months old when she conceived again. In the first pregnancy, the husband took her to clinic on his bicycle but refused to do so in the second claiming that he was too busy.

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Case 2

Abwodha and Achuodho both 18 years did not attend ANC as they feared that their former classmates would laugh at them and they were ashamed of getting pregnant and dropping out of school.

Case 3

In the same category was Adino who was 29 years old and a mother of four and had never gone to clinic ever since. She confessed that she managed through prayers and faith in God. Although she knows that it is good to attend ANC, she says that she has never been sick during any of her pregnancies and has seen no reason to go for hospitalization. She claims that at the clinic, you are charged for no services rendered and instead of going there she retorted:

> "I would rather attend to my livestock and let the future take care of itself as so many women deliver daily and manage in pregnancy without the headache of antenatal care at the hospital, I can take care of myself"

Related to the above were those who reported that their religious beliefs did not allow them to go to clinics. Among the faiths mentioned in the community were the Legio-Maria sect, Power of Jesus and the Voice of Salvation. These sects believed in the power of prayers and anybody who fell ill or sick was seen as having no faith. They believe that as followers of Christ, one should not go to hospital since Jesus himself never set foot in a hospital. The Legio-Maria followers on the other hand believe in the power of healing and exorcising the demons. In the recent past, Father Alphonse (the former in-charge of Nyang'oma Catholic Mission) was also organizing healing crusades that two women mentioned as giving them hope and discouraging them from attending antenatal health care facilities in the belief that Jesus is the cure to all ailments. One of them commented:

> "I am a catholic and we believe in hospital based care. However, since father Alphonse started organizing crusades here in Nyang'oma and its environs, I have believed in him and I have seen miracles. Whenever I feel any pain in my body and attend his crusades, all my problems disappear. I was a regular at his crusades when I was pregnant and did not attend clinic for that matter"

Maternal education was also found to influence the health seeking behaviour in pregnancy or how women view their health in general. In the sample, not many of the women had gone to school. Table 5.5 below shows the level of education attained by respondents.

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Table 5.5. Maternal Formal Education

Level of education	N	%
None	5	5.0
Primary	74	74.0
Secondary	17	17.0
Tertiary	4	4.0
Total	100	100.0

Source: Primary data (Community survey)

Majority at the primary school level did not complete and do not have any certificates but could read and write. Majority reported to have dropped out between classes four and six. As shown on the table, five women did not attend any formal education and only 4% had gone beyond the secondary level to professional courses. A total of 17% had reached secondary though a number reported that they dropped out of form two as a result of their inability to afford school fees. Among the longitudinal follow up sample, all of them had attended at least some formal schooling with two being high school graduates.

The two high school graduates did attend antenatal clinic regularly and were more inquisitive during the follow-ups. They observed the general hygiene during pregnancy and were more conscious of their diet, workload and health care. They are also part of the group that had familial discussions. One of them delivered at Nango dispensary under the supervision of the nurses and in the presence of her husband who had brought her.

Formal education was noted to have a bearing on maternal awareness and patronage of the antenatal clinics. Those with no formal education were not adequately prepared to deal with the health care delivery system whereas the respondents with formal education were more likely to seek facility based care. The examples of Nyaboro and Akoth below illustrate this difference.

Nyaboro who was one of those who did not attend any formal education believed that the hospitals and the nurses have no time for illiterate women. She said that she feels ashamed going to clinic to be asked her age and other details during her social history taking process since she does not even really know when she was born. She also confessed that she cannot tell anything written on her card and during her pregnancy, she failed to go back to the

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clinic since she could not read the return date and the provider did not tell her anything but only indicated on the card. She said:

> "I do not know how to read or write and when you go to the hospital, they indicate for you the return date on the card and they expect you to be able to read it on your own, secondly, the kind of questions they ask in their examination requires some responses that illiterate people feel uncomfortable with like calculating your age and all that"

Akoth who is a 30 years old mother of two and a primary school teacher says that she does not give room for any disease symptom. She treats it however light. When she was pregnant with her second born, she went to Kisumu to be attended to by a qualified gynaecologist as this according to her saves time compared to long queues in public facilities. In her own words she said:

> "After all, people work for their health and welfare, I invest in my children right after conception and I would be doing total injustice to myself if with my education, I cannot help myself on issues that are straight forward"

In the sample, five women reported that they went to clinic because of the information they had received from school on the importance of antenatal care in their science lessons. Another group reported that they knew about the advantages of ANC from the parent magazine. Most of the time, women cannot even read the simple health information bulletins available in clinic notice boards. Some women complain that the providers refer them to these writings and they are ashamed to reveal that they cannot read and write, so they avoid the embarrassment by staying away. At the Nyang'oma clinic, one of the providers said that they do not have enough time to teach pregnant women basic hygiene, diet and how to take care of themselves as a result of the large number of service seekers. She however, commented:

> "All the required information is here on the notice boards. They can read how to take care of themselves, how to family plan, how to do exercises during pregnancy and the clinic requirements in pregnancy"

The above statement assumes that all women who go for services are literate and can read for themselves the health information posted on the notice boards.

The other noted problem at the mission clinic was on the means and ways to family plan and stay free of HIV/AIDS. The health chart from the ministry of health included condom as one of the ways to stay safe, however, the church doctrine does not allow condom use. This is therefore, rubbed out from the chart.

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Still on education, it was found out that the biggest problem in integrating the illiterate TBAs into the official health care system has to do with the two training methods and also the inability of the TBAs to have clear records of their consultations prior to going to clinic. They also find it difficult to read the recent literature on maternal health and therefore, cannot advance and be at par with the recent developments.

In summary, the following were some of the social, physical, religious and economic reasons women advanced for not being able to attend to antenatal as well as postnatal clinics as expected of them:

- Maternal ignorance
- Poverty and the inability to finance health care.
- Shame (Embarrassment of teenage mothers, very mature mothers and multi-paras).
- Distance to the health care facilities
- Peer influence
- Rumours about immunization and their consequences- that 'clinic children' often die. (This is a common re-current rumour in most villages concerning immunization of children in rural environment).
- Husband/ spouse attitude, fears and suspicions.
- Cultural 'virtue of endurance' and women who have previously delivered at home without medical intervention.
- Religious beliefs where prayers are seen as satisfactory and those who fall sick have their faiths doubted.
- Mother in laws' influence.
- Heavy workload and the competing alternatives to the clinic time.
- Seasonality and bad weather (either excess workload during the rainy season, i.e. gardening, farming or tending livestock or the impassable infrastructure and the difficulty of accessing the facilities.
- Availability of competing alternatives such as Traditional Birth Attendants (TBAs). Traditional herbal medicine women/men, religious care e.t.c.
- Laziness on the part of the woman.
- Reaction of some women to the lack of spousal responsibility.
- Some women attend clinic late in pregnancy and this creates friction with the clinicians and they opt to stay away.

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- Fatalism and the belief that God is the sole provider of health. With or without attending clinics, God's will still prevails. Belief that children are part and parcel of the 'Divine Intervention' and nobody has control over the process.
- Some illiterate women say that they fear being probed (the questions asked, life histories are intimidating and expose their ignorance and illiteracy).

All the above factors combine to explain why most rural women do not patronize official antenatal health care facilities. However, there are other factors and shortcomings within the system itself that also act as impediment to proper patronage of the facilities.

5.4. Supply side factors influencing access to antenatal care

Most women attributed their failure to attend antenatal as well as postnatal clinics to several factors related to the facilities (**Supply side**) even though they acknowledged the importance of ANC.

Most respondents who believed in professional facility based care acknowledged that it is in the best interest of every woman to be attended to by a professional who can detect a head of time any potential complication. They underscored the fact that home deliveries are matters of chance occurrence and cannot be relied on irrespective of their outcomes. One respondent had this to say;

> "If every one was thinking the way I do, all women would promptly attend antenatal clinics since this is the only place with trained professionals with the ability to offer both emergency as well as adequate care. With all its shortcomings, facility based care is still the only available avenue for women to be able to carry their pregnancies to term risk free. I have been to clinics and I have witnessed the shortcomings, but still, given an opportunity, I would still go back there for lack of a competing alternative" (A 23 year old mother of two).

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Other respondents acknowledged the importance of the ANC clinics but regretted the manner in which the services were provided. The structural difficulties of access and cost made them least desirable. They said that the individuals though economically poor and illiterate have to be respected and their dignity observed. They saw the clinics as places where the differential power structure were exemplified with the care seekers seen as least knowledgeable. The respondents' attitude can be summed up by one of them who reported that she had a bad experience with the clinic;

"When you go to the clinic, you meet very unconcerned and hostile staff who will do everything to make you feel inferior and unwanted through their actions and how they communicate with you. They will sit and chat away as you wait to be attended to. When they finally start attending to people, they ask you for money to buy a card, then, they touch your body all over, asking you about your clothings and at times advising you to eat foods you cannot afford, after all these, they give an injection that most likely will lead to your body swelling without any explanation as to what the injection cures and then, they will give you a list of drugs to buy from the pharmacy telling you that there are no supplies. After all these, you will be told when to come for the next visit and on your card will be indicated the expected date of delivery (EDD) which in most cases is never accurate. Instead of going through all these, most women prefer staying at home and resigning to their fates" (A 22 year old mother of three).

Most of the above health care facilities such as the health centre at Nyaguda, Ouya, Anyuongi and Nango dispensaries were quite low in consumables and neonatal equipment. They lacked the basic equipment such as the weighing machine, stethoscope, and foetoscope among others. This meant that the women could not know their weights during pregnancy. It was only Nyang'oma Mission dispensary that had most if not all the consumables and equipment. It was, however, seen as very costly and therefore, out of reach of the majority. Some mothers also had problems here with some providers who were catholic nuns. There were silent feelings that since nuns do not get married, they lack practical experience in pregnancy and childbirth and they singled out some of them whom they said were quite rude to them and they always avoided them. Some respondents also complained that they were being attended to by two very young girls who were on internship and therefore, lacked professional and practical experience in antenatal care.

One respondent who says that she had delivered her first born at the Nyang'oma dispensary commented thus:

"I loved coming to Nyang'oma when Sister Katrina was here but since she was transferred and Sister Javelin brought here, I have never liked this clinic. She has a very boastful and arrogant attitude and prefers to speak to people in Swahili or English since she does not know dholuo. Moreover, as a nun, she will never experience the pain of childbirth and she is not good hearted as sister Katrina was. They have also brought these young girls who are here on attachment to experiment on people's bodies" (Comment by a 23 year old mother of three).

The other shortcoming with Nyang'oma dispensary is that it is associated with the catholic mission and the non-Catholics see it as an extension of winning converts. One of the mothers in the survey reported that she was not catholic to go for clinic at Nyang'oma.

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With respect to the WHO recommendations for Emergency Obstetric Care (EOC), most of the facilities did not have the ability to offer adequate care. Each health centre should have the capacity to provide trained staff to detect complications, conduct normal deliveries, and provide obstetric first aid (e.g., initial treatment of eclampsia, manual removal of placenta among others). The hospitals on the other hand should have the ability to admit at least 24 or more mothers and to provide surgical obstetrics (such as caesarean section); anaesthesia; medical treatment of sepsis, shock, eclampsia, e.t.c; blood replacement; manual procedures (e.g. vacuum aspirations) and labour monitoring (e.g. partograph) management of women at high risk and family planning support.
At Nango dispensary, women always complained of lack of supplies, the delivery ward had only two beds, there was water shortage (lack of reliable safe water supply) and the lamps for use in the wards at night were faulty. The overall environment was not conducive for safe delivery. There was also staff shortage as one of the antenatal health care personnel was a community based health worker who was assisting other than being a full time employee of the ministry. The clinical officer in-charge communicated to mothers in the Kiswahili language as he was not a speaker of the native language and women felt intimidated, as most of them were not conversant in Kiswahili. This created a language barrier between providers on one hand and the clients and their families on the other.

The other facilities apart from Nyang'oma did not have adequate delivery beds and related equipment conducive for deliveries. At Nyaguda, services were offered at intervals and not daily. Qualified medical personnel were only available on particular days of the week. Overall, women reported that the quality of care was very low and most of them saw no need of going for services that did not respect their personhood.

The above observation lead most women to attend clinic only once or twice for the sole purpose of getting an antenatal card. When women were asked the number of times they visited clinics, the following pattern emerged as shown on chart 5.3 below:

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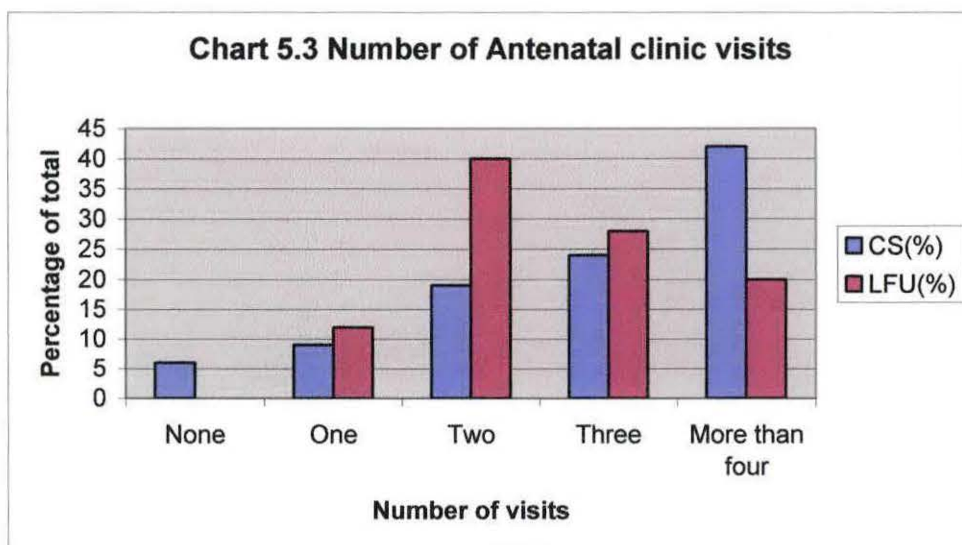

Source: Primary data (Community Survey & Longitudinal follow-up)

It can be noted from chart 5.3 that 34% of the respondents in the community survey only attended clinic at most twice. Most of them as indicated on chart 5.4 went to the clinic not for ANC but because they were sick and required to be treated. In the survey, 42% of the respondents reported having gone to the clinic four or more times whereas in the follow up, only 20% of the respondents reported this number of attendance. Most of the mothers in the follow-up (40%) went to the clinic only twice with 28% attending three times. This does not reflect the recommended attendance level. Though, the current policy guideline on focused ANC talks about four elaborate visits, by the time of the research, women were expected to attend as many as twelve times depending on when their first visit was. It was difficult to authenticate the reported number of visits from the survey as we only relied on what we were told. More accurate results can be inferred from the longitudinal follow-up since we were present and even analyzed their ANC cards despite the low number of respondents that makes generalization impossible.

Related to the number of visits and the quality of care therein, is the timing of the first visit. This determines the subsequent number of visits and the care women receive and the ability of the health care system to diagnose problems ahead of time. The timing of the first visit is as shown on table 5.6

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Table 5.6: Timing of the first ANC visit

Timing	N	%
Below 4 months	10	10.7
Between 4- 6 months	32	34.0
After 6 months	52	55.3
Total	94	100.0

Source: Primary data (Community survey)

Table 5.6 shows the timing at which women visited ANC clinic for the first time. Only 11 % of the women came before the fourth month and even the majority in this group did not come to seek antenatal care, but came because they were facing some problems with their pregnancies and needed treatment as shown on chart 5.4. They were also never regular attendants thereafter. More than 50% of the respondents came to the clinic more than six months after getting pregnant. This is considered late and complications could arise before then that could be fatal to the women. It is also noted that eight women attended clinic for the first time in their 8th month of pregnancy and five women in their 7th month of pregnancy. This is a clear testimony that they were only interested in planning and preparing for delivery and to get the ANC card that would enable them get admission in the event of any obstetric complication during delivery.

Since the interaction with the official health care providers has been seen as a major factor in barring women from attending clinic, we look deep into the interaction in the following pages to see what women think and how that interaction influences the care seeking patterns.

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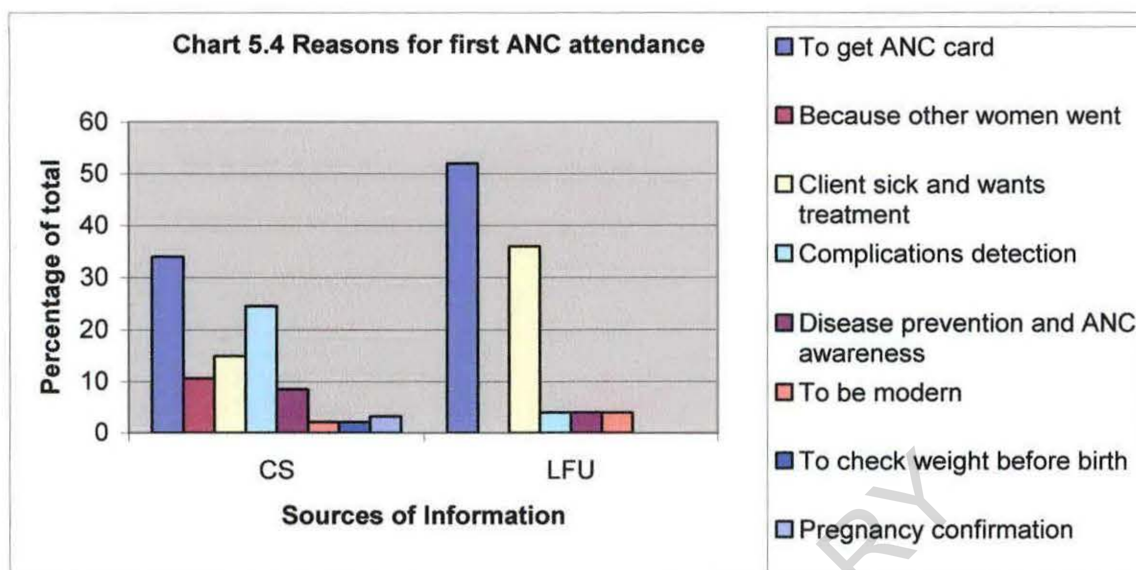
5.5. Reasons for attending antenatal clinics

Throughout Kenya, ANC attendance is relatively high. Almost all women (92%) made at least one ANC visit during pregnancy, and 60% of women made four or more visits (KDHS 1998). In Nyang'oma, the results indicate that 94% of the women attended clinic at least once and 42% made four or more visits. Most respondents recognized the importance of early and regular antenatal care. Even those who apparently do not use ANC, acknowledge its importance. Some of the reasons advanced by the women for attending clinic are as shown on chart 5.4.

When asked why they opted to attend the facilities in their first visits, the emerging pattern clearly indicates that most women do not attend out of the conscious attempt to ensure that the pregnancy period is safe but for other reasons as indicated on the chart below:



Source: Primary data (Community survey & Longitudinal follow-up)

As shown in the above chart, among the reasons women advanced for attending antenatal clinic were the need for prevention through immunization and examination in pregnancy, to be checked on being over or under weight, quite a good number went to clinics not because they were pregnant and wanted antenatal care, but because they wanted treatment, others wanted a detection of any potential complication in pregnancy ahead of time, others just wanted to confirm that indeed they were pregnant, others went simply because they had seen other women go to clinics in pregnancy, the majority went to get the antenatal card which is an assurance of quality care in the event of an emergency, two respondents reported that they went because it was the most modern thing to do and that it was not good for an enlightened couple not to attend ANC and finally, some respondents reported that the information they have read in the parent magazine about antenatal care made it mandatory for them to go so as to avoid any complications real or imagined that may interfere with their pregnancies. One married woman 25 years old and a form two leaver and a mother of three commented: "Problems arising from pregnancy are mine alone and I decided to go and take care of myself"

In the community survey, 15% of the respondents went to the clinic because they wanted treatment, whereas in the longitudinal follow-up, this accounted for 36% of the respondents.

Most mothers (32% in the community survey and 52% in the longitudinal follow-up) reported that the main reason for attending ANC was the desire to obtain the antenatal card which is available only at facilities where skilled ANC is provided. The clinic card is now regarded as a basic entrance point and 'passport' to skilled childbirth care (Moore et al. 2002; MOH 2002; Allen 2002). Most obstetric and facility based delivery relies heavily on the cards as a way of showing that the mother has been under skilled monitoring.

Respondents reported that those who do not attend ANC are never well received at facilities at the time of delivery. The providers (doctors and nurses) placed great importance on women having antenatal cards since this is the only reliable way of tracing the history of the pregnancy and the level of complications. Majority of the respondents indicated that their ANC attendance was occasioned by the 'push' factors rather than the 'pull' factors.[34]

One of the key informants (a nurse at a local clinic) reiterated the importance of ANC during pregnancy. She took the study through the specific things that ought to be done in the routine check up during ANC. It was not only the issue of the antenatal card as alleged by the mothers. She also admitted that the card is the only certificate of proof that a particular woman has been attended to by a professional and in a facility. The following were some of the things she said are recommended whenever a woman goes for ANC:

- ANC card as a first step
- Taking the family history, social history and past pregnancy history
- Checking the mother's weight, height and blood pressure
- Physical examination from head to toe (This involves checking on the hair for dandruff or any other sign of sickness, to the eye (Conjunctiva where pale mucus membrane is an indication of anaemia), the ears for any infection or discharge, Nose for any type of discharge or whether it is blocked, Mouth for the mucus membrane, teeth, gum, tongue for any sign of anaemia, the neck (the glands, tonsils, thyroid gland to rule out goitre)
- Checking on the chest, breast palpation for any mass, squeeze the breast for any discharge, see if the nipples are open, check for chest movement and heart beat

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[34] Push factors are seen as those conditions such as sickness, anxiety and the need to prepare for the unknown rather than the pull factors that make ANC an end in itself. The advantages of antenatal care have not been propagated widely for women to believe in its crucial role in pregnancy.

- Checking on the Abdomen, palpate the spleen, liver if they are enlarged both left and right, check for the fundal height and palpate to show the gestation period
- Oscaltate- measuring the foetus heart beat by use of a feotoscope to know the position of the child and presentation from the fifth month.
- Check the private parts for any discharge, infection, type of discharge if any- abnormal or normal (Use a vaginal speculum (small, medium and large))
- Check the lower limbs, venus thrombosis, oedema, detect the woman's gait, see if the legs are of the same size
- Pelvic assessment at around the sixth month to show adequacy of the organs.
- Take specimen for urinalysis test, VDRL test for syphilis
- Counsel and test for HIV/AIDS test
- Take specimen for Malaria test
- Besides the tests and physical examination, give counsel and Health Education on Prevention of Mother to Child Transmission of HIV/AIDS (PMCT, Nutrition, Individual Birth Plan (IBP), Exercises and general personal hygiene.
- Administer or prescribe Intermittent Presumptive Treatment (IPT) drugs for malaria, iron folic for anaemia and give tetanus toxoid (TT) injections.

The above list of activities looks elaborate and includes all the requirements in the new policy guideline as well as the recommendations of the WHO driven goal oriented package of ANC (Focused ANC). The only missing link is the number of times the mothers are expected to attend clinic as the focused ANC recommends four elaborate visits whereas she still talked of the monthly visits from the 12th week.

She, however, acknowledged that due to the pressure of time and the impatience of some mothers, all the above are never done. According to her, the recommended clinical attendance in ANC should begin at the third month of pregnancy (12 weeks), then monthly to the 28th week (7 months), and then fortnightly up to the 36th week (9 months) and then weekly till delivery. She reported that on average, most women come to the clinic in their seventh month (28 weeks) of pregnancy and then regularly on appointment there after.

On her part, she also saw some clients as being very difficult to deal with. Some of the mothers are too closed and secretive in terms of their sincerity in their personal health histories. Some see the whole process as time wasting and are at times too hostile to the

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ANC providers. Some of the mothers use the clinic as the place to settle their domestic squabbles with their spouses. She also mentioned poverty as a limiting factor among women and the maternal ignorance as a hindrance to proper antenatal care.

There was a general consensus amongst the nurses in the local health facilities (Bondo, Owen, Nango) that at times, lack of essential supplies (such as scissors, umbilical cord clamp, weight machine, gloves, delivery materials, urinalysis kit among other basics) limits their abilities to offer adequate care. They also blamed the cultural environment in which women are as a constraint to proper care. The service providers also reported being overwhelmed by the large numbers of clients/mothers seeking ANC services thereby making it difficult to provide quality individualized care and attention. Other problems they identified as hindering their adequate delivery of health care services included lack of proper training in most recent technologies, under staffing, delay in decision-making resulting from the bureaucracy and the limiting chain of command. Those in the private clinics who were employed by the entrepreneurs who owned the clinics complained that at times, they are forced to under dose patients because of the profit drive and this made them really sad. Providers in both public and private facilities were in agreement that educated patients were more questioning and at times more difficult to treat satisfactorily. Owing to the time pressure, they also could not educate and counsel the women appropriately as required and give them personalised attention, as the contact time was very brief.

Most respondents in the maternal cohort had differing views on their interaction with the antenatal health care providers during their pregnancy. The majority saw the hospital environment to start with as intimidating, the providers as arrogant and unprofessional and the time taken waiting for services as extremely long and unnecessary. Although they acknowledged that the procedures necessary in the check up were helpful, they indicated that the procedures are for the books and they had never at any one time in their birthing history been checked that elaborately. The chart below show the average duration reported by women as time taken waiting for services in the facilities.

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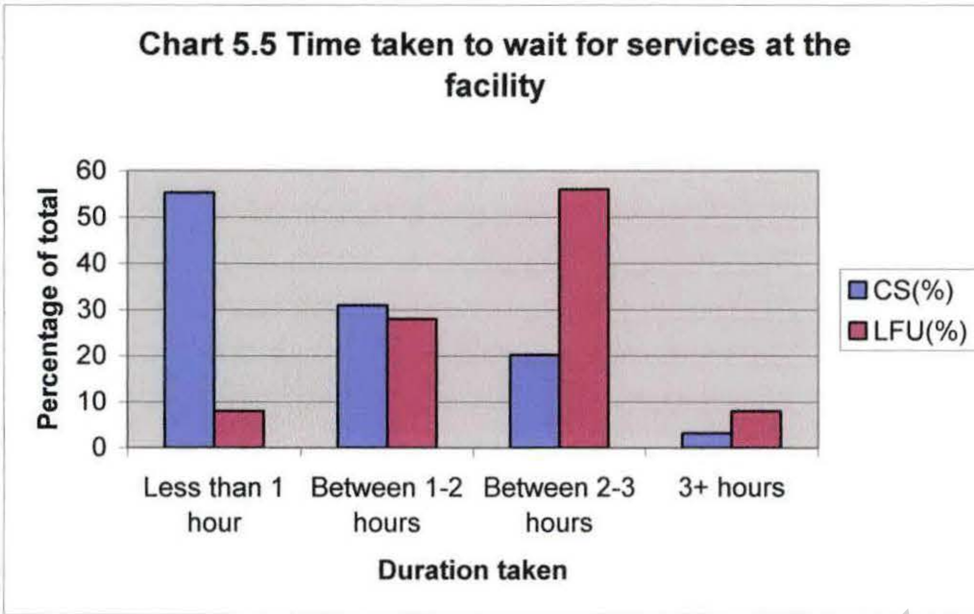

Source: Primary data (Community survey & Longitudinal follow-up)

Although most women in the community survey (55%) reported less waiting time for the services, more than half (56%) of the women in the longitudinal follow-up reported that they waited for more than two hours before being served. Some of them were accompanied to the facilities by the research team and the time taken from arrival to when they left recorded. If one arrived in the morning by bus as there was a bus plying the Sirongo route and women who had the bus fare used it, they had to contend with delays as the nurses waited for the women until a certain number arrived before they could start attending to them. In most cases, they started services at around 10.30 a.m. and did more charting than giving services. Besides, the slowness and late opening, services were also offered based on the proximity of the client to the providers. The providers personally knew two of the clients in the longitudinal follow-up who reported that they took less than 10 minutes to receive services and one of them was a daughter in-law to the chairman of the dispensary board. Those who were in a better social standing like the teachers or the economically stable women were favoured in the services delivery either in being attended to without queuing or getting warm personalised care that was not available to the other women.

With respect to the quality of services provided, majority of the respondents said that ANC in their knowledge was just a question of somebody touching your tummy, massaging you a little and an opportunity to meet other pregnant mothers. Rarely are the mothers taught how to take good care of themselves and their newborn babies. They reportedly had

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experienced verbal and physical mistreatment at the facilities which acts as barriers to their subsequent attendance.

One respondent saw personal communication as central to the overall care. She reported that health care providers did not know how to rightfully communicate with their clients. They order them round and make them feel unimportant and worthless. She said;

> "In terms of personal communication between the clients and the providers, you are made to feel like you are less human. You are ordered around, treated with contempt, quarrelled, tossed left, right and centre. When you arrive at the clinic at around 8 a.m. in the morning, you have to wait until around 10.30 a.m. before you are attended to. During this time, the nurses just relax chatting away and whenever you complain, you are scorned and made to feel inferior".

They reported that they just kept quiet and only avoided the clinics to show their concern. Some women also reported that the intimidating hospital environment requires a proper introduction and guides. The observation at the district Hospital where the women had to find out for themselves where each service is offered and queue in wrong lines without assistance wasted a lot of time and discouraged most women from attending clinics again.

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Those who have delivered in hospitals report that they are ordinarily left on their own during labour and delivery. They are also ordered to 'push' and even slapped at times when the baby delays. They feel abused, neglected and abandoned in an environment where there is no family or any other person to assist them. This neglect is more acute in the night when the nurses are mostly a sleep and may not want to be 'disturbed'. A cross section of the respondents however, claimed that those with additional resources to spare for the nurses are accorded preferential treatment both at the time of delivery or during the antenatal care period.

Three respondents summed up the overall providers' attitude towards the clients and the delivery environment within the facility set up who had experienced it before. One of the respondents had this to say about antenatal clinics, the providers and the subsequent hospital deliveries:

> "I attend clinics simply because they insist that you must have a clinic attendance card to be attended to in-case of any emergency. For this reason, since you may not be too sure of the whole process, you just go there just in case your pregnancy becomes problematic. I gave birth to my first son in Nyang'oma clinic. I went there with my own nyamrerwa who was even barred from attending to me. The sisters (nurses) who were supposed to be attending to me were all a sleep and whenever

my nyamrerwa tried waking them up, they were very indifferent, abusive and less concerned. My nyamrerwa is the person who ended up delivering me and I vowed never to go back there. When the time came to give birth to this child (3rd born son), I decided to simply do it at home where I was comfortable under the considerate care of my nyamrerwa and a birthing position of my choice instead of being forced to sleep on my back. I am used to the sitting position which the authorities in the facilities do not allow" (A 26 year old mother of three).

The other mothers reported that the health facilities offer their services against a backdrop of arrogance and an attitude that is discouraging to the health seekers. This position was eloquently summarised by one of the respondents who had this to say;

> "Whenever you go to the clinic, you find very unwelcoming staff who arrive very late at work, do much gossiping (discusses the client's attire and clothing) and empty talk at the expense of the waiting patients, when they begin offering services, they are sluggish, practice favouritism, are unprofessional, lack basic facilities (weighing machines etc.), are abusive, authoritarian and above all, the supplies are never there" (A 32 year old mother of four whose experience during her second birth in a facility discouraged her from any further visits).

The third respondent who had the worst experience during delivery at night in a facility had to leave the following morning. She delivered on her way home as she did not want anything to do with the ward because she had witnessed her friend struggle alone resulting in a stillbirth the previous night. In her own words, she said:

> "I was taken to the clinic at around 8 a.m. on Tuesday after experiencing false labour. That evening, my friend Akeyo was also brought in while in labour pains at around 8.30 p.m. We started comparing our previous experiences. At around 1.30 a.m., my friend went into intensive labour and by then the nurses were sleeping. I woke up from my bed and tried to wake them up. They told me to go back to bed and stop disturbing them that they did not make us pregnant. I felt so bad and went back and found my friend struggling alone and in too much pain. She was unable to push the baby on her own and when she finally managed at around 3.30 a.m. in the morning, it was a stillbirth. The lady cried till morning and when the nurses came at around 4.00 a.m., they were not even remorseful, in fact, one of them commented that the problem with us poor women is that we eat too much of cheap foods that the child grows too big for normal delivery. At dawn, I decided to sneak out of the hospital and on my way home, delivered with the help of a Good Samaritan who fortunately enough was a community Health Worker (CHW)" (Confession of a 30 year old mother of three).

In a sample of twenty-five, only three mothers expressed satisfaction with antenatal care and the subsequent facility delivery. All of the three had attended the clinics previously out

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of the District and had heard very unforgettable experiences. One of the mothers had this to say:

> "During my second delivery, I did not attend clinic till the 9th month. When I went, the baby was discovered to be lying in a bad position. The nurses however advised me to just go back home that everything would be normal. On the day of delivery, there were complications and I had to be rushed to Russia (Nyanza Provincial referral hospital). The doctors helped me a great deal and from then, I promised myself that I would always be punctual with antenatal visits" (A 24 year old mother of two).

The second respondent was previously staying in Nairobi where the husband used to work and was medically covered by the employer. She used to attend company facilities and since the husband was a driver, she received good care during the birth of her second born. Since then, the husband was retrenched and they both went back home. During the period she was in Nairobi, she had a very good experience with the caregivers that she still believes that all is not lost. During the study, she said that she had been receiving good care at the hands of the local attendants. She blames the women for their predicament. She said;

> "The biggest problem with the mothers and why they receive inadequate services is that they go to the clinics with a formed negative attitude and we never open up for proper care. The Doctors and the nurses are all human beings who are suffering just like any other Kenyan and require good attitude from their clients for good care. I believe that clinics are the only way out to safe motherhood and all deliveries must of necessity happen within the facilities. Everybody should struggle to ensure their own safety, after all, the problems and suffering will always be with the women and not the providers"

Majority of the respondents were of the view that being accompanied to the delivery ward by one's *nyamrerwa* was the safest way to safe delivery and it also reduced delay in the receipt of skilled care. She would personally take the initiative to ensure that one delivered safely. In the event that you did not receive attention from the nurses, they were handy as long as the nurses were good enough to allow her to take care of one. In the event of any obstetric complication, the specialists would be at hand to assist.

The Key informants (Traditional Birth Attendants) and community members in the FGDs agreed that the most important thing would be the relationship between the TBAs and the nurses since some facilities do not think highly of the TBAs. Some providers see the TBAs as the sites of delay as they only refer mothers whose complications are beyond their

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abilities. One mother who was accompanied by her *nyamrerwa* was scorned and the *nyamrerwa* was not even allowed into the ward. This is what she reports to have been told;

> "Why are you coming here if you knew very well that the *nyamrerwa* could have provided you with the necessary assistance far away from here? You chose between her and the hospital, look at how tired you are. She has wasted your time all this long and you are now coming here very weak and then you will blame us for not assisting you in time" (22 year old mother of two).

On the contrary, another respondent reported how helpful and understanding the nurses were when her Nyamrerwa accompanied her. She reports that her nyamrerwa happened to be a stepmother to one of the nurses and the relationship and understanding was of great help. She said;

> "When I was about to deliver, my nyamrerwa detected that the baby was sleeping in a dangerous position that required closer monitoring and more professional care than she could provide. She decided to accompany me to the hospital. Not only was she handy in assisting me in carrying all the valuables, but she also assisted in monitoring my progress on the way to the clinic. When we arrived, the reception was so warm that she is the one who explained my condition and we were all allowed to stay in the ward. I received maximum care and every attention necessary. I was given the best food and when the time to deliver arrived, I had three nurses next to my bed encouraging me on and ensuring that everything was taken care of. All the concern was courtesy of my nyamrerwa whom I have been very indebted to" (A 26 year old mother of four).

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The emerging pattern here is that services are provided differentially and the social relationship becomes of great importance. Whereas one client complains, the other rejoices. Providers themselves come from different social backgrounds and cannot be said to provide services in the same way. They are part and parcel of the larger Kenyan society with other familial and relational issues to deal with on a daily basis. However, there is need to have a clear policy guideline on the role of 'birth partners' during delivery and whether they should accompany the mothers to the facilities.

The interaction with the providers and their services as factors prohibiting proper antenatal care can be summarised as below:

- Prohibitive costs. Women complain that the charges in facilities are high and the services poor. They do not see the reasons why they should pay for prescriptions and later be told to buy the supplies and medications.
- Poor services provision (harassment from nurses because of their attire i.e. high heeled shoes, lack of maternity dress and the epithet from the medical staff

reminding them of the responsible man in question). They see the staff as uncaring, arrogant, patronising and unwelcoming.

- Side effects of the injections given as a result of allergy (swelling yearly from the anti-tetanus jabs). There are limited explanations to allay the worries women face as a result of the side effects of the injections.
- Disagreement with the hospitals' prescribed birthing positions that differ from the culturally known and practiced position. Most women prefer giving birth in a sitting position other than being forced to lie on one's back.
- Hospital congestion and long waiting hours for services.
- Drugs unavailability and other forms of scarcity at the facilities.
- Lack of high level of professionalism, poor communication and poor observance of time by the clinicians (late opening, early closing, extended lunch time, too much gossiping and engaging in rumours and charting at the clients expense).

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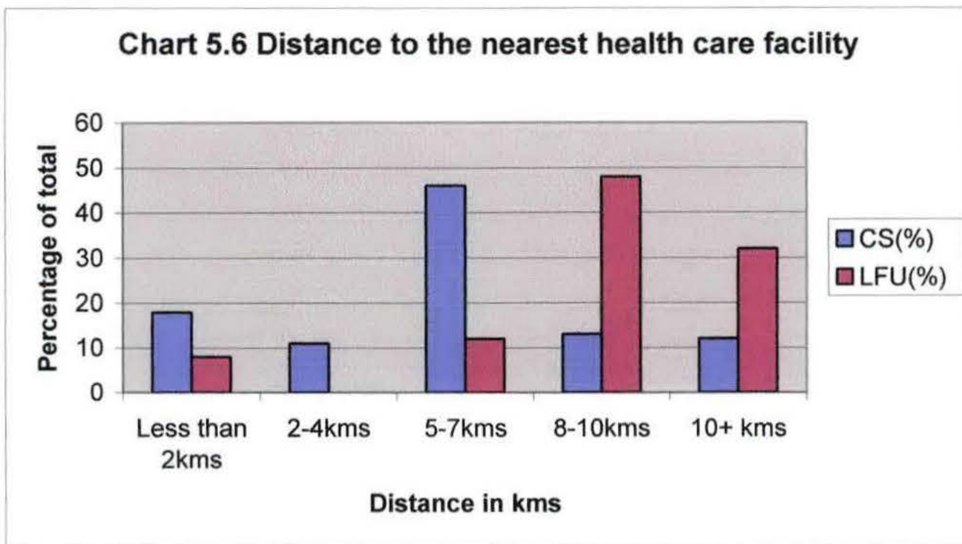
5.6. Distance and Cost of Services

Besides the complaints about service delivery, most clinics were reported to be located very far away from the two villages of Orengo and Sirongo. The terrain was too rough and means of transport unreliable.

Although respondents expressed many barriers to the use of skilled care, most respondents emphatically agreed that cost of services and the distance to a facility were major barriers to the use of skilled care and ANC attendance.

Women complained that they were expected to buy or carry with them basic supplies such as gloves and cotton wool at delivery. This meant that one had to have adequate finances to be able to prepare some of these items in advance. Besides the facility based charges, the location of many facilities are beyond the reach of many in terms of distance. Many facilities are located at the peripheral market places far away from the care seekers. Women have to walk long distances in rough terrains and at times in unbearable weather (either too sunny or too rainy). The costs of transportation far much outweigh even the cost of services at the facilities.

The chart below shows the reported distance from the homes to the clinics in the study sample for both the community survey and the longitudinal follow-up.



Source: Primary data (Community survey & Longitudinal follow-up)

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Over 70% of the respondents in the community survey lived more than five kilometres away from the facilities and 25% lived even far off covering a distance of more than 8 kilometres to reach a health care facility and if one had to walk as this is the most common mode of transport, then one would take more than four hours in walking to and from a facility.

As indicated in chart 5.6, most respondents (48%) in the longitudinal follow-up covered more than 8kms and 32% lived more than 10kms from the health care facilities. Those who lived in Orengo village had to cover more than ten kilometres to the nearest clinics (Nyang'oma or Uyawi/Nango). The road to the clinics is hilly and with a lot of stones. If one decided to go on a bicycle, it was not possible as the '*boda boda*' (bicycle taxi) business does not thrive here because of the rough terrain unless one had a personal bicycle which as already discussed, were owned by men and out of reach of most women. There is equally no public transport vehicle operating on the route. This leaves only walking as an option to the clinic or going for clinic at the Bondo District Hospital where the charges are even higher besides long waiting hours. One has to have money for transport, clinic charges and something for lunch.

On the other hand, the distance from Sirongo Beach to the nearest clinic (Nango/Uyawi Dispensary) is almost 10kms. Going to the clinic via *boda boda* is even more expensive as a return journey would cost Kshs120 besides the clinic charges. The high charges are as a result of the poor infrastructure and unbearable terrain. There are two vehicles on this route

at very irregular intervals. The vehicles would charge Kshs 40 one-way. Most respondents complained that they could hardly afford the charges and the vehicles also left Sirongo very early in the morning. Those who boarded them had to contend with a long waiting duration for the services and had to walk back home as the vehicles only went back in the evenings. The vehicles were also used by fish traders to transport fish from the landing beaches to Kisumu. Some women complained that they did not like the smell of fish in the vehicles and therefore, did not use them and had to walk to the clinics if ever they had to go there.

The table below shows the means of transport as reported by the respondents.

Table 5.7: Means of transport to the clinic

Means	N	%
Walking	58	58.0
Vehicle	23	23.0
Bicycle	19	19.0
Total	100	100.0

Source: Primary data (Community survey)

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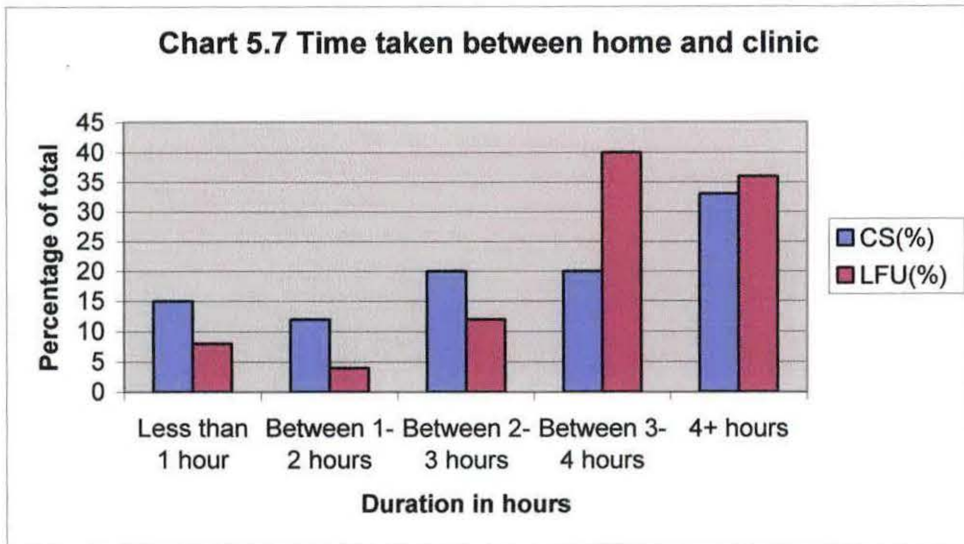
As shown in table 5.7 above 58% of the respondents in the community survey reportedly walked to the clinic or regarded walking as the only option available to them. The six women who did not attend clinic at all in the community survey indicated that in the event that they were to go, they would walk. In the longitudinal sample, fourteen women walked to the clinics and only two used bicycles and the nine who reportedly used vehicles could only use it one way and had to walk back since the vehicles plied the route at irregular intervals. Given the long distance and the mode of transportation accompanied by poverty, most women reported that they took very long time to reach the facilities. The chart below shows the duration of time taken between home and the facility for the respondents in the Community Survey (CS) as well as the Longitudinal Follow-up (LFU).



Source: Primary data (Community survey & Longitudinal follow-up)

Responses were also received from the six women who did not attend clinic. They said that it was because of the distance and the time taken that they saw no need for going to queue for the whole day. The longest duration reported was 8 hours by a woman who was coming from one of the Islands (Sifu) who had to wake up early and wait for the boat to Sirongo and then walk to Uyawi dispensary. The shortest time reported was five minutes by those who were staying at Nyang'oma. Most mothers took more than two hours to the nearest health facility. As can be noted in chart 5.7, 76% of women in the longitudinal follow up took more than three hours to reach a facility as the commonest mode of travel was by walking and they had to cover long distances.

Overall, almost 33% of the women in the community survey and 36% in the longitudinal follow-up reportedly took more than four hours to the facilities and back home. Given the competing demands for their time, this can be a real barrier to proper antenatal care for a great number of women. Distance and transport issues in rural areas are highly significant factors affecting women's access to health services.

The physical features, landscape and topography are also important impediments to ANC attendance. It was reported that during the rainy season, the vehicles plying the Sirongo route get stuck in the mud and some of the businessmen withdraw them or they become very irregular. Additionally, women from Orengo village reported that when the stream/river that connects Orengo with Nyang'oma through Wagusu gets over flooded, it becomes impassable. One of the respondents reported how she failed to attend clinic as a result of the flooded stream. She said:

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"Last week, when I set out to go to the clinic, since it had rained the whole week, I was not able to pass through the river between Orengo and Wagusu as the bridge was covered in water and therefore, very risky. I had to come back without reaching the clinic" (A 28 year old respondent in Orengo village).

In emergency situations where the mothers must be referred, the road network and the terrain can pose a great problem and danger. A woman in a rural village must also leave her family behind; have a large amount of money to spend on transport if she is to reach a hospital that can deal with obstetric complications. If a friend or a relative accompanies her, this friend must also find the time and resources to stay near the hospital during the time of treatment. One case in the longitudinal follow-up illustrates this:

Nyalego is 35 years old married woman and a mother of two. She was assumed to be pregnant (case 1 in chapter 4) during the research and recruited into the study. After visiting her for three weeks, she complained that she suspected something was not right as the baby was not growing and there was no sign that all was well. She opted to go for check up in Nango and was referred to Bondo. After finishing with Bondo, she went to Kisumu where she was informed that there was a growth in her tummy (tumour). She and her husband decided that she goes to Nairobi where their daughter was living for treatment. In Nairobi, she went to a big mission hospital and was diagnosed to be suffering from tumour and was supposed to be operated. However, the operation could not be done since her husband had to sign and since he was a teacher and due to lack of enough finances, they could not travel together. In Nairobi, the daughter had to arrange for her a place to sleep as the avoidance relationship could not allow her to sleep in her married daughter's house. When she came back from Nairobi, they could not go back as they did not have enough money and the husband was also fearful in signing to authorize an operation.

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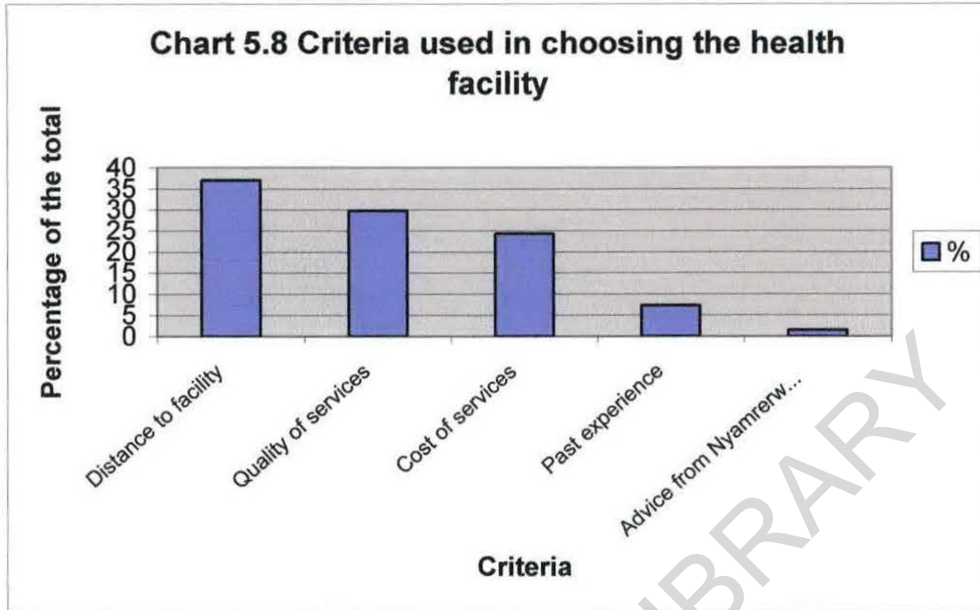
The husband's absence from the hospital in Nairobi delayed the decision to perform surgery on his wife and financial difficulties barred them from going back in time for another appointment. Nyalego was left to contemplate other cheaper options like the herbal clinics or the traditional healers as noted in chapter four.

Antenatal care providers also admit that distance and transportation costs are major limiting factors to the utilization of health care facilities. They report that women will most likely

use facilities that are closer to them whether it satisfies their needs or not. They will even consult 'quacks' as long as they are more readily accessible. This to them explains the wider utilization of the TBAs services. The women themselves when asked the criteria they use in choosing the facility to attend, the following pattern emerged as shown in the chart below:



Source: Primary data (Community survey)

Note: Multiple responses allowed since more than one reason was advanced by a single respondent.

Those who were coming from a closer distance to the facilities were more likely to mention distance as the most important consideration on determining which facility to patronize. Those from far off places were more likely to look at the quality of services as the most important determinant. In total, 37 % of respondents in the community survey mentioned distance, followed closely by the quality of services, which included the availability of supplies, medicines, working equipment and staff attitude at 30%. The cost of services and the individual's ability to afford the services accounted for 24% of the reasons. Others were past experience in the facilities that was related to the quality of services. Women were of the opinion that the level of care they received in any given facility at any one event was an important determinant as to whether they would to be back there for services. Mothers who ever received unsatisfactory services at any one facility had a tendency to generalize bad services for other facilities or felt discouraged to seek services at other health facilities.

Related to the above was the advice and influence from other women who have had contact with the facilities before. At times, it was a question of relationships and who knows who

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in which health care facility. There were a lot of informal referrals based on social familiarity. The pattern in the longitudinal follow up was slightly different with the highest proportion (37%) of women mentioning quality of services and 32% mentioning cost of services as the most important determinants of which facility to attend.

During the study, the research team assisted two mothers who had developed complications but were not able to go to a facility in time. Their reasons for not being able to go to the clinics were varied. The reasons included distance to the facility, lack of social support, economic dependence and lack of money for transport and for buying food and the fear of being laughed at by other women. Below are the two cases that illustrate these constraints.

Case 1

Auma had been pregnant for the last nine months and was getting very worried since she was past her EDD (Expected Date of Delivery). She knew very well that she was required to go for professionalized care but she continued seeing her local TBA who only massaged her and gave her hope that all was well. When we visited, she confessed to us that her major obstacle was financial;.

> "*Wuod Ugenya* (Son of Ugenya –as I came to be known locally), I cannot be able to afford to go to Nango, my husband has been away on a fishing expedition to Riangiti Islands and I only have twenty shillings. The foods I eat are what he left five days ago. We do not have a bicycle that any Good Samaritan can use to take me to the clinic. *Liech* or *Rabet* (nick names for the two vehicles plying the route) cannot take you to Nango without the money. Even if you go to Nango, after you have been checked and all the other women are going for '*uji*' (porridge) at the market, what do you do? I could have walked as I used to do but I am now too weak and Nango is not near here. I will sit here and pray that God helps. I am also very worried as my days have passed" (25 year old mother of two and in her third pregnancy).

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Case 2

Ayieko was 22 years old and was in her 7th month of pregnancy. During this visit, she was having severe stomach and back pain. She was very worried that she could loose her baby. She had attended clinic only once when the research team had gone to visit her in the normal fortnightly follow-up visits. She expressed her desire and willingness to go to the clinic but the distance and cost of services were the limiting factors. This was her story;

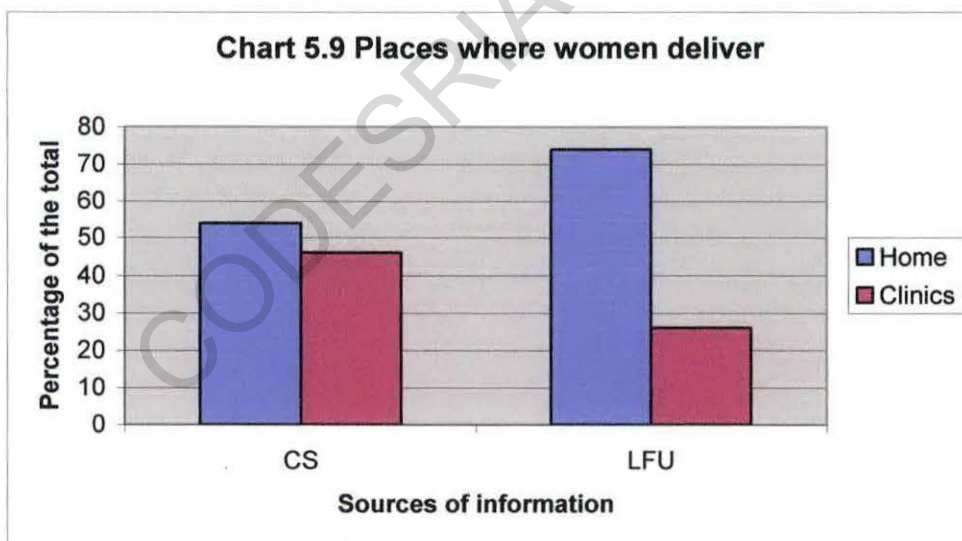
> "*Wuod wegi* (son of someone), how can I go to the clinic with my own hands (meaning without money). When you arrive there, you are asked for this and that and when you do not have, you become a laughing stock. The amount required for transport between home and the clinic is even higher than the charges. I am comfortable with my nyamrerwa who always come to see me here in my house"

As can be discerned from the results of the research, besides the routine known costs and financial barriers to ANC access, women expressed other worries that had financial implications. They expressed the need to have additional money for the purchase of food and other basic supplies during the facility visits. Women without these additional resources had to bear huge psychological burden.

Secondly, women who had problems and had to be referred to facilities far away outside the division had to make additional arrangements on how to finance their travel, accommodation and food for themselves and for those accompanying them. They also had to make adequate arrangements for those remaining behind. This involved looking for a helping hand to take care of the home and feed the husband and other children. Sometimes, the social costs of hospitalization far much out-weigh the economic costs and involve high balancing strategies.

5.7. Places where women deliver

In attempting to explore further whether the clinic attendance was subsequently followed by delivery in a facility or with the assistance of a trained attendant, the results indicate that clinic attendance was never followed by clinic/facility delivery.



Source: Primary data (Community survey & Longitudinal follow-up)

Note: Two women in the follow- up had not delivered one year down the drain after the beginning of the field work and have been discussed elsewhere in the thesis as feigned pregnancies.

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More than half of the respondents (54%) in the community survey delivered in their own homes and in the homes of their nyamrerwas. Most of them did so without any professional assistance or with very minimal assistance from the village based traditional birth attendants or community health workers or the religious maternal health care providers. Only 46% in the community survey delivered in a health facility. Included in the home deliveries are those who delivered at the homes of TBAs and at a religious facility; the Legio- Maria sect.

As shown on chart 5.9, among the twenty-five mothers who were followed up in the longitudinal study till delivery, 74% delivered at home and only 26% delivered in a health facility. Three of the mothers got assistance from a Legion Maria mother who is knowledgeable on birth issues. She is one of the prime providers of antenatal care in Sirongo Village and its neighbourhood. She is a trusted elderly woman who uses religion and other traditional methods of care to offer women a cheaper and available alternative. One mother in the religious category gave birth with the assistance of ACK church leader in the village. Four of the mothers delivered at the homes of nyamrerwas who assisted them in the delivery process. Among the eleven mothers who delivered in their own homes, they received assistance from several quarters. Four of the mothers were brave enough to deliver on their own without any external assistance, two of them were assisted by the Community Health workers (CHWs), others were assisted by relatives as follows; two were assisted by their aunts, one was assisted by a sister-in-law, and one was delivered by her own mother and one by her grandmother. The last mother was assisted by her female neighbour who came to her rescue at the hour of need.

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Most of the women in the follow-up who delivered at home outside the health care system expressed their desire to be in control of their destiny and to give birth in friendlier environments; some of them blamed the timing, rigid birthing position, mode of placenta disposal, distance to facilities and the formal health care providers' attitude for their birth places.

The following are some of the confessions of the women explaining why they did not deliver in a health care facility.

Case 3

Akinyi was 20 years old and married. During the research, she was in her third pregnancy. She had been attending clinic but not so regularly as a result of the distance and lack of

finances. Besides the clinic, she also had her nyamrerwa whose home was close by. On the day of delivery, she went for assistance while in labour at the nyamrerwa's home and delivered there.

Akinyi's labour pain began on the eve of Christmas day at Nyang'oma Catholic Mission where she had gone to attend the evening mass. She did not alert her colleagues of the development. She persevered till the following morning despite the fact that the ANC clinic and the maternity/delivery ward were close by and were part of the mission facilities. The following morning, she walked back home alone, a distance of almost ten kilometres instead of passing by the clinic. Her reasons of not going to the clinic were mainly three; first, she had a bad previous experience with the hospital based care during the birth of her second baby and she therefore, did not want to go through the same experience, secondly, she feared that she would be the only one in labour pain at the clinic and many faces would be on her during the process since it was Christmas day, and thirdly, she feared that the cost would be high and she was not too sure as to whether her husband would be willing or even able to pay. She feared being detained at the ward after delivery for non-payment.

On arrival at home, she went straight to the home of her Nyamrerwa who delivered her free of charge in a homely and friendly environment. According to Akinyi, she did her work 'professionally' and assisted her by cutting the child's umbilical cord and washed it. Akinyi has promised to give her a token of appreciation. Part of her fear for facility-based delivery was on birthing position. She says that she prefers the sitting position to the dorsal one that she had been subjected to in her previous delivery.

Case 4

Atieno was a 28-year-old class six leaver who was in her 10th pregnancy. During this pregnancy, she was attending clinic at Nyang'oma though she says that she was never satisfied as everything was routine check up in a hostile environment as the sisters in charge did not understand the pain of childbirth. Five of her previous children died in their 1st month after birth. On the day of delivery, she was alone in her homestead and went through labour without any assistance. She gave birth on her own, cut and tied the child's umbilical cord and washed the baby before laying her to rest. All this long, the husband was not at home to offer her any assistance.

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Atieno was only able to receive assistance with domestic chores from her grown up children who were in school at the time of her delivery. They assisted her in the preparation of meals, fetching water, fetching firewood among other domestic chores.

Atieno's reasons for delivering at home were slightly similar to Akinyi's. She had economic/financial problems, she complained of intimidation at the clinics and the unprofessional way of handling clients, lastly, she complained that the Expected Date of Delivery (EDD) as indicated in her card was deceptive as she gave birth a month earlier than expected. She however, confessed that even if all the conditions were favourable, she still would not have gone to deliver at the hospital. All her children have been born at home and she had gotten used to that. The knowledge that the death of her other five children before the age of one month could have been as a result of lack of immunization at birth and exposure to treatable infections did not deter her from insisting that the fact that her other four children were alive was enough testimony to the fact the others were just bewitched and she did not act in time to save them. She also expressed her wish to reunite her newborn baby with the ancestors through the placenta burial in the compound like she had done to all the rest and raise its stakes in the family inheritance. Giving birth in hospital in her view would deny her this opportunity.

Case 5

Anyango who was 20 years old had separated from her husband and was staying with her paternal grand mother after the death of both her parents. The separation was culturally related under the general rubric of '*chira*'. It was claimed that Anyango and her husband had slept in the house and on the bed of their mother-in-law and their marriage could therefore, not hold. She was sent away while sick and unable to fend for herself. At her parental home, she was seen as a dying person who was wasting away, a condition associated with the dreaded HIV/AIDS. Her grandmother accused her of suffering from the disease and was too hostile to her. At the time of the study, she had been kicked out of their home by her uncles and was putting up with a Good Samaritan who was their neighbour. She was receiving minimal support from her two brothers who were engaged in fishing.

All through her pregnancy, Anyango was very sickly. On the day of her delivery, labour pain started when she was alone at home in the entire homestead as her grandmother had gone to attend a burial of a close relative in the village (By the time of delivery, she had been sent back to their home by the neighbour so that she could get assistance from her

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people). Anyango moved from one homestead to the other within the extended family arrangement in search of help and in great pain. She moved to three different homesteads. After failing to get anybody responsible enough to assist her, she sent her step sister-in-law to go and call the grandmother from the funeral. The step sister-in-law was just recently married and had not delivered and therefore, lacked any practical experience.

Anyango's grandmother came immediately from the funeral to her rescue. She found her writhing in pain. She warmed up some water and poured some on her back and some on her belly as a way of facilitating quick delivery. Later that evening, she gave birth to a baby girl and named her after her late mother. The after birth came out immediately after birth, but a piece locally referred to as '*wino*' (string) remained behind which took four days before coming out. Anyango informed her grandmother about the '*wino*' a day after delivery. She discovered this when she went for a short call and saw something hanging downwards. When the grandmother was told, she administered some traditional medicine that did not help much. On the fourth day after delivery, another woman who had come to the home for a gathering (*nyoluoro*) helped her by warming up water and massaging her belly several times before the *wino* came out almost rotten and very smelly. This was very painful to Anyango. In her own words, she said;

> "I almost died. My experience in birth was limited. I had been sickly and even those who were supposed to help were at times very indifferent. the clinic was far away and even if you went, you took the whole day and received inadequate treatment. Besides this, the nurses saw me as a sick person who could not be touched and I felt very sorry for myself the whole period. It is only by the grace of God that I am still alive. It is only you the research team that I have come to regard as family in this last days and the only people I found considerate enough for me to tell my predicament"

It was however; sad that Anyango died a month after delivery and her daughter also died three days later due to lack of food and proper care.

Case 6

Awino was a 20-year-old mother of two and this was her third pregnancy. She was married in the village. Awino started going to the clinic in her 6th month of pregnancy. She reported that she had delivered all her previous babies in Hospital. During her pregnancy, she did all her household duties and even went gardening. Her parents in-law who are generally of good economic base assisted her a lot in providing for food and even engaged a domestic servant who assisted her in fetching water from the Lake.

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On the day of delivery, which was one month earlier than the EDD. she had gone visiting at her birthplace to see her long lost sister who is married in South Nyanza. When her labour pain began, her sister rushed to the Lakeshore to call one of the village *Nyamrerwas* who had gone to fetch water. She was left at home with only a young daughter to her sister who was very fearful, scared and not helpful to her. When the sister arrived back with the *nyamrerwa*, she had already delivered all by herself. The nyamrerwa only cut the umbilical cord and advised her accordingly. The same day after delivery, she took a bicycle taxi (*boda boda*) to come back to where she is married. This is a distance of more than 20kms and on a very rough terrain. She however, arrived safely and she was welcome by her husband and the parents-in-law. Besides the baby, Awino carried the placenta with her for burial in their homestead claiming that since the baby was a boy, his inheritance rights could be jeopardized if this was not done.

When the research team requested Awino to narrate the differences she had encountered between the hospital and home deliveries, she said;

> "I prefer home deliveries if at all they can be well planned and if individuals are able to know ahead of time when their due dates are. At home, the nyamrerwa offers comfortable care and in a familiar environment surrounded by family and friends and other assistance in a variety of ways such as washing the baby, warming water for massaging you and also ensuring that one is part and parcel of the process. The hospital environment brings with it the idea of medical professionalism which alienates the women themselves from the process and makes them over dependent on other people. The handling of the afterbirths in the clinics also does not respect the cultural requirements as you are never allowed to carry the placenta away for burial".

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The respondents who had delivered in the hospitals did not have good experiences either. They complained that they were abused and handled in ways that they did not like. Besides being left on their own, they were slapped and beaten by the providers and even scolded. Two respondents commented:

> "I delivered at the Bondo hospital where I was ordered to push and beaten when I ran out of energy to do so. The nurses treated me as if I was pretending and joking with them. I felt so bad" (A 24 year old mother of three).

The second respondent reported that the providers even called other providers to see her naked during delivery and she felt very embarrassed and abused. She said:

> "When I was delivering, the two nurses attending to me ordered me to push and even called the third male nurse to come and see what was happening. Since I was naked, I felt that it was only fine to be with the nurses who were participating in the delivery other than the spectators. When I was done,

all of them were laughing sarcastically which left me more ashamed and I could not wait to leave the clinic" (A 20 year old mother of one).

Overall, Women feel that the health care delivery system is not responsive to their needs and fails short of meeting their expectations in the delivery of quality health care.

The Role of Traditional Birth Attendants

Most respondents indicated that they had consulted TBAs in their pregnancies. Some had very good accounts of how they had received assistance from the TBAs. The TBAs themselves also narrated stories of how they have been called upon to save lives in the community and beyond their villages.

The cases below illustrate the experiences and episodes as narrated the TBAs in the community as special cases they have encountered during difficult deliveries:

TBA 1

Akello gave birth in the morning at around 9 a.m. and by 5 p.m. in the evening; the afterbirth had not come out. During all this time, she was praying in the company of her sister-in-law, mother-in-law and neighbours who were all members of a miracle church called *soul winning*. They had hope that a miracle would happen and the after birth would come out. When they realised how dangerous it was becoming, they sent for a village nyamrerwa who administered her traditional herbs successfully thereby, expelling the after birth.

TBA 2

A woman was brought to the nyamrerwa with a swollen arm; she spent two days there and had a stillbirth on the third day. She could not wake up thereafter having lost a lot of blood. The nyamrerwa says that she got blood from her cow and fed it raw to the woman till she woke up. She later stayed with her in her home feeding her for two months after this incidence since the mother-in-law did not have money to either take her to hospital or buy her required food.

TBA 3

A woman who was delivering on her own at home had difficulties as the child refused to descend. When the nyamrerwa was called, she was able to 'cool down' the baby through her tender touch of the woman's tummy by massaging her and at the same time praying. Later, the woman delivered successfully

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TBA 4

An old TBA reported how she has assisted women in distress. The first case involved a woman who after giving birth, the afterbirth refused to come out and all attempts was made to no avail. She is the one who succeeded after applying her medicine. The second of her case was a lady who after delivery, the *ligeyo* blood was oozing in a dangerous way; she administered her medicine which immediately stopped the bleeding. She had a similar experience when she had gone visiting in Kisumu where she found a mother who had given birth and the *ligeyo* got cut and the woman had been bleeding for several hours. She assisted by getting the right herbs from the shores of Lake Victoria, prepared the herbs by boiling which she spread on the woman's head, her shadow and gave her some to drink. The woman later recovered fully and the baby is still well.

From the foregoing, it is evident that there is a general lack of birth preparedness. However, there are traditions and customs specific practices that are considered to be related to birth preparedness. Most respondents reported occurrences such as reduced activities both private (domestic) and public (at community level) with respect to the workload, adequate nutrition, abstaining from sexual activities (here respondents differed on the duration, some were of the view that sexual encounters should be stopped at the 5th month of pregnancy, others reported six months, whereas others said that this depends on the individual needs and preferences). However, there was a general concern that sex in late pregnancy could lead to the birth of a child covered with a lot of sperms on the body (dirty).

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Other traditional forms of preparedness included the use of '*yadh agulu*' (Luo medicine or pot medicine). This involved the use of traditional herbs throughout the pregnancy. This was seen as a precautionary measure that ensures safe delivery. Pot medicine is also said to make a woman lighter, expels all bad things in the stomach and cushions the child from any form of harm both external and internal. One respondent was against the idea of advance preparedness. She used a common Luo song that goes like this "*Min Onyango dhako yach, gima otin'go podi wakia, kata otin'go mana opuk, gima oting'o podi wakia*" (This literally means that when a woman is pregnant, what she is carrying inside her nobody knows and it would be futile to prepare since she could even be carrying a tortoise). Such attitude barred women from adequately preparing for fearing the unknown.

This mystery of the unknown is an overriding theme in the Luo cosmology as regards pregnancy and it limits familial dialogue that is critical for the preparation for the ultimate delivery as already noted.

Proper preparation is also hampered by the poor prediction on the expected dates of delivery (EDD). Among the twenty-three mothers in the longitudinal follow-up who finally delivered, eight of them gave birth more than one month before the expected date of delivery, five women gave birth three weeks before. In only six cases were the deliveries plus or minus two weeks. The remaining four women gave birth one month after their EDD. This has great implications on the abilities of the women to prepare adequately and timely.

Providers however, complained that the EDDs are determined from the information given to them by the women themselves. The calculation is based on the last menstruation dates and the accuracy cannot be relied on unless the women can rightfully remember the dates. Women on the other hand believe that providers are adequately trained to be able tell when a baby is due and any deviation from this is considered incompetence. The problem emanates from the inability of the providers to explain to the women how they determine the EDD and the importance of remembering one's menses.

It should be noted that all the above discussed demand and supply factors have great implications for safe-motherhood. The provision of health care services must conform to the demands and must reflect the environment in which they are provided. Clients have to be made to feel safe, respected and valued for the antenatal care to make a difference in maternal health.

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CHAPTER SIX

ANTHROPOLOGY AND THE MEDICALIZATION OF PREGNANCY

"Imagine a pregnant woman in labour balancing on a wheelbarrow at midnight in the middle of nowhere being pushed to the hospital 8 kilometers away in a rural village in Kenya for emergency care. Also, imagine the fact that even arrival at the hospital is not a guarantee that professional care and supplies will be available" (Oyando, in the daily nation of 15th march 2000:15).

Other than the known and repeated demographic and epidemiological statistics on reproductive health that indicates high maternal mortality and morbidity, there is the anthropological view which is rooted in agency, identity, suffering and resistance to (dis)ease that produces social relations and conditions that shapes the actions of individuals during pregnancy. The anthropological rationalization of pregnancy forms the foundation of this chapter. It dissects the contestation of traditional knowledge of pregnancy as being a normal condition and the official medicalization, hospitalization, biologization and technologization of women's health.

The struggle for control over reproduction is continuously being negotiated by a range of local, national and transnational interests that challenges the conventional thought and practices stretching the dominant social ideologies. The above quote by Oyando presupposes that there is a centre of 'rescue' where the women are able to get all their problems fixed as long as they can arrive in time and as long as the services can be available. This view assumes the fundamental reality that the worldview of a people as instilled in them through the process of enculturation and socialization imposes certain knowledge which does not just go away because pregnancy and childbirth must be westernized, pathologised and the female agency downplayed.

The other fundamental omission in the statement is the entire process that makes a pregnant woman wait until she has to be carried in a wheelbarrow despite the fact that pregnancy takes nine months and within this period, it is possible to plan if she believed in hospital delivery and birth away from home. It assumes that women are not knowledgeable agents in their health seeking behaviour and must be assisted by the wheelbarrow pushers and the experts in hospital where her hopes lie and from where her entire future depends. This is because reproduction has so strongly been associated with biology in our 'modern' society and viewing it through cultural lenses present significant challenges to some of our basic

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tenets. Tensions arise in questions of agency vs control, nature vs culture, identity constructions, and reproduction under varying conditions and so on. In this regards therefore, the study of reproduction offers a window into the heart of anthropology itself.

The study reveals that while women are faced with multiple subordinations in the pregnancy process where they have to negotiate with their male counterparts to provide the resources and the authority to attend to clinics on one hand, they have also to contend with male dominated medical knowledge that undermines the female cultural knowledge. However, they are far from being passive individuals. They are reflective and active agents, often with both influence and authority within their daily reality. What the epidemiologists routinely perceive as lack of adherence to routine clinic requirements can also be interpreted to mean conscious attempts by women to be in full charge of their health and to limit pregnancy and childbirth in the hands of 'experts' who experience the pain, the women.

Medicalization, biologization and technologization of pregnancy

Medicalization has been defined as a "process by which non medical problems become defined and treated as medical problems" (Conrad, 1992). As noted in chapter four, the community believes that pregnancy is a normal condition that should not be pathologised. In this regards, many scholars have argued that the definition of pregnancy and childbirth as illness transforms women's natural bodily processes into deviant behaviour in need of correction and gives the medical profession the power to construct women's views about the meaning of pregnancy and child birth and to control, at a more immediate level, their involvement in those processes (Davis-Floyd, 1992; Martin, 1992; Rothman 1991).

Starr (1982) reports that the process of medicalizing birth resulted from the struggle of medical practitioners to gain cultural authority and economic power in the USA and to increase demand for their services. This process was accomplished by the extensive medicalization of pregnancy and childbirth and the ultimate elimination of the competition of midwives.

Sullivan and Weitz (1988) reports that prior to the 19th century, childbirth was treated largely as a natural process requiring little or no medical attention. They write that in the mid 1800s, however, a number of social and cultural factors converged to open the door for

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medical involvement in birth process. The factors included the cultural belief in science as a means to improve the living conditions and to minimize pain and suffering, as well as the Victorian gender roles that portrayed women as frail and weak and, therefore, unable to withstand the pain of childbirth.

Davis-Floyd (1992) and Martin (1992) report that the rise of medical involvement was also supported by a broader philosophy that emerged around the time of Industrial Revolution. In this paradigm, the human body is seen as the prototype, and, consequently, the female body is defined as a deviant aberration. Applied to reproduction, this paradigm suggests a production metaphor in which women are seen to manufacture or produce a child. Resulting from this metaphor, the female body is viewed as imperfect and prone to "malfunction" and the resultant of the metaphor is to conceptually shift control over childbirth from women to the medical profession so that "the woman becomes the recipient rather than the producer of the child" (Rothman, 1978:125). This metaphor enters the day today language of women who also portray themselves as having received the babies from the doctors in such statements as 'this is the doctor who *delivered* my baby'. Some evidence indicates that few expectant mothers refer to delivery as "*my labour*" or "*my childbirth*" and instead employ expressions that depict a relative lack of active participation (Martin, 1992). In this regards therefore, women may have been successfully and safely delivered of a child, but often do not feel that they have subjectively experienced their own labour.

Medical concerns about the safety of the woman and her unborn child do not always incorporate either the woman's own concerns or her informed demands. This produces conditions inimical to a harmonious staff-patient relationship and instead, it creates a patron-client relationship. In the same view provided at the beginning of the chapter by Oyando, "Imagine a pregnant woman strapped to a table and commanded to push or subjected to a variety of unexplained needles and examinations and foetal monitoring machines that relay the information to the provider other than the pregnant woman" this indicates that women in labour in health care facilities are denied choice in this settings and they experience a variety of negative reactions ranging from frustrations, anger to disappointment. This process of over medicalization of childbirth produces a concomitant reaction, that of dissatisfied female patients. This dissatisfaction finds expression in female behaviour as they relate to the official health care system.

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Anthropologists who have been critical to the medicalization of pregnancy and childbirth have been of the view that the process has eliminated a definitive member of the birthing team; the female patient. The process has made the woman an object upon which the staff works and from which it delivers what is often perceived as the primary patient, the baby. In this regards, Hahn (1987) criticises the role of the physician as 'the conductor of physiology and reproduction, with the woman a fairly discernible participant' (1987:262). This is further seen as the validation of women's birthing experiences through the traditional, patriarchal realm of medicine. According to Martin (1992), science represents a male-biased model of human nature and social reality, and therefore, infuses the scientific, hospital experience for labouring women with male oriented ways of seeing.

As already mentioned in the results, birthing position in hospitals is a contested area where most women find the medicalization process inconsistent with their cultural practices and perceptions of the birthing process. In most societies, birthing while squatting, sitting or standing where gravity is an additional aid in expelling the child, are recommended over the usual lithotomy (supine) position. It can be argued that the truth is that delivery can be accomplished with the mother in a variety of positions. This can enhance a woman-centered inclusion instead of the recommendations of the dorsal lithotomy position. Korte and Scaer (1992) further argue that the upright position with the assistance of gravity increases the strength of contractions and dilates the cervix faster. Women report less pain in the upright position (1992:105). As for most women in the study area, squatting was the preferred birthing position. Though, others mentioned that they find the sitting position more appropriate.

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The holism of these women and their sincere belief in the inherent normalcy of birth and the oneness of mind and body should never be taken for granted. There should be an assurance in the existence of options that benefit all women. The society should never deny women their power as birth-givers and confine them to institutions where their individual capacities and the joy of motherhood are limited and only shared 'second hand'.

As a result of these societal and cultural changes, childbirth and eventually pregnancy came to be defined as illness in need of medical attention and technological intervention (Sullivan and Weitz, 1988). As reported by Raikes (1990), the process of instituting antenatal care in Kenya came from Britain and it was a missionary driven process. Little

was done to transform the cultural thinking towards a belief in science and to alter the definition of pregnancy to make it amenable for medical intervention. Lack of that ground preparation led to protests in women who were supposed to be assisted by the said technology. The forms of subtle protest has persisted to date in which women 'refuse' to at times go for medical care as a means of consciously being defiant of an imposed logic that has no relevance in the cultural system.

Although there is little doubt that medical intervention in pregnancy and childbirth serves a number of important purposes, especially the protection of the health of the mother and the baby when complications arise, research indicates, however, that medical involvement often has a negative impact on the expectant mother's level of perceived participation in and control over their pregnancy, childbirth experiences and indeed over their own bodies. Martin (1992) reports that the use of technology and other medical interventions appears to make some women feel personally removed from the birth process. The expectant mothers report that their bodies seem separate from their overall sense of themselves and must be manipulated for birth to successfully occur. Other women feel that their bodies are defective and blame themselves when complications arise during childbirth (Davis-Floyd, 1992; Martin, 1992).

Pregnant women have to deal with several power relations. Besides their husbands and men in society, they have also to contend with the power of the medical profession that exerts control over their childbirth experiences that is evident in the passivity of many expectant mothers during labour and delivery. Research suggests that many women feel constrained by hospital etiquette and are afraid to express excessive pain or make too many demands (Davis-Floyd, 1992). This has been seen to result partially due to the transfer of ownership of the childbirth process from the expectant mother to the medical profession. The results of the study indicate that women truly wish to have ownership of their pregnancies and their babies in such a way that their visiting the facilities and the pragmatic oscillation in several health care facilities are meant for the ultimate positive outcomes.

The numerous issues involved in biological and social reproduction have moved anthropological study of reproduction to a new terrain, towards an examination of the many local and global social, political and economic practices involved in the biological and social reproduction of people and societies. Social constructs have been validated in which

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maternity is represented as a central dynamic in the gender identity of women. Men have been portrayed as being distant in the reproductive process, while women are portrayed as receptive and passive: 'men make women pregnant, women get pregnant'. Furthermore, as fathers, men are also not expected to have much direct contact with newborn children, at least until they start to walk or talk. This process further marginalizes one of the central actors in reproduction with express complicity of men and socialization from fully experiencing fatherhood at a time that is critical for bonding and their influencing infants' personality.

From the results of the study, it has been clear that there are certain customs and taboos observed by pregnant women relating to food avoidances, relationship during pregnancy and the power structure, which are all the reflections of the social attitudes of the Luo women to the birth of their children. In this regards, women act as competent social agents responsible for their actions and negotiating for social space in a culturally defined environment without necessarily shaking the social order. As already mentioned by Ominde (1952), "the aim of the customs and taboos can only be appreciated in the light of a social desire for the woman to give birth without difficulty", from this we can discern that the two approaches; that's the cultural approach and the medical approach are at times at crossroads and that needs to be understood. Concerns with ensuring the health (survival) of the mothers and child are evident in the various rituals that are observed throughout pregnancy and following delivery in all cultures. In nation states, this concern has parallel expression in the medicalization of reproduction.

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In Kenya as evidenced in the results of the research is that with respect to pregnancy and childbirth, the policy portrays us as a nation state. As a nation state therefore, there is the willingness to subject pregnancies to medicalization and biologization thus, removing it from the hands of 'social experts'. This is done without bearing in mind that the rural areas have limited contact with the advances in technology and that the infrastructure cannot be able to conform to this expensive devices that are invented, promoted and driven by the international health programmes in liaison with big profit driven pharmaceuticals that find an expanded market by subjecting pregnancy and childbirth to the biological realm.

Anthropologists such as (Davin, 1978, Lewis, 1980 and Manderson, 1996) have noted that over the past century, women and children have been increasingly subjected to health

programmes designed to reduce maternal and infant mortality, which emphasize antenatal care, supervision of birth and the regulation of midwifery, and the monitoring of early infant care and feeding. The problem is that this process has been done without recourse to the women's daily care of their own bodies and without consultation with all shades of women in order to understand their own demands and wants. In the process, there has been a dominance of the medical understanding of women's bodies that has reinforced control creating new terminologies like 'Doctors giving birth and not women'. Statements like 'this is the doctor who delivered my first son' are common nowadays in the discussion of pregnancy and birth.

During one of the FGDs with school teachers, the WHO generated statistics on maternal mortality and morbidity was stated, they were informed of maternal life time risks in Africa in general and Kenya in particular and the number of women dying world wide as a result of childbirth. To many women in the group, they saw this as an attempt to scare them and portray birth in a language that made nonsense of their knowledge on pregnancy and childbirth. They confessed that the picture painted was one that made them feel more scared in getting pregnant and they had a feeling that this process markets medicalization as the only way out of the high maternal mortality. Most of them were of the opinion that they were better of being ignorant of the statistics and carrying their pregnancies to term without the anxieties created by the scaring numbers. In this we concluded that the quantification and interest in numbers may interest the donors and development agencies but it may have negative effects on those who experience the pregnancies. It does not help to travel if you must, to know that the day before, there existed a plain crash and all on board died. Many women in this sense today, approach birth with more fear and less confidence than ever before resulting from the information on the possibilities of complications and for the inevitability of routine interventions.

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The foundations of cultural knowledge among Luo women is the belief that birth is a normal and natural process and that women have an inherent ability to give birth. Women with confidence in their abilities are able to tap into an inner wisdom when giving birth. This is quite different from the prevalent view that birth is fraught with the likelihood that things can go very wrong, that birth is safe only with continuous monitoring, management, and interventions by the health professionals and that many women simply cannot give birth safely without medical intervention.

From a social constructionist view, the doctors do not simply reveal realities but construct and reconstruct for example, their patients as informed or articulate or as that difficult woman whereas patients reconstruct their doctors as caring or vague, or arrogant, incompetent and all that. Patients just resist becoming the kind of persons the doctors supposes them to be. In this regards and view, providers are more at home with the controlled and patients who show extreme ignorance and less questioning tendencies. They complain of educated patients who are too aware of the procedures and question certain provisions. When the two worlds appear apart, the patient as the less powerful partner in the arrangement has to give way. The simplest form of dealing with this powerlessness is to avoid the facilities all together.

In addition to the power of the health care system, women have to deal with the male power and control over their social lives. Men are seen as important influences on the reproductive health of others. These influences are numerous and may involve direct effects, such as social violence, as well as more indirect effects, such as the mediation of resources available during pregnancy and childbirth. Because most societies privilege men in both the private and public domains, men also structurally affect the reproductive health of others in ways that women do not, namely, the positions of authority that they occupy, the resources that they control, and the sexual and reproductive norms that they support or subvert. The results have clearly shown how men are the providers of finances and the people consulted in decision making and at times, the sole decision makers on where, when and who their spouses consult during pregnancy. The fact that reproduction is a biosocial event also implies that other people besides the biological mother and father are usually involved in it in all societies making it a socially collective effort.

In the current demographic analysis of reproduction, there are a few interpretations that address the issue of gender power imbalances. These analytical models tend to legitimize assumptions about gender relations since the paradigms are based on concepts of gender that place men and women on opposing spheres. This type of analysis assigns men the privileged positions of defining the socio-economic context in which biological reproduction occurs. These models do not indicate men's detachment from the biological reproduction and their concentration on social reproduction.

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With reference to Oyando's statement. the assumption that reproduction is primarily a biological issue and that its management must of necessity be facility based indicates how socially constructed realities that are mediated by power differences are played out in contemporary thinking. Kenya has invested too little in social welfare and more particularly in the rural areas. The little investment they have had was also interrupted in the early 1990s when the Breton woods Institutions insisted on cost sharing in health care. Besides poverty and illiteracy that are primary determinants of accessing services, Kenya is also faced by political considerations in the resources allocations. The past two regimes from independence singled out Nyanza Province for blanket punishment owing to political differences at the National level. The punishment found expression in social public institutions and services such as education, infrastructure and health care.

In health care, the central government starved the region of resources both human and supplies. Not only was this done, they also created demand for hospital based care in pregnancy by demonizing all, the cultural institutions that women used for care. If it were not for women being conscious agents of their own health and by use of pragmatic means, the results would have been more disastrous than the statistics we are bombarded with every five years in the Demographic Health Surveys.

As the results reveal, there is minimal father involvement in the birth process. This limitation reflects the social and institutional barriers such as gender roles that define the father's role largely as breadwinner (Lorber, 1994), work place norms that discourage men from taking time off to care for children and the relative lack of resources and instructional materials aimed at educating new and expectant fathers (Doyle, 1995). There is need to rethink our work place practices with a view to institutionalizing paternity leave with a clear mechanism to compel men to be more involved in postnatal care.

Overall, the discussion should not be seen as inherently anti-medicalization of pregnancy and childbirth, but more as a critical process that calls for the due recognition of the women as the primary owners of the pregnancies and as the people who ultimately deliver the babies other than the professionals. It should be able to recognize women as conscious agents who shape their destinies in certain pragmatic ways other than being passive recipients of male driven technology.

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Above all, the discussion should be seen as a wake up call for society to provide forums for thoughtful discussions, reflections, awareness creation and analysis. The final right decision is always a personal one, made after exploring options based on full information. Our beliefs, values, language, and habits cannot easily be detached and changed but are part of our identity, and this raises the troubling question about the extent of free will and autonomy. Attempts to alter people's responses, such as to control chronic pain or to promote a healthier lifestyle are more likely to succeed when the social context is seen not as a set of separate variables but as a complicated overlapping mixture of many interacting factors. The experience of pregnancy and the inherent pain in it is partly a social construction and at the intersection of body, mind, and culture and it varies according to complex personal differences, and effective health care has to be sensitive to these.

The concept of health as a right to all people requires the recognition of gender equity and equality as a basic premise for its attainment, calling into question the models of social and institutional relations that have been constructed to define the setting for reproduction.

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CHAPTER SEVEN

SUMMARY, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

SUMMARY AND DISCUSSIONS

The results of the research reveal several socio-cultural and socio-economic factors that make safe motherhood problematic in Bondo district. Among the socio-cultural practices, views and perceptions that hamper proper antenatal health care include the community's views and definition of pregnancy, the gender avoidance behaviour patterns, the cultural pressure on women to reproduce, the cultural idea of endurance exemplified in the heavy workload during pregnancy, low male participation in reproductive concerns, lack of appropriate communication between spouses at family level on pregnancy and childbirth, food taboos and avoidance, disjointed social support system, the role of co-wives and the associated jealousy during pregnancy, the belief in spiritual and ancestral intervention in birth outcomes and the gender power imbalance that reduce women to mere spectators in their own pregnancies.

Additionally, there are problems with the demand as well as the supply factors that hinder proper provision of health care and that must be considered for safe motherhood interventions to succeed.

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7.1 Pregnancy in the cultural arena

Pregnancy and childbirth is found in all communities of the world. The difference is how it is handled in various cultural settings and how much power and self-determination women have in different cultures. The findings of the research reveal the following pattern of activities and beliefs about women and reproduction in the study community:

- Pregnancy is a welcome state and a means through which women prove their reproductive power.
- Pregnancy is culturally viewed as a normal condition and women continue with their normal routine even in pregnancy. All the cultural activities surrounding a pregnant woman do not pathologize her condition and are geared towards the safety of her unborn baby.
- Several cultural practices such as avoidances, proscription and prescriptions in behaviour and feeding patterns accompany pregnancy.
- Many women get married or begin reproducing at a young age.

- There is belief in the power of prayer and ancestral spirits in birth outcomes.
- Most women have high birth rate with many children.
- There is co-existence between traditional beliefs and dependency on modern health care services and women get care from both traditional and biomedical systems in an oscillatory manner.
- TBAs are a major source of antenatal care and deliveries.
- Women relate poorly and have negative views of official health care.
- Most deliveries happened at home or outside the facility arrangements.
- Poverty, distance to facility, terrain and low status of women in the community are factors that limit women's reproductive choices.
- Women have an array of therapy managing group that assist in decision making which at times constrain their choices. The decision making process is hierarchical and patriarchal thus alienating women who are the primary bearers of pregnancy.
- In terms of coverage, the division has very few and scattered maternal health facilites which limits access to healthcare.

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Over time, qualitative research has clearly demonstrated that there are several culture-based barriers to timely obstetric care. However, more often than not, individual specific cultural studies with long-term longitudinal follow-ups are never done to clearly spell out the depth of the effects of culture. This lack of deeper inquiry into the local contextual factors within which pregnancy and childbirth occurs does not often bring out the true picture or produce the desired results for elaborate health care interventions. As Moore et al. (1997) observed, it is the detailed understanding of the specific socio-cultural and other underlying factors, and the distinctly local interaction of these factors, that allows for the development of a truly effective behaviour change programmes.

The study results give a picture of the female experience of pregnancy and childbirth and amplify the maternal voices in the cultural wilderness. This mode of thematic analysis brings out a clear pattern of what the primary bearers of pregnancy feel and how that feeling determine the outcome.

Definition of pregnancy and the cultural pressure

The normalcy of pregnancy in the Luo community means that it does not require medical intervention, more so, the hospital based care. Traditionally, pregnancy and childbirth was

seen as a female domain and most TBAs if not all were women. This situation is however, today being challenged by the promotion of facility-based care.

The normality of pregnancy imposes certain cultural conditions on women that makes them dependent on the 'custodians' of community values regarding pregnancy and childbirth who insist that the process should not be pathologised. At the individual level, pregnant women have to contend with the definition and interpretation of the social reality as handed over to them by the old women in the community. They are forced by social circumstances to follow the advice of the *nyamrerwas* and the mothers-in-law. Right from the time of conception, a young woman's life and actions are never in her own hands and she cannot determine her own destiny. She has to contend with patriarchal avoidance relationships, culturally prescribed food avoidances, be involved in tasks that do not recognize her condition, be a spectator in her own pregnancy and act in accordance to the whims and wants of those around her other than her own self. Right from the family level to the larger society, the pregnant woman has to act in ways that conform to certain prescribed norms other than her own physical, psychological and physiological demands.

Despite the lack of due recognition of the female bearer of a pregnancy, men had high expectations and derived prestige from the outcome. The cultural belief in the centrality of children to the continuity of a lineage created a lot of pressure on the women to reproduce. The peer pressure, personal internal pressure and the cultural pressure to conceive and give birth was found to be so strong in the Community. Birth is so important to the survival of a marriage and the family unit and women are seen as the bearers of the reproductive responsibilities.

The strong cultural belief in the desirability of the male children, who are expected to continue the patrilineal lineage and are seen as heir apparent in inheritance creates further reproductive pressure on women and in the event that a couple have only daughters, the woman takes the blame and is hounded in the marriage and threatened with divorce, separation or the marriage of additional wife. The fear of loosing a husband in a community where marriage is central to female identity places heavy psychological burden on women and they live in constant fear while pregnant. Others go as far as trying to please the men though temporarily through 'feigned' pregnancies.

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The pressure on women comes from all quarters including from fellow women who are already established in the clan. These women include the mother in-law, sister in-law, the aunties to the husband and at times, the wives to one's brothers in-law who may have been 'blessed' by giving birth to sons. Women in the study often relied on their own kin for emotional support in situations of extreme disregard resulting from the birth of daughters.

Additionally, pregnancy definition limits the health care options women can resort to. Pregnancy in the cultural set up involves the belief in the influence of 'spirits' on the birth process as well as the outcome, the belief in the traditional medical regimen and the efficacy of traditional herbs, low perception of overall risk and less expectations of obstetric complications, disregard for birth plan or delivery preparation and the preference of home deliveries. It also involves the belief in fate and the intervention of ancestral spirits in the conception process. There is a belief in God, *Nyasaye* the Supreme Being who as Ocholla-Ayayo (1976) observed controls life and from whom all powers originate including the 'gift of birth.' As mentioned, when a woman delivered, it was said that God had helped her (*Nyasache osekonye*). This was a clear testimony to the belief that the power of childbirth was beyond the human person. In the same vein, the ancestral spirits were seen as being 'alive' and playing a big role in the life of the living. They are seen to be the intermediaries between the people and the Supreme Being. The spiritual causes of discomfort were dealt with through prayers (Luke, 2000) and through the intervention of ancestors by means of rituals and sacrifices.

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Despite the cultural urge to have a child and the cultural definition of normalcy, a pregnancy was noted to have certain unpleasant experiences and consequences that women have to deal with during the process. Some of the symptoms and risks during pregnancy include nausea, hypersensitivity, dizziness, tiredness, testiness, swells, constipation, frequent need to pee, hypertension, abdominal cramps, heartburn, swollen breasts, darkening of the nipples, backaches, itching, pimples, stretch marks, spots, medical tests and treatment, warnings, dietary rules, fears, guilty conscience, reduced sex drive and attractiveness, depression, dependence, vulnerability, early or late miscarriage, scars, anaemia, painful delivery, premature birth, permanent scars, injury, loneliness, worries, sleeplessness, exhaustion, loss of blood, reduced mobility among some of the unpleasant experiences. These experiences had to be endured by women and the more endurant an

individual was in dealing with the above risks, the higher the chances that the husband and his kin highly regarded her.

Towards delivery, there is reduced mobility. Since women derive satisfaction in care giving, reduction in mobility creates frustrations and disappointments. These results from the societal expectations on women to continue providing care to all family members at all times.

Inspite of the discomfort, it was observed that the cultural pressure to have one's own child far outweighs the inherent problems. During the forty weeks of pregnancy, the woman becomes a centre of attention in ways that are not geared towards her safety, but the safety of the potential and future member of the lineage she is carrying in her. She becomes an arena of cultural power play, a site of male prestige and proof of their fertility and an important rite of passage in the community. The observation lead to the conclusion that women bear the heaviest burden in childbirth and culture sometimes acts as an additional burden in the process. In this regards, safe motherhood intervention strategies must be designed right from the communal level for it to succeed in ameliorating the female burden.

Avoidances relationship, the case of Mary

Pregnancy state as observed in the research is accompanied by a myriad of social prescriptions and other culturally imposed avoidance relationships at both the family level as well as the society level. Of importance here are the behaviour patterns expected of the pregnant woman in relation to her other relatives particularly the father-in-law. Other requirements mentioned by women in the follow-up involve the proscribed encounter with other women in ways that can be defined as quarrelling, sitingt on a grave, fighting while pregnant or attending the burial of a woman who dies in childbirth. The husbands of the pregnant women are also expected to observe certain behaviour patterns that do not pose any danger to the welfare of the wife or the unborn child. One of the above customs that was encountered during the research was that of daughter in-law, father-in law avoidance.

Take the case of Mary, mentioned at the beginning of chapter four, the avoidance was observed at the expense of assisting a needy case who would have died in the process. Mary's case required immediate medical intervention, as she was not diagnosed during her

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pregnancy as having twins. The interval at which the two babies were delivered was too long and she was becoming frail and tired. The means of reaching the health care facility was only by bicycle and it had to be men to assist in pushing the bicycle given the terrain. If it were not for the intervention of the research team, the consequences would have been more tragic.

Culture in this regard can be seen as a bottleneck to proper care. The men who were not really Mary's father-in-law but appropriated that position inferentially resulting from the extensive value of *wat* (relatives) insisted that getting in any direct contact with Mary would have been a cultural disaster and if anything had happened to Mary, the husband would have held them responsible. After Mary had successfully given birth to her twin babies after the intervention of the research team, when the men were asked whether they regretted having not assisted Mary, they reported that they were very lucky to have respected the cultural demands The fact that Mary gave birth to twins meant that it would have been a very expensive exercise to cleanse them. The men avoided seeing Mary during the temporary seclusion period immediately after delivery and had not come to see her one-month after delivery. When the husband came back, he invited the *nyamrerwa* and other people who were reported to have assisted Mary. During this occasion, he slaughtered a goat and people ate and drank as a gesture of appreciation. The celebration, we were later told was a cleansing ritual requirement that usually accompany the birth of twins. The members of the larger clan particularly the fathers-in-law avoided the ceremony and were later heard talking ill about the whole affair.

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The moral assumption is that when an individual assumes a sick role as in Mary's case (not because of the pregnancy, but because of the complications in delivery), the expectations would be that anybody would be willing to assist her irrespective of their relationship or irrespective of the misunderstandings and shortcomings at the local level or the village politics. However, as noted, other factors beyond the sickness come to determine whether one would be assisted or not.

Other taboos observed that had bearing on maternal welfare included the concept of *chira* mentioned earlier in chapter four to explain Anyango's condition. Instead of the family trying to find out means and ways of assisting her during her pregnancy, she was seen as a dying case resulting from the belief that having slept on her mother-in-law's bed; she was

not 'rescuable'. This idea determined how the rest perceived her and was responsible for her ill health and the burden in pregnancy.

The other case of ill health emanating from the taboo as explained by the respondents was the case of Akinyi (case 9 in chapter five) whose child's ill health was explained as having resulted from their eating together with her brother in-law who had not married. Her explanation has the potential of limiting sibling contact and increasing rivalry and bad faith amongst brothers and their families. Overall, it was noted that the proscriptions and prescriptions in behaviour limited the female choices in pregnancy and increased the burden of childbirth and postpartum care. Culture also reduced the number of people who could assist the expectant mother in times of distress. This therefore calls for birth preparedness and plans before time.

Gender power difference and pregnancy

The results indicate a clear pattern of gender subordination and differential power play. In all the cases as noted in chapter four, the determining factor is patriarchy and its characteristic face of domination. Men for instance insist on having sons and see women as the problems whereas it is a biologically known fact that the determinant of the sex of a child is the man, but since women are less powerful in most African set ups if not all, they are called upon to bear a burden and to suffer the consequences of a mistake that is not of their making. Women are never accorded the respect they deserve. They are blamed for all manners of shortcomings, punished for mistakes not of their making, denied access to medicare, culturally impoverished and downtrodden in most spheres of their rural lives and beyond all these, denied the freedom to make personal and informed reproductive choices.

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Reproductive health which has been defined as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes (WHO, 1998; Toroitich, 2004) implies that people should be able to have a satisfying and safe sex life. It also implies that people have the capability to reproduce and the freedom to decide if, when, and how often to reproduce. In this regards, proper and healthy reproductive health should include the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant and at the same time recognising the needs and demands of the mother.

There is always a tendency to assume that proper health care can only be achieved in biomedical institutions, however, it has been recognised that the medicalization of pregnancy and childbirth has also marginalized women to a greater degree and taken control out of their hands.

Most anthropological studies (Jordan, 1980; MacCormack, 1982; Davis-Floyd, 1992; Rice 1995; Kang-Wang, 1980 among others) have highlighted the importance of reproduction to women with respect to their personal identity and social status, and in terms of the ways in which their lives have centred around the events of biology, however, little has been done to ensure that women derive equal satisfaction from the products of their reproduction. Though it has been alleged that procreation is a woman's greatest achievement and the means by which she has any authority, I would wish to assert that through reproduction, women confer more authority to the men who are seen in most communities to confer identity to the children. Women 'assist' men in becoming 'powerful' and more grounded in their lineage and kinship network.

Central to choice making is proper sexual health whose purpose is the enhancement of life and personal relations and care related to reproduction. The empowerment and autonomy of women that ensures gender equity and equality are highly important. The present situation among the Luo where women are not only powerless but are socialised to believe that they are a supportive gender, a 'garden' or a 'vessel' for reproduction whose worth is in the product make most women to look forward to bearing as many children as the womb can allow. This not only lead women to having so many children as already seen but also leads them to mental anguish in trying to have the 'right sex'. The socio-physiological pressure created on women results from the societal expectations in which they are viewed as invisible agents in themselves but relegated to physical bodies through which the clan, lineage and nation can reproduce and develop (Gottschang, 2000). This pressure manifests itself in several ways as noted through the feigning of pregnancy, the fears and risks TO motherhood as well as through the unquestionable intrusive acceptance of the medical interventions.

Polygyny, which is acceptable in this community as well as in most African communities, creates maternal competition for the attention and love of the husband and in the process burdening women emotionally and creating more demands to outwit the co-wives. As seen

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in the study. co-wives strains relationships and are at times sites for individual discomfort and mental anguish making the pregnancy more difficult to bear and carry to term. The competition created by co-wives also brings with it a situation where women compete for the highest number of children and in the process, endangering their lives in trying to out do each other in order to be comfortable/powerful in the communal hierarchy. The value for children drives women to have many of them as an identity marker.

The socialization process in the community is geared towards marriage and teaches women the importance of marriage in their lives. They are socialized to be good and obedient wives, good mothers and obedient servants of society who must confer with their husbands before making any important decisions in life including decisions on their own health. Many girls look forward to marriage and quite often, they marry or are married out when they are still young. This poses health risks from a reproductive standpoint.

As Luke (2000) observed, polygyny, bride wealth and patrilineal descent combine in the community to exert powerful influence on women and respect is an important definition of manhood. Several instances were observed in the research process where women were compelled to see things from the male perspective and to unquestioningly agree with their husband's views. An example was in the conversation when the wife was reminded to keep quiet when men are talking. This was done in spite of the fact that the topic under discussion was about her and her pregnancy. Instead of her expertise as the bearer of pregnancy and her knowledge being respected, she was told to keep quiet and not to contribute before men.

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Besides the husband and the influence of men, a married woman falls directly under the influence and domestic authority of her mother-in-law and must be obedient to her and respect her at all times. Most women in the informal charts report that mothers-in-law are always not different from co-wives, as they tend to want to compete for the attention of the son. In this regards therefore, women find their capacities to determine their own destiny in matters of reproduction severely limited.

In terms of antenatal care and other health related decisions, women have to ask for permission not only from the husbands but also from an array of his kin network in order to attend to professional care or any care outside the home. She is not in a position to make

decisions independently and therefore, may not enjoy exclusive reproductive freedom. The women's young ages or more advanced ages are hindrances to proper antenatal care either as a result of the negative attitude of the providers or as a result of the fear of the unknown in the young teenage mothers who are still shy to face the society in their new roles. The belief in and benefit of facility based antenatal care are not yet evenly distributed in the community.

Additionally, the sexual freedom men enjoy and their unfaithfulness has the disastrous potential of STI infections to their wives as women do not have the power to negotiate for safe sex. The Luo culture also does not expect women to deny their spouses the conjugal rights irrespective of the circumstances. Denial can lead to divorce as shown in the case of a second wife who was diagnosed with STI and the husband could not take any of it. Instead of him going for treatment too, he saw the wife as the bearer of the bad news and sent her away. The secrecy in which women are expected to operate and keep family secrets including the secrets of their suffering is burdensome to say the least. It may be difficult if not impossible to suffer in silence knowing very well that the silence cannot be a solution to one's problems.

Wife beating and other forms of physical, verbal and psychological assaults appear to be tolerated in the community. Though it is not culturally acceptable for men to assault their wives verbally, women faced violent home environments resulting from mistakes that were not of their making. The case of the woman who was beaten and sent away because of the STI is a clear testimony. The other case was of the lady who gave birth to daughters only and the worries of several women as reported in chapter four. Moore et al. (2002) in their study of Homa-Bay district concluded that wife beating appears to be a common culturally acceptable practice among the Luo community. The overall picture is that women live in constant fear of those they 'love'. The institution of bride wealth and the view of marriage as a lifelong undertaking and the conferment of identity to children on the male line (patrilineal descent) all combine to deny women the ability to walk away from violent and falling marriages or from being critical in the relationships. All the above have greater implications for safe motherhood.

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Social support system in pregnancy

The expectant woman in the Luo community has to depend on other people for assistance in decision making in her daily living. This is done by a number of people in her immediate environment. She is not the sole decision maker regarding her care-seeking pattern during her pregnancy. The social network and the therapy managing group consists of a network of related kinsmen and women who ensure that the woman observes the traditional rituals, attends to antenatal care be it biomedical or ethnomedical, is protected against the effects of jealous relatives or other people with evil designs.

There is generally a visible concern for the protection of pregnancy and the expectations of the outcome. This is perhaps where there is a problem. The observation in the community is that the concern shown for the expectant mother is not in her honour but in view of the product of her reproductive success.

At the family level, there are minimal if any discussions or communications that place the woman at the heart of the talk. Men were reported to give assistance in monetary terms but women wanted comfort emotionally, expression of love and affection and other care beyond the money. Men on the other hand felt that the women were sometimes too demanding. This divergent opinion and difference in expectations created familial tension with discussions only limited to sporadic question-answer session after clinic attendance or whenever the women complained of any illness.

Among the few men who gave assistance to their wives in the domestic sphere, the accusations made against them were clear reflections of the socialization process and the gender role divide which did not allow men to venture into the domestic/private domains such as in the cooking and performance of all other duties traditionally defined as female preserve.

Mothers, grandmothers and aunties were a pillar of support for the teenage pregnancies. The mothers went out of their way even risking or confronting the violent behaviour of their husbands to create an enabling environment for their daughters who had conceived out of wedlock. In the process of doing this, they were assisted by their other female kin in ensuring that the pregnancies were carried to term and that the daughters gave birth in an environment of love and care. In situations where the fathers were too hostile, the teenage

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girls through the arrangement of their mothers went to stay with their maternal grandmothers or aunties. In the long run, the men came to accept what they could not change.

The support system as noted determined the health care seeking pattern of the pregnant mother and assisted in easening the pregnancy burden. In other situations, the support system acted in ways that curtailed individual choice and limited the female agency.

Importance of social support

It is clear that lack of intra-familial communication about matters related to childbirth such as routine planning for anticipated normal births, ability to discuss problems when they arise, and particularly the onset of a complication and the need for emergency care hinders timely use of skilled care (Moore et al. 2002). Programmes now tend to encourage dialogue and discussions between and among the various support networks around the woman. It is now recommended under the focused antenatal package that during antenatal care when women visit clinics, they have to be told the advantages of family communication, Individualised Birth Plan (IBP) and other related issues that make the pregnancy process socially bearable.

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The results indicate that women and men operate in two different worlds and only converge in their expectations of the pregnancy outcome. Women feel shy and unable to share their experiences and feelings with their spouses and in the process become the sole bearers of the burden of pregnancy and childbirth. Men on other hand have been accused of being aloof beyond 'implanting' the seed. Rarely do they initiate discussions and wait for the women to open up. The opening up process is never easy on the female side as they operate within the cultural confines where pregnancy and childbirth are a female burden. The ensuing tension limits the degree of social support available to a pregnant woman.

Women who received care and support from their spouses like the wife of the high school teacher reported in chapter four indicated that the assistance enabled her to go through her pregnancy with minimal stress. Although she had several malaria attacks, she was able to get to Owens clinic where she received high-professionalized care and was one of the clients who gave birth in a clinic. She was generally happy with the pregnancy and the outcome at the end of the day.

The social support system is very vital for individuals who are faced with difficult situations and need maximum care. The family becomes the first line of care and support and bedrock of safe motherhood intervention. It is from the family that all the social ills that afflict pregnant women emanate and it is therefore, the arena where it can also be eliminated for the general good of future generations. The whole question of socialization and patriarchy as the overriding principle can only be effectively challenged in a micro familial level before being applied at a larger societal level.[35] Women with strong social support system whose partners are responsible can be able to have reduced workload, eat well balanced diet and be able to have less stressful pregnancy episode. In the long run, this can improve and make motherhood a desirable undertaking.

Feigning pregnancy

As noted in the study, the cultural value of children created tension among women who could not have children as is expected by their spouses and culture. The two cases presented in chapter four clearly illustrate this societal pressure. Allen (2002:176) also reports similar findings in Tanzania and calls it "pregnancy that turned to the back" and cites a case of a woman who was reportedly pregnant for three years before delivery. The explanation she has is that either the women were trying to conceal their pregnancies or abortions that go awry. She further reports of a Sukuma man who informed her that a pregnancy that turns to the back was a socio-psychological condition that reflected the social pressure exerted on women to bear children. In the man's experience, women who had never given birth before, or those who had histories of miscarriage seemed quicker than women without prior history of fertility problems to define their missed menses as pregnancies.

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According to Allen's analysis, the stigma of infertility diminishes somewhat or least initially if a woman is instead diagnosed with a pregnancy that had temporarily disappeared and turned to the back (2002:178). The difference between her findings and the present findings is that the prolonged pregnancy in her study resulted from concealed pregnancies and attempted abortions whereas in the present research, the pregnancies were cherished and welcome and women were eager to be seen and recognised as pregnant. Overall, the two examples cited in the study are a clear show of the dangers in pregnancy and the

[35] It would be important to have a systematic but incremental gain in the field of female empowerment. Starting from the family by giving women the voice and freedom of choice in this arena becomes the best approach.

different views to safe motherhood that must be incorporated in any safe motherhood programme.

The cultural and communal expectations and pressure make women live a life of fear and discomfort as they are always called upon to go an extra mile to prove their fecundity. Motherhood as already noted defines the status of a woman in marriage and increases her value, worth and power in the husband's lineage. In most situations, marriage is meant for procreation and rarely for companionship and the onus to procreate is always on the woman. Male infertility is rarely if ever envisaged as a problem or talked of openly.

The process of reconciling the two divergent views of normalcy and pathologising pregnancy has not been fully done as the biomedical side has always assumed that the benefits of antenatal care and facility deliveries are so obvious that all can see. The International Policy and Programme designers have also fallen into the biomedical trap thereby rubbishing the local worldview as ignorance and paying little attention to it. The result has been the disastrous statistics year in year out indicating increase in maternal health burden shown by maternal morbidity and mortality and the minimal utilization of health care facilities even in situations where they are provided and physically and economically reachable.

At the societal level, the programme planners place all the blame on individual women instead of the constraining nature of the relationships and control by others at the community level. This process of blame and buck passing marginalises women further and find support in the male voices that always see any shortcoming to be attributable to women. In the follow-up, it was not uncommon to hear men complain how their spouses were not willing to respect the drug regimen and how they feared going to the clinics and had to be reminded.

7.2. Care seeking behaviour in pregnancy

Looking at the Kleinman (1980) model, most pregnancy concerns were dealt with within his so-called popular sector that was culture-laden and took cognisance of the local cultural system. This sector functioned as the chief source and most immediate determinant of care. In his analysis, he concluded that self-treatment by the individual and the family is the first therapeutic intervention resorted to by most people across a wide range of cultures.

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Resulting from the difference in definition and worldview between ethnomedicine and biomedicine, women oscillate between the various available therapeutic options in a pragmatic way in their health seeking patterns. Therapy managers in individual cases move back and forth between specialists and activities of both systems. Yet the beliefs and practices constituting the systems rest upon different premises.

As observed, individuals have to take decisions in light of incomplete information, make difficult judgements, regarding future risks, or choose among imperfect alternatives, it is important to develop the conceptual and methodological tools that can capture the iterative process of decision, and throw some light on the uncertainty that surrounds individual choices. Men are the majority determinants on whether the woman seeks treatment or not, but are not competent in making informed choices since they have limited knowledge on pregnancy and childbirth. In the community, women often resorted to options that were available to them and more commonly, the TBAs and self-medication. As noted, the Legio Maria mother (*madha*) took her services to the clients in their own houses and attended to them in the comfort of a familiar environment devoid of travels and financial burden. The TBAs were also in a position to share in the female tribulations, as they were not only aware of the cultural demands, but had also been through similar process in the past. They offered help and provided hope to the poor and traditionalists who did not attend to official ANC either as a result of poverty and related constraints or as a result of the difference in worldview between the two distinct systems.

On a more critical level, Kleinman (1980) observed that the clinical realities of the different sectors (popular, folk and professional) differ considerably. Their sub-cultural components shape their illness and therapeutic experiences in distinct ways. But the power to create illness and treatment as social phenomena, to legitimate a certain construction of reality as the only clinical reality, is not equally distributed. For example, he underscores the fact that the sick person enters the modern professional medical sector by establishing her patient hood in a clinic/hospital. Similarly, in the family or folk arena, she must receive sanctions from others for a particular type of sick role, she may claim and be given an acute, chronic or impaired role, or she and those around her may disagree about the character of her sick role. Given the communal definition of pregnancy and childbirth, it is obvious that the therapy managing group may in most cases fail to accord the pregnant woman the sick role and therefore, limit her options in the health seeking process.

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The ease by which husbands or other kin members provide the funds for hospitalization or for consulting other specialists all depend on the urgency with which they view the woman's condition and how they accord her a sick role.

These conflicting social constructions have led to the reification of the professional sector represented by the medicalization of pregnancy. The professional sector requires that its form of clinical reality be accepted as the only legitimate clinical reality with professionals being insensitive to the views of clinical reality held by other healers and the expectations and beliefs of their patients. And as Kleinman observed; the process of indigenizing and popularizing that clinical reality is far from being accomplished to enable the cultural re-patterning to accommodate it fully and to see professional care as the only safe care in motherhood. The rebuke and accusation of being the site of delay by a nurse to a *nyamrerwa* who had accompanied her client to the clinic for delivery is a clear testimony to the differences in view and the demonization of the clinical reality of the other providers and the patients themselves. The confessions of a former nurse turned TBA further amplifies this tension that exist between the two groups of professionals whose goals are the same but with distinct approaches and operating in two different social worlds.

In view of the situation on the ground, Obermeyer (1999) underscored the need for a proper understanding of the multiplicity of views of health that exist in a given context, their convergence or divergence, the factors that shape such limitations, as well as the health consequences. The process requires an approach that can draw on both public health models and social sciences explanations and an ability to uncover the logic underlying practices that appear to contradict familiar models of health. She concludes that such a perspective can yield important insights into motivations and attitudes needed to improve communications practices and promote the design of better health interventions.

TBAs as the main source of health care

It was observed that in Nyang'oma, women consult TBAs throughout pregnancy for a variety of reasons, and labouring women are frequently taken to the homes of TBAs for care, sometimes remaining for several days or weeks or even months after delivery.

It was equally observed that at times, TBAs act as the initial points of contact to the official health care delivery system. Some of them engage in referrals in which case they introduce

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the women to the facilities. There were two cases where some of the TBAs were recognised and incorporated into the official health care system as a result of the shortage of staff and the lack of enough trained health care personnel in most rural facilities. The two were seen to be the darling of most mothers as they provided their services in the most acceptable ways to the women and could also be seen in their homes after working hours, over the weekends or anytime. Besides, they could visit the women in their own homes. The relationship between the women and the incorporated TBAs was a bit informal and cordial. It was not as tense as the normal patient-provider interaction in other hospital environments.

The TBAs have also been observed to offer solid social support system where women are accorded different levels of assistance. They are at times involved in the process of helping women overcome the risks TO motherhood as well as helping them through the risks OF motherhood. In the traditional set-ups, there is always the unity of body, mind and soul. The individual is seen in a holistic sense and as a member of the larger community. In this sense, the TBAs are seen to offer their services with that unity in mind paying greater attention to the socio-cultural environment.

The TBAs were equally seen to be the only professionals who offered 'postpartum care' as they continued visiting the women after delivery. They were able to advise the women on diet and provide for their other needs such as emotional comfort, share in their joy of motherhood and reintegrate them to normal life after the short period of seclusion occasioned by delivery. Culturally, the TBAs were regarded highly by women as a result of their kindness and caring attitude which was in stark contrast to the characteristics that the respondents ascribed to facility based care from skilled providers.

Overall, women in the community were more positive and receptive to the care by TBAs much more than they were about the facilities and the skilled providers. The TBA is a resource that could be further exploited as advocated for by WHO (1986) since they are already there and willing to assist. Since they are drawn from the local communities, their enculturation and socialization processes make them experts in the societal values and are more likely to understand the women in the cultural sense. They are able to fill the existing personnel gap in most rural areas as long as the process of identification and training respect their cultural knowledge and is done in transparent and well thought process

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avoiding the pitfalls of favouritism or other considerations as noted in Allen's study in Tanzania.

The religious provider, *madha* was seen to fill a big void that existed. Besides being able to visit the mothers in their own homes, she was able to give them spiritual assurance too. Among the young mothers who are newly married and pregnant for the first time, she visited them in their homes and was able to care for them in their own backyard.

7.3. Antenatal Care (ANC)

Antenatal care at biomedical facilities and provided by professionals have for long been touted as the best care in pregnancy. To begin with, Nyang'oma Division is not very well covered by the biomedical facilities and even the few that exist are constrained by lack of adequate supplies and equipment. Women who overcome the barriers of transport and other cultural constraints to reach the facilities must contend with other shortcomings that often discourage them from going back to the facilities.

Although the patronage of ANC facilities by women more particularly for the first visit is encouraging, the net benefit of that patronage has not yet been realised. It has not translated to reduced maternal mortality and morbidity as expected. The problems and constraints encountered at the facilities by women bar them from further attending as is recommended. Further, the hospital system is seen as an intimidating environment where the women are lowly regarded by the providers. Most women complain that skilled providers at the facilities are arrogant, bullies, abusive and disrespectful to their clients. Others are accused of offering their services selectively to those they know or respect in a biased way. They are further seen as not caring and full of themselves. Women feel relegated to second-class citizens who know nothing and have to be 'saved from motherhood' by the providers.

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Most women assert that they value their dignity and despite their poverty, they deserve to be respected. They see the behaviour of most providers as unacceptable and reason for not adequately patronising the facilities.

As with so many other research findings, the nature and magnitude of poor treatment of clients by skilled providers is not unique to Nyang'oma Division. The shortcomings involving both verbal and physical abuse of women during routine ANC visits, labour and

delivery have been widely reported in other parts of Kenya as well as other parts of Africa and the World (KMMBS, 1996; Allen, 2002; Neema, 1994; Moore et al., 2002; MOH, 2002).

As noted and recommended by Moore et al. in Homa-Bay, skilled providers definitely need an "attitude adjustment" (2002:106) as all categories of respondents consistently described situations of actual abuse as well as instances where widely circulated stories about abuses of patients cause women and families to hesitate to seek skilled care.

The association of certain discharges with immorality, attempted abortion and other social vices that defined women as social misfits in the eyes of the providers barred them from attending clinics. As noted by Rice and Manderson (1996), women resist from reporting and seeking care for sexual health problems, for example out of embarrassment and fear that any abnormality will be interpreted as social aberrance and physical symptoms of disease as evidence of breaches in propriety. In most situations, women themselves assume that changes in bleeding, discharge and so on, are evidence of immorality, perversion of sin; as negative constructions of women's bodies are always internalized. Overall, lack of education about reproduction and sexual health more particularly pregnancy and childbirth maintains the silence and hence the discomfort that women experience. Additional strains emerge when pregnancy and childbirth are subjected to extensive medicalization thereby alienating women further and subjecting them to a different social construction of reality.

It was encouraging to note that the providers themselves also acknowledged that their attitude was not encouraging and that they needed to change. They however, noted that the excessive physical and psychological demands placed on them by the difficult conditions of service made matters worse. Most of them complained that they work in a less appreciative environment, serve unpleasable patients, face shortages of supplies and operate under stifling bureaucracy. They also noted that they are overworked but under paid, stressed in their jobs and are exposed to the risks of infections more particularly to the HIV/AIDS virus.

Other than the staff attitude, the facilities were found to be low in supplies and had inadequate infrastructure. Apart from Nyang'oma, the other dispensaries did not have the required equipment to offer adequate maternity care such as tables, stools, weighing

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machines. BP machine. and equipment for gynaecological examination among others. They also lacked laboratories to be able to adequately offer an all round care to mothers who had to undergo VDRL and other tests. There was also inadequate water supply and this affected the sanitary level of the facilities. The whole division does not have a health centre or a hospital. The Kenyan medical set up has the dispensary at the lowest level of health care and this determines the level of facilitation by the government. Dispensaries are lowly funded as compared to the health centres and hospitals.

There were also reports of lack of medicines and other consumables required for maternity care. This made the mothers to complain that whenever they visited clinics. they were always directed to go and purchase medicines and were at times expected to carry their own gloves and other requirements at delivery. Most complaints were made regarding the shortage of antimalarials and iron tablets that were reported to be constantly out of stock in some facilities.

It was noted that though the health care providers both formal and informal acknowledged the need to refer mothers to the facilities for emergency obstetric care or for assisted delivery, most of the required items for assisted delivery (Scissors, suture needles and materials, long needle holder, artery and dissecting forceps, vacuum extractor, and sponge) were lacking from most facilities. This implies that reaching a clinic in search of safe assisted delivery as Oyando (2000) observes is not a guarantee that one would get the services. This led to the conclusion that the demand being created for facility based ANC and professionally assisted deliveries is unmatched by the available resources to offer the required level of care. This still leaves a substantial number of women unattended to and the TBAs become the only option available to the majority.

Another important cultural barrier to proper ANC patronage found in the community is the view of men and the associational link they have between ANC and family planning clinics. In Africa. as in all civilizations, there are taboos surrounding sexuality, opposed to the use of contraceptives and family planning. Family planning and the limitation of family sizes remain strong among the Luo men. This was noted as a major worry and concern of a number of men. Some men associated ANC with family planning and therefore, complained or rather; saw no need for their spouses attending the facilities. They often associated family planning with affluence and those whose financial might can support

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their proper health care and that of their families to ensure that every child born will survive childhood illnesses and diseases.

The feelings against family planning meant that the average fertility in the community was high and women gave birth to too many children. Additionally, family planning just like abortion has a moral equivalence of murder in the minds of the heavily religious and most traditionalists. Since marriage in the Luo community is procreation driven, family planning is often frowned upon as morally corrupting and anybody practicing it is seen to be engaging in a foreign behaviour. Men therefore, 'protect' their wives from what they perceive to be morally corrupting. The conflicting messages that emanate from the religious movements predominantly the Catholic Church and other independent churches as noted in the case of condom use and other aspects of family planning are seen as reinforcing this cultural attitude. The predominance and centrality of the Catholic Church in the lives of most Nyang'oma residents cannot be underrated, as it is the nuclei and centre of activities in the division. The number of children in this regard and the power to procreate are all God given and the determinant is God's will.

Additionally, most male respondents were worried about the side effects of the pills or contraceptives. The widely held view is that the pills can cause infertility or the birth of a child with physical deformities. Given the controlling nature of men resulting from the power of culture via patriarchy, and the fact that men had the last word on matters of health care, women could only obey and this meant low ANC patronage.

Despite all the shortcomings, it was noted that the motivation of most women to attend ANC was to get the clinic card. Just as in other studies (Moore et al., 2002; Allen, 2002; Raikes, 1990; Neema, 1994), the desire for antenatal card has been viewed as the most important motivator for the use of ANC. All categories of respondents in the study acknowledged the critical importance of having an antenatal card. Both women in their motivation to attend ANC and the provider's view converged on the need for ANC card.

Women on their side expressed the need to get the card as a preparatory requirement in the event of any obstetric complication at delivery. They were 'pushed' to get the card as the most important piece of paper that opened the doors to professionalized care during delivery. This drive to prepare for the unknown was too strong that some women only

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visited clinics once for the card and waited to deliver at home if no complication cropped up. The nurses at Nyang'oma and Nango dispensaries on the other hand expressed the centrality of the card as the basic entrance point to professionalized care. To them, it was the only means through which the obstetric, reproductive and family history of the individual woman could be obtained. This information was crucial for any assistance during emergency.

Allen in her study in Tanzania had noted that ANC card is the key component of the risk referral system and functions as a tool for the efficient evaluation of pregnant women's health status and a kind of mobile hospital record that facilitates and ensures constant prenatal care. The card further functions as a screening device where nurses mark the appropriate boxes on the front of the card to indicate whether the woman is considered at high risk of experiencing obstetric complications. This as noted in the facility survey is part of the problem in the official health care system. In some situations, it was noted that the nurses marked on the face of ANC cards as having given some women antimalarial drugs and the iron tablets though these drugs were at that moment out of stork. This meant that the cards might not provide true reflections of the care already received by the woman in situations where the markers are not sincere and vigilant.

At the community level, the need for ANC card for emergency purposes also comes from the other maternal health care providers. The Legio Maria *madha* categorically stated that she always demanded that all women attending her clinic had to have ANC card. This she explained aided in her referral in the event of any delivery complications. This requirement was seen to create linkages with the facilities and encouraged women to seek care in a zig zag manner in order to prepare for any eventuality. In her view, since she did not have everything it takes to guarantee safety, she needed to collaborate with the hospital system to ensure maternal safety. Women did comply with her demands as they were always pragmatic and did all they could to guarantee their safety in pregnancy.

The TBAs in the villages equally encouraged women to have ANC cards. To them, the cards gave them confidence that in the event of any complications, they could easily refer the women to the facilities and they would be accepted. They also did this to avoid any blame in the event that the women were denied professionalized care at delivery.

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Overall, the card was seen simply as a certificate or 'passport' (Moore et al. 2002) to the envisaged or anticipated complications. All the community providers demanded it only as a way of conforming to the hospital-based demands and not in the belief of its importance. From the foregoing, it would appear that if mothers can be accepted for delivery and emergency obstetric care at the facilities without the ANC cards, then ANC attendance might drastically reduce. The question therefore, remains, would this be a good thing for the women or would it increase maternal morbidity and mortality resulting from pregnancy and childbirth? Does it really help if a woman attends ANC only once for the card? How difficult would it be to assist a woman without a card at delivery? Are there other alternatives and ways of going round the card or taking advantage of the demand created by it? These are some of the questions whose answers must be provided through the joint efforts between the communities and the health care delivery systems.
Since the cards are bought and are not seen as treatment in themselves, most women have not been well briefed to understand the importance of the cards and why they should even pay for them in the first place. Some facilities always run out of the cards and use exercise books to indicate what has been done. In instances where an individual looses her card, there is no care at all and women are sent away. Instances were reported by the TBAs of their earlier experiences in the hospital system where women were sent away from the facilities when they were in need of emergency care. They were told that they did not have ANC card and believed in the TBAs and could therefore, not be attended to. This attitude only enhances maternal burden since even the decision to go to the clinic in itself is a long excruciating process. Additionally, the need for the card draws most women to the facility and can be said to be the reason why they do not come back. The experience they encounter with the providers may hinder them from coming back. Once individuals encounter hostilities in their first visits at facilities in health problems defined as 'normal' and bearable, coming back to the same facilities becomes a burden that most women would rather avoid.

Some researchers (Moore et al., 2002 and Allen, 2002) have recommended that the demand for the ANC card that already exists can be exploited so that when women attend clinics for the card, they can be given all the necessary care taking into account all the dangers posed by malaria, anaemia, STIs, HIV/AIDS or any other ailment. My belief is that this situation can be exploited by the providers in order to offer the best services and create a conducive hospital environment that women would love to return to.

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Overall, Raikes' (1990) observation on the development of maternity care and the establishment of a system of medical auditing instituted in Britain is still lacking and needs to be looked into for the success of the safe motherhood endeavour. From the foregoing, it can be seen that the pregnant woman is a site of contested power from all corners as soon as she gets pregnant. The idea of a hospital based care is never explained to her in a way that lends well to her own knowledge, but rather, in a manner that serves the interest of other people be they the facility based providers or the community based providers who use women to gain acceptance in the medical realm by being part of the referral system.

7.4. Transport and cost of services

Cost of services and the transportation constraints have also been identified as primary to proper antenatal care. Previous studies (KDHS, 2003; Jirojwong, 1996; Raikes, 1990; Addai, 2000; Addai, 1998; Mekonnen and Mekonnen, 2002, Magadi, 1997, and Leslie & Gupta, 1989) had reported transport and cost of services as barriers to proper antenatal care. The latest KDHS (2003) report for instance indicates that widespread poverty is a major barrier to the provision of quality reproductive health services. Raikes (1990) looks at poverty at the household level and reports that the status of the household is an important determinant to proper health care services utilization. Nyang'oma division is not an exception in this regard. Most of the division as already noted are remote and the most basic public transport unavailable and unreliable.

The economic life of most people in the Division revolves around fishing activities. This is predominantly male activity. Women are therefore, relegated to the periphery of the economy. Women who engage in small-scale businesses that revolve around the fish landing beaches cannot effectively make ends meet. They therefore, rely on their spouses to finance their healthcare.

Research has revealed that women in higher socio-economic groups tend to exhibit patterns of more frequent use of maternal health services than women in the lower socio-economic groups (Addai, 2000; Addai, 1998 and Leslie & Gupta, 1989). The teacher in the study reported how she had to go to a professional in Kisumu since her health was more important than anything else. Those in lower economic status are equally aware of the importance of their health but have no means of actualizing that awareness owing to the constraints in resources.

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Mekonnen & Mekonnen (2002) sums it all by asserting that fees reduces women's use of maternal health care services and keep millions of women away from having hospital based deliveries or from seeking care even when complications arise. They rightfully note that even when formal fees are low or non-existent, there may be informal fees or other costs that pose significant barriers to women's use of services. These may include costs of transportation, drugs, food, or lodging for the woman or for family members who help care for her in the hospital (Gertler & Goog, 1988: Gertler, 1988) as noted in the case of Nyalego.

The other physical barrier to proper services utilization in the findings and in literature is the physical distance to the facilities and the cost of transport. As noted, the predominant mode of transportation was by walking. This resulted from several interrelated factors such as poverty -inability to afford transportation; poor infrastructure and roads network where vehicle transportation was not possible; lack of joint ownership and use rights over family resources such as bicycles where women reported that they were denied the rights to use them.

Distance and lack of transportation had earlier been reported by Family Care International (1997) in their Safe Motherhood General Fact Sheet, and the Technical Fact Sheets as contributing factors to improper clinical attendance. The scarcity of vehicles, especially in remote areas and poor road conditions, accompanied by the fact that nearly 80% of rural women live more than five kilometres from the nearest hospital, make it extremely difficult for women to reach to even relatively nearby facilities. Walking is the primary mode of transportation, even for women in labour (World Development Report, 1994; World Bank, 1994b; Williams et al. 1985; Mekonnen & Mekonnen, 2002; Safe Motherhood Technical Consultation 1997).

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Other studies such as Moore et al. (2002), Trangsrud and Thairu (1998) and MOH (2002) have reported the difficulties experienced by women in the rural set up in accessing antenatal care and even women who would wish to deliver in a health facility end up delivering at home due to distance and lack of transportation (Bicego et al., 1997).

According to the KDHS (2003) report, the poor infrastructure in Kenya complicates the matter further and is a great impediment to a great number of people in seeking health care. Allen (2002) in her study of maternal health care in a Tanzanian village concluded that the

physical distance from a woman's home to a health centre or hospital is an important factor that affects whether or not she would survive a given pregnancy should complications arise.

In areas where there have been improvisations in transportation means i.e. the bicycle taxi (*boda boda*) as in Nyang'oma, the terrain may be too hostile to comfortably transport a pregnant woman or a woman in labour to a health care facility. The bicycle taxis as noted are at times more expensive than the fare charged by the few vehicles. The hilly roads meant that besides paying dearly, a woman would still be called upon to do much of the walking. This discouraged the majority who regarded walking as the only option to the facilities. This therefore, meant that women took longer hours to the facilities and they complained that this delayed their other domestic activities. The impassable roads during the rainy season and the hot weather during the sunny season makes walking which is the commonest means to the facilities a painful exercise for most women.

In a heart rending story and extreme example from a Tanzanian study, Price (1984) quoted in Sundari (1994) reports how a rural woman had to walk 70 kilometres after the onset of labour to reach a hospital, only to collapse and die on arrival.

Though the above literature indicates that physical distance is a barrier, the results have indicated that issues of quality access are at times more vital than physical distance. As noted in the study, women value several things and consider a lot of other factors before deciding on which health facility to attend. Considerations of quality of care and the past experience in a particular facility by self or through proxies are important determinants. A lot still needs to be done to situate health facilities within the reach of the majority who need them and for the well being of mothers and society at large.

Deliveries and TBAs' assistance

The study indicates that TBAs are lifesavers at the community level and are called upon to give their services in emergency situations. It can be deduced from the examples and the confessions of TBAs that they often offer their services with a belief that all power lie with the supernatural. They are also experts beyond the boundaries of their communities and see their expertise as a call to a moral duty. They also give shelter and feed women who are at times in distress and less endowed economically. However, they could also be blamed for

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giving false hope in situations where they may not be sure of what to do in the event that their therapeutic options are not successful.

From the experiences of TBAs and the births they have attended to as emergencies, it is evident that pregnancies are never planned for in advance and in good time. There is also lack of advance planning for the use of skilled birth attendant for normal births and inadequate preparation for rapid action in the event of a complicated obstetric problem. Deliveries seem to take place in a chance occurrence. The clients appear not to be in a position to determine ahead of time their professional needs and potential risks and clinics are regarded as just a by the way. The TBAs in this context are mostly seen as the last resort and are often caught in the muddle and confusion between traditions and modernity.

The deliveries by the TBAs are accomplished within the home environments. They take place either in the homes of the delivering woman or in the homes of the TBAs. This environment as women indicate offers them the opportunity to give birth in a private arena away from the intruding eyes of strangers and away from the men who intimidate them. The female modesty gets protection and preservation from home births and the whole process is in the hands of women. The feeling of being delivered by somebody you know personally increases the confidence in the exercise.

Women also report that home births allow them the opportunity to assume any position at birth. They can choose to sit, stand or squat as they are not rigidly ordered to assume certain positions like it is with the health care system. The TBAs are also regarded as polite and not quarrelsome. They do not order women around; compel them in rude and harsh tones to push and the entire birthing process, apart from the 'normal' pain is graced by familiar faces who are genuinely concerned.

Home births are also seen as acceptable by women as they are allowed to at the same time engage in ritual activities that are meant to protect the mother and the new born baby from the evil spirits or spirits of nature. Home births also accord women the opportunity to lay ahead of time, the claims for inheritance for their children. In communities like the Luo where the burial of the placenta is an afterbirth ritual whose importance is still observed and whose importance is seen to connect the newborn to the ancestors and to root the individual into the lineage system, home births still remain the most coveted option.

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Previous studies (Raikes, 1990; Neema, 1994; Jordan, 1980; Allen 2002 among others) have recognised that women traditionally delivered at home where they have had control over their own bodies and where childbirth and delivery have been an affair of women. Jordan noted that home births provide women with the support at a time of crisis because of the extensive assistance of female relatives, neighbours and traditional midwives. Neema (1994) reported that the Banyankole view hospital based births as done by women who fear the baby. The above studies have noted that most communities have reproductive rituals that provide each woman with a model of comprehending and interpreting her own physical and psychological experiences and this is seen to affect the birth location and the attendants.

Colgate-Goldman et al. (1994) in their study in Guatemala had equally found out that the feeling of shame, need for privacy and the birthing position of choice (squatting, kneeling e.t.c.) makes the home the ideal birthplace. The home has also been recognised as offering a more familiar and less threatening environment by a Nigerian study (Public Opinion Polls, 1993). The Nigerian study further recognised that procedures such as placenta disposal, cutting of umbilical cord, after birth practices are all culture specific. Kyomuhendo (2003) further observes that the proverbial honour is also a factor in home births where the woman gains prestige through suffering and being 'courageous in birth'.

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From the foregoing, home births with all its shortcomings and the female subordination by culture and other considerations that are patriarchal in nature, still remains the preferred option by many women because of the dislike and fears of the hospitals resulting from the knowledge of maltreatment and the centrality of traditions and care continuity offered at home.

At the facilities, women still complain of being intimidated and despised during labour and delivery. Women report that they are harassed and forced to push during birth and left unattended in labour. The case of the lady who had a stillbirth as told by her friend sums up the attitude of the providers in some situations. It is disheartening to learn that a woman would go through labour alone while the nurses or other providers in the facility are asleep and do not wish to be 'disturbed'. When such sad stories are told to other women in the community, even those who would have wished to go to the clinics may shy away from doing so.

Other women complained that the facilities do not offer them adequate privacy in the birthing process. Most women reportedly preferred to be seen naked by only those who are attending to them other than other providers. There are reported cases of where women complain that the providers attending to them call others to come and see what is happening while giving birth. This to them is shameful and makes them nervous.

The providers in facilities also believe in un-cultural placenta disposal methods that do not augur well with most women. To the providers in the facilities, the placenta is a waste that is dipped into the pit latrine. This in most cases is not acceptable to the community members.

Previous studies (such as Allen, 2002 and Raikes, 1990) had reported the problems women undergo in hospital setting during delivery. They report that women are abused, insulted for crying out during labour. Allen reports that overall, there appears to be a consistent lack of attention to the labouring women on the maternity ward, "I have observed births where at least five nurses are sitting around a table laughing and joking and virtually ignoring the labouring woman, may be once or twice calling out to her to quit crying and making so much noise" (2002:189). She further reported how a few of the midwives at the delivery wards were particularly abusive to the women during labour, often yelling at them to stop crying and sometimes slapping them on the legs if they tried to sit in an upright position or raise their hips off the birthing table.

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The nature of treatment most women reportedly received from the facilities leaves them with little option, but to deliver in their homes. Scholars have also noted that the appropriation of childbirth by medicine tend to ignore the women's own belief and the social and cultural meaning of childbirth. Scholars lament that birthing has increasingly moved from familial and social domain to that of hospital-based medicine, for many an alien institutional setting and knowledge base (Oakley, 1975; Shorter, 1984; Cosminsky, 1982; Davis-Floyd, 1987).

The ultimate success in safe motherhood intervention must be a middle ground between the new medical approach and the women based knowledge of childbirth. The appropriation of childbirth and the promotion of hospital-based care must be respectful to the female person and be able to convince her that her safety, prestige, dignity and honour are guaranteed.

One of the starting points would be to have a consistent and well spelt out process of birth planning that takes into account the culture of the concerned.

On the whole, even the TBAs assisted births are seen as unplanned. To address the problem of lack of birth planning which has a disastrous potential, presently, birth preparedness has been globally endorsed as an essential component of safe motherhood programmes (Trangsrud and Thairu, 1998; WHO, 2000). There are several recognised and accepted key elements of birth preparedness that includes planning for both a normal birth and the possibility of an obstetric complication. These elements include:

- Identification of the preferred birth location and birth attendant
- Finance
- Transport
- Chaperone to accompany a woman in labour to the care site and
- Advance identification of a compatible blood donor in case of an emergency

Besides the above elements, Moore et al. (2002) identifies another new and important element as the Identification of preferred early postpartum care visitor. This presupposes that a woman requires a lot of postpartum care and closer monitoring after delivery. This has been a forgotten need since most pregnancies are considered complete and over after delivery. This also lends well with the cultural belief patterns where a woman needs a helper beyond delivery who would be responsible for making her meals and participating in the cooking process and other rituals meant to welcome the new member of the lineage. In the Luo community, not just anybody is allowed to get in direct contact with the mother after delivery as a preventive measure against those with evil intentions.

In the process of planning for childbirth, the women themselves must be accorded the respect they deserve and what they feel and want must be incorporated. Planning does not necessarily imply facility-based delivery, but anticipation ahead of time of all possible outcomes and being ready for any eventuality.

Conceptually, from the results of the study, it is evident from a theoretical point of view that women are constrained at several levels in their pregnancy episode. At the very local immediate level, they have to contend with their families, demanding work load, cultural realities that define pregnancy as a normal condition and with husbands or spouses who are

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in themselves part and parcel of a culture that consider women more less as reproductive vessels. The mismatch of origin in the disease etiology and the efficacy of treatment differ in the two health care systems found locally. The belief in the effectiveness and appropriateness of facility based ANC is not yet uniformly distributed in the community and it is women who must bear the burden of the ensuing confusion.

Beyond the family and still within the community, they have to cope with the elderly women who are seen as the custodians of cultural issues on pregnancy. They may have a different view based on their exposure and education but must frustrate it to be seen to be conforming to the traditional definition of a good wife who respects the mother in-law or the elders. The perception of the overall concept of risk and the degree of personal risk are all defined for her. The definition may not be at par with her feelings or thinking or that of the health care delivery system; but she has to contend with it as the cultural form of reality upon which she has to operate.

Despite a woman's previous childbirth experience, the therapy-managing group is the sole determinant of when specific conditions are recognised and perceived as severe thereby, requiring triggers to action. Decision-making by a hierarchy of socio-familial relationships may delay the urgency of care if the symptoms of any ill health are attributed to other causes. The woman's own awareness to problems may not result into health actions owing to the constrains of resources, the need to ask for permission to leave home, seek skilled or other care, spend money for obstetric costs in the absence of the male head of family, and the need to have others define her problem and initiate remedial actions other than herself.

At the communal level still, the individual woman has to contend with specific religious practices, rituals and the belief system that reifies the living dead and from whom the gift of childbirth comes. Her fate is therefore, intertwined with that of the larger family and community. Her agency must be seen within this larger picture. Although the woman tries to be a mover and a conscious agent. she has to be privy to all the above considerations in her immediate environment unless she is prepared to be defined in culturally unacceptable ways. When fatalism crops up resulting in a 'wait and see' attitude and approach to care seeking and the acceptance of maternal death as an outcome of complications or women deciding not to go for care in the pretext that it is the responsibility of their husbands and are even prepared to die in the hope that it will be the husband to suffer, then, individual

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agency and issues of informed choices are heavily compromised. The acceptance of death as an outcome elevates pregnancy to a higher level in the risks in life and makes childbirth a life threatening undertaking.
At the micro-social level, women must contend with the patient-provider relationship that serves the needs of physicians and conform to the official health care system with its inherent bureaucracies. They also have to conform to the process of pathologising pregnancy that differs radically from the one propagated at the community level and accept the process of medicalising social distress. The patient-provider relationship is one of tension where the provider acts in a uni- directional communications and women have to accept their low status and ignorant positions. The whole consultation process serves to deny women their rights over reproduction and alters the traditional view of 'women producing children' to 'doctors producing children'.

Further, the consultation process is not without bias. Factors outside the examining room come to haunt the woman. Her status in society or the status of her family or friends and her disposition in life are crucial considerations that determine whether the physician views her with respect or with contempt. The economic status of the woman, her marital association, age, parity and education are additional considerations that come to haunt her in the process of seeking care and determines the level of care and respect she is accorded in the interaction. At no time in the life of a woman during her pregnancy episode is she respected and valued as a woman and as she is. At the community level, her value is in the potential product; the baby.

The power relationship between the patient and providers is in such a way that the woman must feel the dominance and mystique of western medicine and its scientific origin. The practitioners' view of professionalism considers women as mechanical objects whose bodies can be fixed and each and every practitioner is a specialist on just but a few parts of that machine. In this regards, the woman who comes to clinic and finds NGO experts doing HIV/AIDS testing and counselling, the CDC group doing malaria testing and IPT and the nurse doing physical and gynaecological exams and finally the lab conducting laboratory tests must see her body as composed of parts that require different specialists. In the process of being attended to by all these groups of people, she has to be prepared for harsh and disrespectful treatment at practically every stage of services delivery.

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At both the intermediate and macro-social levels, the imposing sizes of referral hospitals and the overall capitalistic system reify the class relations and profit making motive that brings out clearly the hidden reasons behind the medicalization of social distress. Pregnancy and childbirth become compartmentalised and specialists who have the preserve of knowledge in the field of reproduction who are in most cases men become the 'magic savers' of society. Gynaecologists and obstetricians emerge at the top of the professional hierarchy and are found only at the referral levels. The consultation process with them is a capital-intensive endeavour and one that only the chosen few can manage. This creates another level of distress to women, the feeling that poverty and economic inability will never allow them to produce their children in the best of conditions. Additionally, where one gives birth and which doctor attends to you is a question of class rather than one of safety.

Overall, pathologising and medicalizing pregnancy and childbirth has been the best capitalist strategy world over to ensure constant profit to the multi-nationals and pharmaceutical firms and to further mystify the medical profession. In a country like Kenya, the success of the process of childbirth medicalization has been hampered by the general poverty among the majority of people, the differential allocation of resources from the exchequer resulting from political considerations and the overall politics of patronage using state resources, the cultural adherence of the majority of the people who value their cultural ways of doing things, the emphasis on the provision of services in the urban areas at the expense of rural areas and the general lack of adequate trained personnel to adequately serve the growing population.

With birth rates at their lowest in most European countries and North America where there has been a long tradition of medicalizing pregnancy and childbirth, the patient base has been dwindling. This reduction in demand has increased the urgency of spreading the technology to other parts of the world where pregnancy and childbirth still marks important rites of passage and is a source of prestige and honour to women at personal level and to men at the societal level. It has also taken advantage of the high fertility rates in most parts of the world dubbed third world countries where the patient base is assured as long as the social construction is successfully altered to view pregnancy as a condition requiring medical intervention. In the event of success in the change of worldview regarding pregnancy and childbirth, this is then an area where there is assured way of sustaining

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demand as people will always want to have babies of their own. The major problem still at the moment in the third world is the inability of the promoters of hospital-based care to appeal to the inner conscience of society and the bearers of pregnancy and the pregnancy managers to change their cultural views and knowledge acquired over years and serving its purpose.

In Europe and North America, there has been a shift in focus to the new reproductive technologies such as invitro-fertilization that answers the problem of risks TO motherhood traditionally the domain of ancestral spirits and spiritual intervention in Africa. This has been viewed further as intrusive devices that alter the human perception of sexuality and reproduction. placing more reproductive power in male hands and alienating the women further from the reproductive function (Strathern, 1992).

Safe motherhood interventions must respond to all the above shortcomings in a way that satisfies the primary bearers of pregnancy and be culturally compliant for it to get wider acceptance. It is on the above background that the conclusion and recommendations are drawn. Overall, there is clear evidence that the health care system has not adequately met the needs and aspirations of women. There are several causes of delay that need to be addressed for the achievement of safe motherhood. The delays could be at the individual level, the cultural level, the socio-economic level, the infrastructural level, the facility level and the overall organization of health care in general.

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CONCLUSION

In conclusion, it is worth noting that now that governments all over the world including Kenya have embraced Safe Motherhood, there is an urgent need to either introduce or strengthen the existing programmes that reduce maternal deaths, improve reproductive health services and protect and promote women's health and well being especially during pregnancy and childbirth.

The goal of Safe Motherhood programmes is the reduction of Maternal Morbidity and Mortality. The components of these programmes are family planning, antenatal care, clean and safe delivery and essential obstetric care (Toroitich, 2004). Researchers have noted that reproductive health has always been relegated to the periphery in terms of policy, and has been regarded as a 'woman's issue'. It has therefore, been limited to aspects of contraception, conception and maternity. As a result of this, important concerns have been given little attention (Ibid) including the way in which gender influences the risk of most if not all infections (Rice and Manderson, 1996).

It has been asserted that women's reproductive success determines their social status, the role they play in a given society, and indirectly, the control they can exercise over their own lives and those of their children, and their continued wellbeing. Women's status (broadly defined including their economic wellbeing, the power they are able to exert domestically and publicly) affects their access to property and resources, but also their access to health, their access to information that influences treatment seeking behaviour in the event of illness, choices about whether and when to have a child or children, and their ability to control their own bodies (Rice and Manderson, 1996).

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It has equally been argued that the existing state of affairs in the health care system that contributes to high maternal mortality is not the consequence of mere inept planning or poor organization and managerial capabilities, but a reflection of the priorities set by an elitist system in which the poor and powerless do not count. For a change, demands must be fought for as part of a much wider struggle for equity and social justice (Rozario and Samwel, 2002). Maternal health advocates must create partnerships and form part of the civil movement to rightfully champion the rights of mothers and to bring the messages to the doorsteps of policy planners, government bureaucrats, international agencies and above all, to the users of services with the information that antenatal care can make a difference.

Too often, International Health Planners design programmes based on the assumption that 'all else is equal' and that each participating nation has the same level of playing field. This assumption of uniformity of context may be necessary to the process of planning global health programmes, but also may create needless barriers to their effective execution (Whiteford and Manderson, 2000). There are always tensions between global forces and socially constructed local identities. This is because; the global forces are never accultural or supracultural. They are rather, historical artefacts that derive from western domination; they reflect western values of rationality, competition and progress, in which context there is an implicit assumption that with modernization, local traditional institutions and structures will be replaced by western systems and patterns (Ibid). Local realities as seen in Africa are that countries have their peculiar cultural constructions and local capacities that are never reflected in the International programming. More so, even in a single country, there is too much diversity that proper planning have to pay attention to for it to achieve any meaningful success. As anthropologists, we are also aware of the discordance between centre and periphery, global ideal and local reality. The anthropological creed of 'culture' insists on the importance of context and believes that success cannot be transferred from one culture to the next, as programmers would want us to believe.

Efforts to improve the quality of maternal care must find a balance and avoid 'overmedicalisation' of maternal health, which occurs when specialised interventions and technologies are used routinely. Safe Motherhood can also succeed if it is accorded a multi-pronged approach to address all the health service factors, patient factors and the cultural barriers in a way that takes cognisance of the universal barriers as well as the local barriers.

Allen (2002) recommends both long and short-term strategies. She sees long-term strategies as being non-medical such as the implementation of educational and legal practices with the goal of improving the overall status of women. Short measures she says should focus on immediate medical concerns such as improving the quality of care in government health facilities, improving people's access to health care by training lay persons as village health workers and TBAs. Kaisi (1989) on the same vein proposed a multi-sectoral approach that includes the participation of key governmental, non-governmental organizations working on various related issues such as health, family planning, women's status, nutrition, information and education, and research. She also proposed the formation of local Safe Motherhood Committees comprising of members

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from the various sectors who would work together to develop a coherent Safe Motherhood strategy.

The trend set by WHO (1986) of regarding tradition as part of the solution rather than the problem and recommending the training of TBAs since they are often the first if not the only health care workers with whom pregnant women in poor countries have contact should be enhanced further. What Countries should avoid here is the pitfall discovered by Allen in Tanzania of targeting the wrong people for training. She discovered that those who were trained as TBAs were selected by village officials on the basis of friendship. some had never assisted in birth before. and one was selected on the basis that she had given birth ten times. The selection process needs to be transparent and based on past experience and the women's interest in antenatal care and in assisting others. In this context, TBA will be more of a 'calling' than just another job where the programme planners can select their friends, relatives and spouses to get them opportunities. The selection must involve the women and the larger community stakeholders for success to be achieved. The training of the selected group should also not be based on de-culturation process and enculturation to biomedicine but to the safety of the pregnancy and birthing process. This requires a careful evaluation of the knowledge already possessed and going from there to other heights as may be necessary bearing in mind the importance of the cultural context.

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RECOMMENDATIONS

On the health System side, the following should be done:

- Locate health services as close as possible to where women live. Invest heavily in reproductive health by involving donors, NGOs and other stakeholders and above all, the local communities. This will assist in ensuring that distance does not become a barrier to professionalized care. This could also involve the introduction of satellite clinics or mobile clinics that bring services closer to the people. In the extreme, maternity hostels could be constructed to accommodate high-risk mothers who live far away from the facilities where they can be able to reach the facilities as soon as possible for any emergency obstetric complication.
- Ensure that all health facilities are equipped with the capacity to offer affordable, high quality ANC, PNC and obstetric complications services (adequate number of trained staff, regular supply of drugs, equipment and supplies, functioning referral systems and availability of transport to ensure that women in need of higher level care get it quickly). Proper antenatal services that include treatment of STDs, Tetanus Toxoid Immunization and treatment of anaemia and malaria in pregnancy, and access to essential obstetric care are key. Since the majority of the Kenyan population is rural based, more skilled attendants should be motivated to work in rural areas.
- Systems should be put in place to ensure that service providers are respectful of and responsive to women's needs, preferences and cultural beliefs. Culturally competent communication that respects the client is necessary and mandatory. The widespread behaviour among the skilled providers of either delaying or mistreating women who come for routine check up or emergency obstetric care with or without the ANC cards should be discouraged. This can be done by a refocus on training of providers and entrenching cultural and medical anthropology into the medical training programmes to give medicine a 'human face'.
- Enforce standards and protocols for service delivery, management and supervision, and use them along with feedback from clients to maintain and evaluate service quality. Any progress has to be monitored through the gathering of reliable data to evaluate reproductive health programmes periodically. Overall, there should be a periodical 'medical auditing' to ensure that standards are maintained and that any deviation is detected in time

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- Since it has been recognised that women go to the clinics for the sole purpose of getting the clinic card as a 'passport' to emergency obstetric care, this can be exploited by devising a system where the women are given other essential elements such as malaria prophylaxis, STI screening, VCT, iron foliate supplementation and other birth preparedness counselling that enable them to have a safer pregnancy. In other words, the first contact can be exploited to do several things that are essential for a pregnant woman. Besides, this opportunity can be utilised to make the clinics worthwhile places and encourage women to come back again through the compassionate care they receive on this first visit.
- The rigid adherence to certain birthing positions should be relaxed to have as many people as possible regarding facilities based births as the norm. For mothers who insist or their spouses insist on carrying away the placenta, they should be allowed to do so without being made to feel ashamed or as traditionalists or witches. The providers should be trained to be privy and sympathetic to some of these cultural practices surrounding birth that are not in any way harmful to the mother but only act as psychological therapies to reassure the mothers of their wellbeing as well as that of their newborns.
- On the TBAs, they are available and since it is recognised that they are helpful, focus should be on retraining and to equip them with the latest technological skills to offer emergency care and to support them to make timely referrals to the local health units. There is need to have a well spelt out cooperation where they can be the link between the care seekers and professionalized care providers by building trusting and mutually respectful relationships between them and formal health sector personnel. Change of attitude among other categories of providers is required here where they will compliment each other's work rather than competing with them. A good network of communication links and referral system that integrates and incorporates the TBAs should be introduced. They can also be important links in breaking the language barriers seen in multi-cultural and multi-ethnic environments where posting of health personnel is centralised and one can be posted anywhere in the nation.
- The authorities should address the demanding and stressful work schedule placed on the providers. There is need to improve on the working conditions to boost the morale of the maternal health workers. Most providers operate in very poor working conditions where they are expected to provide non-existent drugs, work in

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deplorable conditions, work for longer hours and weekends without additional pay, provide services to a large number of demanding clients and generally, make personal sacrifices without recognition. An enabling environment must include a supportive policy and regulatory framework; adequate supplies, equipment and infrastructure; an efficient means of communication, transportation and referral and above all, proper remuneration and adequate staff at all levels. The issue of staff shortage is an urgent one and requires immediate attention.

On the Patient or demand side, the following areas need attention:

- Expand educational opportunities for women, engage in extensive poster campaigns to attract women with little or no education, educate women and communities about the importance of maternal health and availability of safe motherhood services, and the need for women to have decisions making power over their own health and more life choices, remind women and their care takers that 'every other pregnancy is unique' In this regards, the churches, spiritual leaders and other community leaders need to recognise the importance of skilled ANC and make it one of their top priority topics either in church sermons or community *barazas* where they spell out their policies and act as maternal health advocates. Let the importance of postpartum care also be emphasised as presently, women do not see the need for it. If the educational campaigns deem it fit to change the community perception of pregnancy to pathologies it for the sake of maternal welfare, that be it.
- Specifically and in a very special way, there should be a constructive involvement of men as partners in reproductive health. They should be targeted with reproductive health education. Make them understand their roles and expectations in childbirth. Organise educative seminars, radio programmes and awareness training involving both men and women in a bid to creating a more caring home environment. Men who are the decision makers on whether their wives go for antenatal care are never in the first place aware of the benefits of ANC and moreover, they rarely if ever step into the facilities to know what is expected of them. For them to have informed decisions, campaigns targeting them specifically should be launched. The confusion and suspicion men have of relating all maternity issues to family planning can only be corrected through such campaigns at all levels. The campaign will improve on family dialogue and assist in avoiding the confusion and uninformed decision making in the care-seeking pattern.

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- Birth preparedness as soon as one conceives is very necessary. Women should be encouraged to know their expected dates of delivery, be members of community based '**merry go rounds**' (financial saving schemes that can lend them money to finance their professionalized care), organising ahead of time the preferred places of delivery and arranging ahead of time the person of choice to accompany them there. This approach requires a change in the traditional view that does not recognise the preparation of birth until the baby arrives. The assistance of the local administration, community leaders and the custodian of traditions in every community need to be approached to lead in this crusade. The resources mobilization strategy should be truly community driven and should involve all the stakeholders.
- Men should be engaged in proper birth preparedness and we should look at appropriate ways of addressing the issue of '**weakness**' culturally imposed on any man who offers a helping hand to his wife. Since every community has a role model, a hero or a successful son, there is need to engage them in this transformation so that the traditional weaknesses as it were can be transformed into strengths for better pregnancy management. Since men are always eager and happy to be parents, this should be exploited by messages reminding them that if they want quality product, then they have to invest both time and materially in it.
- In a more general and overall way, communities should be mobilised to identify and engage in activities that promote safe motherhood. This is necessary as research indicate that even when health services are available, traditional beliefs and other cultural and socioeconomic factors have a powerful impact on health seeking behaviour. Opting for a traditional birth attendant or traditional healer often reflects the need for privacy, convenience, affordability or the need to resolve a perceived complication of labour by spiritual means. Even when free or low cost, the use of public health services often involve considerable financial and individual support from the family, including the cost of providing food, and the opportunity cost of staying with the patient. TBAs on the other hand, may offer payment options such as paying 'in kind' or by instalments, and may provide vital, personalised postnatal support. Some even offer their services, food and items free of charge to the very poor. This is particularly important to the young girls and those with no source of income. It is important to emphasise that safer birth can be managed within the

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home or the village by ensuring clean deliveries and in a culturally compliant environment where women are in charge of their lives and birth outcomes.

On the whole, efforts should be made at all levels, to bring the plight of women more particularly during their periods of pregnancy to greater focus and to the national debates on health care and to create demand for antenatal and postnatal care.

'Imagine a world where pregnancy and childbirth becomes risk free, the pregnancy process endurable and the pregnant woman seen as the most delicate and beautiful piece of God's creation. A world where equality is cherished and the sex of a baby is immaterial, where women derive comfort and pride in their reproductive strength and a human race that recognizes that without women, even the advancement in reproductive technologies cannot save the whole race from extinction'

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Appendix 1: Data collection instruments
SURVEY QUESTIONNAIRE GUIDE

INFORMANT NO...........

Greetings: This should be appropriate as the case may be. Introducing the subject matter and requesting individuals if they could spare their time to answer just a few questions regarding themselves and their interaction with the antenatal health care providers and the clinics in general. You should also introduce the purpose and the organization responsible for the research (This is done as part of KEDAHR for a PhD at the Institute of African Studies University of Nairobi)

After securing the clients consent, Promise them confidentiality and explain to them the use for which the results will be put including its potential to influence policy for a safe motherhood environment.

1. SOCIO-ECONOMIC STATUS

a). Sex of respondent Male......... Female........
b). How old are you?..........Years/ When were you born?..........
c). Marital status: Single.....Married.......Widow(er).....Divorced/separated.......Other...
d). Who is the head of your household? Husband.....Wife......Other.......
e). Can you read or write? Yes........ No.......
f). What level of formal schooling did you attain? None..... Primary.... Secondary.... College.... University.... Other (specify)....
g). What is your major occupation?
h). How many hours do you work per day?..... hours
i). How many days do you work per week?..... Days
j). What is your approximate income per month in Kenya shillings?..... Shillings

2. WOMAN'S INFORMATION ON ANTENATAL CARE

A.

a). How many children do you have?
b). Have you ever lost a child during birth?
c). If yes, under what circumstances?
d). If no, how have you always managed?
e). Did you attend antenatal care during any of your pregnancies? Yes..... No.....
f). If No, why?
g). If Yes, where did you go and why?
h). Was any of your pregnancy problematic? Yes......No.......
i). If yes, specify the kinds of problems
j). Have you ever had a child with any form of disability? Yes..... No.....
k). If yes, specify

B.

i). How old is your last child?
ii). Where was he/she delivered? Home..... Public health facility..... Mission/private hospital..... Other (specify).....
iii). Are you familiar with the maternal clinics around here? Yes.... No......
iv). Did you attend antenatal clinic for this child? Yes......No......
v). If No, why?
vi).If yes, at what stage in your pregnancy did you go to the clinic for the first visit? Less than six months.... 6-7 months..... 8+ months...... Don't know..
vii). How many times did you visit the clinic?
viii). Which of the following modes of antenatal care did you use?
Self treatment.....
Informal: Peers..... Traditional methods.....
Formal : Government..... Private.....
Religious........
ix).Have you been attending clinic as required? Yes......No.......
x). If No, what were your reasons?
xi). If more than one mode was used, what are the reason(s) for the change?
a). Quality of services
b). Accessibility
c). Cost of services
d). Affiliation to a certain provider
e). Attitudes of the provider

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g). Others (specify)

xii). What influenced you to attend the first antenatal clinic?

a). Advise from spouse
b). Other female sources
c). From parents
d). Parents in-law (mother and father-in-law)
e). Mass media
f). Politicians
g). Community Based Health Workers (CBHWs)
h). Others (Specify)

xiii). Explain how you were influenced.

3. CHARACTERISTICES OF THE HEALTH FACILITIES

i). Which health facilities are within your reach both physically and economically?
ii). What is the distance from your home to the nearest health facility?.......Kms.
iii). How accessible are the services in different seasons?
iv). What are the costs of services offered at the clinic per visit?
v). What is the mode of transport to the facility?

a). Matatu/Bus
b). Foot
c). Bicycle
d). Private means
e). Others (specify)

vi). Cost of transport too and from the facility........Kenya shillings
vii). What is the time taken between home and hospital and back?...... hours/minutes
viii). Time taken to wait for the services.........hours
ix). What kinds of outreach services are organized from the health facilities?

a). Home visits
b). Mobile clinics
c). Public health (Sanitation/Immunization)
d).Family health field educators
e). Contraceptive distribution/Family planning and counseling
f). Other health personnel

x). Which criteria did you use when selecting the facility to attend?

a). Distance
b). Quality of services
c). Options offered by employer

d). Past experience

e). cost
f). Advise from Nyamrerwa
g). All the above
h). Others (specify)

xi). Were you given any lecture during your clinic visits concerning any of the following?

a). Breastfeeding
b). Family planning
c). Danger signs in pregnancy
d). Maternal nutrition
e). Care of newborn
f). Expected number of ANC visits for a normal pregnancy, State the number......
g). Gestation period for the first visit for each pregnancy....... Months
h). Others (specify)

xii). How did you find/understand the lecture(s) given

a). Excellent
b). Good
c). Fair
d). poor
e). Don't know

xiii). How do you rate the services offered in the clinics?

a). Excellent
b). Satisfactory
c). Good

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d). Fair
e). Poor
f). Don't know

xiv). Would you go back to the same facility again? Yes........ No.....
a). If Yes, why?
b). If No, why?

xv). Would you recommend the facility to any other client?

xvi). Do you have any suggestion(s) that you feel can improve the services of antenatal clinics?

4. SOCIO-CULTURAL ENVIRONMENT

i). How is pregnancy perceived in this community?
a). Is it a sickness
b). Normal condition
c). In between sickness and normal condition
d). Just there
e). Other (specify)

ii). Do men play any role in pregnancy issues? Yes....... No......
a). If Yes, what is their role(s)?
b). If No, why?

iii). Does your husband/partner/spouse support maternal care? Yes...... No.....
a). If Yes, how?
b). If No why

iv). Do you make your own decisions on what to do while pregnant? Yes....... No.....

v). Who assists you in making decisions?
a). Husband/partner/Spouse
b). Mother-in-law
c). Father-in-law
d). Sister-in-law
e). Maternal mother
f). Others(specify)

vi). How is the workload of women while pregnant?
a). Heavy
b). Light
c). Moderate
d). Other (specify)

vii). Is there any change from the normal routine while one is pregnant? Yes..... No.....
a). If yes, what are the changes?

viii). Are there any special treatment for pregnant women? Yes......... No........
a). If yes, what are they?

ix). How is a pregnant woman treated by her partner during pregnancy?

x). How often do you discuss your pregnancy with your partner?

xi). Is there any sense of ownership of the newborn by the husbands?

xii). Are there any specific food taboos culturally imposed on women during pregnancy?
Yes........ No......
a). If Yes, what are they?

xiii). Are there any other types of taboos culturally imposed on women during pregnancy?
Yes.............. No...........
a). If Yes, what are they?

xiv). Is there any religion that prohibits women from attending antenatal clinics?
Yes....... No......
a). If yes why?

xv). Do you visit traditional healers during pregnancy? Yes....... No.........
a). If yes, give reasons?
b). If No, where else do you go?

xvi). What is the role of Traditional Birth Attendants (Nyamrerwas) in pregnancy?

xvii). Can Nyamrerwa handle complicated cases of pregnancy?

xviii). Can Nyamrerwas recognize early enough that a particular pregnancy requires professional care?

xix). Do Nyamrerwas accept their inadequacies?

xx). Do pregnant women in this community face any specific problems? Yes....... No....
a). If yes, what are they?

xxi). What are the reasons why women do not attend antenatal clinics as required?

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5. QUESTIONS TO THE HEALTH PROVIDERS

i) How is your work environment?

a) Inter-personal relationship with other staff

b). Relationship with the community

c) Access to required facilities and resources

d). Relationship with the bureaucracy.

e) Qualifications of the provider and competence to offer services

f) Availability of supplies

g) Relationship with the clients

ii) How does this environment affect your performance?

a) What are the urgent concerns that if addressed would improve in your work environment

b) Are the concerns being addressed at the moment?

iii) What kinds of clientele do you normally attend to?

iv) How would you describe your clients?

v) What constraints do you face in service delivery?

vi) Do you offer maternity services?

vi) If yes, what challenges do you encounter in maternity services provision?

a) What are your views about the way antenatal care services are offered to clients in this clinic?

b) What are your views about the way antenatal services are organized in this clinic?

vii) How do you ordinarily handle the clients (maternal health seekers)?

ix) Would you consider the services you offer as being adequate?

x) What do the antenatal care services entail?

xi) What do you think need to be done to improve the antenatal care services?

6. IN-DEPTH INTERVIEW GUIDE

Issues to be explored in the guide include:

Issues of maternal health in general

- Pregnancy practices in the community
- Perception of pregnancy in the community
- Value of pregnancy, sex of child and mental stress during pregnancy
- Place of the pregnant woman in the community
- Health seeking behaviour patterns in pregnancy and healthcare delivery
- Cultural issues of avoidance relationships
- Cultural prescriptions and proscriptions
- Taboos and related practices in the community
- Traditional maternal health care practices
- Biomedical maternity services in the community and how they are provided
- Relationship between tradition and modernity in pregnancy practices
-

7. FOCUS GROUP DISCUSSIONS GUIDE

This will include the following themes;

- Local perception of pregnancy
- Pregnancy in a social context
- Taboos and food related avoidances
- Accessibility of maternity services and their utilization
- Cost of maternal healthcare services
- Distance from health facility and the infrastructure
- Teenage pregnancies and antenatal care
- Female status and maternal healthcare utilization
- Female perceptions of the maternity healthcare services
- Quality of maternal health care services.
-

8. MATERNAL FOLLOW UP GUIDE

-General problems faced by the mothers (probe)

-Whether she has been to the clinic since the last visit and the cost of services (probe)

-General work routine- daily routine (Any change from the last visit should be noted)

-Whether they are discussing the pregnancy with the husband/spouse/partner and the content of the discussion.

-Food preferences and avoidances (foods craved for and the ones disliked)

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-Attitude towards partners and other caretakers and how this influences day today affairs
-Health seeking behaviour patterns beyond the clinic (Issues of self treatment, Nyamrerwa or any other form of health care including spiritual treatment and advice from neighbours)
-Role of important others (in the homestead, neighbourhood e.t.c) in her welfare. These could include the partners, mother-in-law, sisters-in-law, brother-in-law, father-in-law, and one's own parents among others
-When in a polygynous family, the role of the co-wife in her welfare (either positively or negatively)
-Lectures taught at the clinic and how she perceived them
-Quality of health care and treatment in any of the visited options and whether the client was satisfied
-What in her opinion could be done to improve maternal health care.
-Issues of birth preparedness and postpartum arrangements
-Any other thing that the client deems important with respect to maternity in the home, at the clinic or in society in general.

9. PROVIDER-CLIENT OBSERVATION GUIDE

Observation of the interaction between the clients and the provider on the following concerns:

- Establishment of rapport and the overall environment (including greetings respectfully, introduction, privacy and confidentiality
- Taking of client history such as client's age, date of last menstrual period, number of previous pregnancies, pregnancies history e.t.c.
- Questions on risk factors such as bleeding during pregnancy, any vaginal discharge, current medication etc.
- Performing physical examination such as weighing the client, blood pressure, palpation, listening to foetal heart beats, blood testing for syphilis and explaining to the client the reasons for all the above.
- Treatment giving such as iron tablets, explaining the purpose of the tablets, offering the ATT injections and explaining the purpose of the injections.
- Advice or counsel about pregnancy in the following areas; Assessing the nutritional needs using body mass index, quality and quantity of food to eat in pregnancy, signs and symptoms of risk factors and the progress of pregnancy.
- Advice or counsel about delivery or infant care including where the delivery will be done, items to purchase ahead of time, use of skilled healthcare etc.
- Counseling and advise on family planning methods
- Signs and symptoms of STIs
- Physical examination of the external organs and genitalia among other observations.

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Appendix 2. Danger signs in Pregnancy

WHO (1986) and Smith et al. (2004) include the following as Danger signs in pregnancy for which immediate medical attention is required:

- Vaginal bleeding (Ante partum haemorrhage)
- Fever, itching all over the body and severe headache
- Continuous vomiting
- Dizziness and fainting
- Severe waist pains
- Uneven heartbeats
- Swollen feet, hands and face (proteinuria) and high blood pressure
- Yellow eyes
- Blurred vision, fits or convulsions
- Decrease or cessation of baby's movement

Other risks noted by Allen (2002) include:

- Chronic illness (TB, Asthma and today, HIV/AIDS)
- Early primagravida (16 years)
- Old primagravida (30 years and over)
- Intrauterine foetal death
- Grand multipara (6 times and above)
- Malpresentation of foetus
- Presence of operational scar (previous caesarean)
- Short stature

Danger signs after Delivery (Smith et al. 2004)

- Vaginal bleeding (postpartum haemorrhage)
- Stomach pain
- Vaginal discharge
- Vomiting
- Dizziness
- Uneven heart beat
- Genital sore

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Appendix 3. Religious 'Antenatal care' and services 'Hawking'

In the study was a Legio Maria maternal health care provider famously referred to as *MADHA* by her clients and other villagers in Sirongo village at a junction known as Ka John.

Among the procedures she performs on women in pregnancy includes the following:

- She checks the position of the foetus by touching the abdomen when a woman arrives
- She massages the abdomen using Deepak oil
- She prepares traditional herbs/medicine for those women experiencing stomach problems or any form of ailment in pregnancy
- She begins assisting clients as early as one month into the pregnancy till delivery. She gets the clients through "snow balling" or "hawking" of her services in the neighbourhood. This she does by walking around and finding out where there is a pregnant woman or through her other clients, she gets those others. Some women also recommend her to others who have just conceived. In a sense, her services come to women's doorsteps and they are massaged, treated or checked in the comfort of their own houses. This assists in getting even the lot of women who are ashamed of being seen in public more particularly the teenage pregnancies and other married women who are below 20 years of age and still cannot confidently face the public in their pregnant state.
- In all the activities she performs on a pregnant woman, she sprinkles holy water on the client and praying in the process using a special form of rosary called *katena* in the belief that God is the ultimate healer and owner of life.
- She declares that she assists only those clients with ANC card and is reluctant to assist those without the cards in the fear that in case of complications at delivery, she may not be able to handle and in the event of maternal death, she would be blamed. This however, is not reflective of the true position as she gets some of her clients at a very early stage before they begin clinic attendance. She refutes this by saying that in the event that a client begins seeing her early in pregnancy, she ensures that the client attends clinic at one of the facilities for the card. This introduces another angle to the ANC card as the drive to attend clinic. It is also a means and a passport to receive care from some of the caretakers outside the facility arrangements other than the emergency obstetric care at the facilities.

On delivery, she performs the following procedures among others:

- She delivers women and assists those with complications during delivery for example when the baby comes out on the wrong side like hands and legs coming out first
- She hastens the process of expelling the placenta after delivery
- Assists in the delivery of twins and others with difficult deliveries
- She admits that for her clients, she can assist even those without clinic cards
- She reports that she does not send away a mother who is in labour and requires her assistance whether she has a card or not.

Preparation of the medicine:

- Starts by boiling water and prays in the process using a rosary
- She then mixes lemon, tea leaves and *koo* (sweet menthols commonly taken by those with colds and sold cheaply in retail shops) and puts them in a *sufuria* (pan)
- Add the boiled water and continue boiling the mixture until the water turns brown in colour and she lets it to cool
- She administers the concoction to a patient, and it has to be taken when it is still warm, not cold or too hot.
- She says that this medicine is for those experiencing abdominal pains or *yamo* (any bad wind) in the stomach, which the medicine expels.

Her Opinion on maternal health care issues:

- She requests to be given modern health care facilities and trained in order to assist the women who cannot access the health care facilities located far away from them
- She believes and insists that all expectant women should first go to the clinics since this is the only place they can receive proper care in the event of any emergency and obstetric complications
- She says that she refers women with complications to the clinic and cooperates with the official maternal health care services providers for the better outcome of pregnancies.
- Believes that high charges should be checked if women are to attend clinic as expected
- Believes that some of the important cultural knowledge should not be discarded as women are more likely to identify with what they have been brought up to believe in. She for instance says that women

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should not be denied the right to carry away their afterbirths if they so wish and the birthing position in hospitals should not be too rigid as most women complain to her.

- She believes that the training process should tap on the existing knowledge and should concentrate on those already providing the services than training other women as TBAs whose interest in the maternal welfare is doubtable.

On the amount she is paid to deliver the services she says that she only receives token appreciations from the women and their kin. The clients only give her what they have and some make promises, which at times are never fulfilled. She believes that her powers and knowledge are God given and will always assist those who need her help as long as they come with or without anything to offer her.

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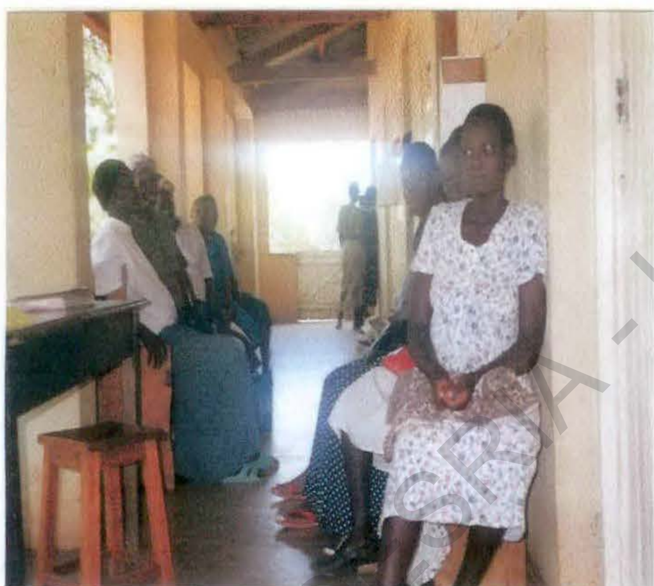
Appendix 4. Pictorials

Pictures showing Women queuing at a health facility for antenatal and postnatal care



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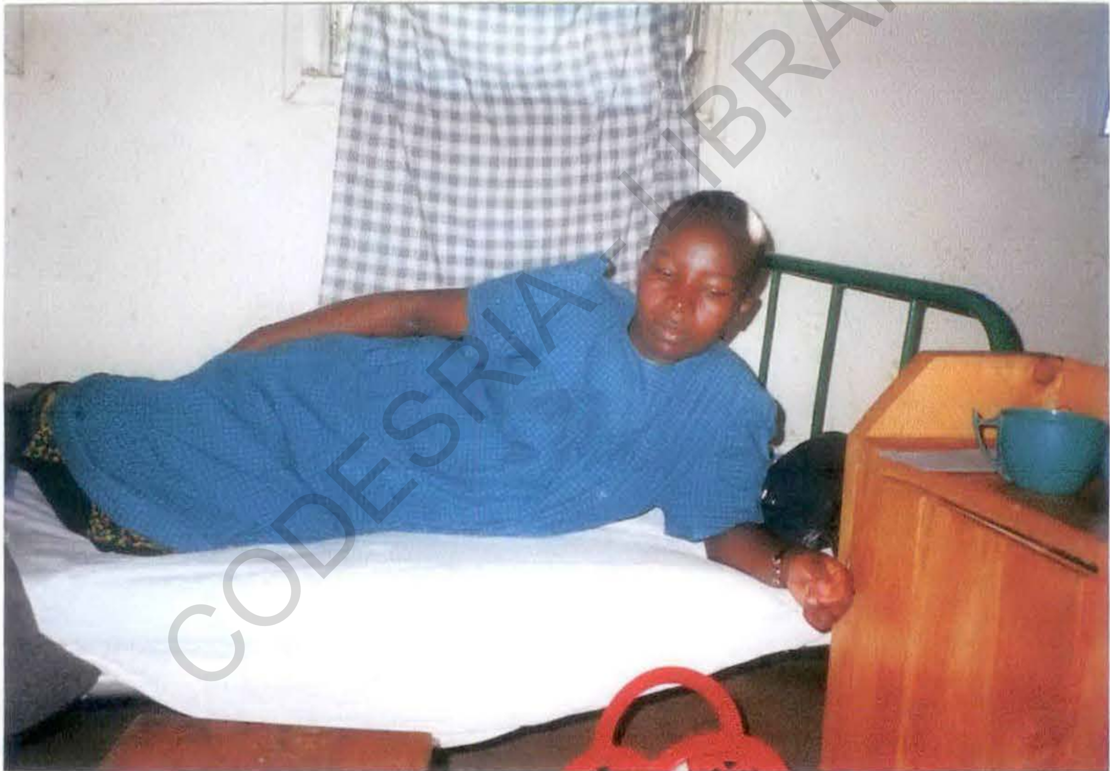
Pictures showing pregnant women being attended to by nurses at local health facilities

A woman in labour at a local maternity ward



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Pregnant mother with her caregivers who were good Samaritans (Later died with birth complications)

Pregnant mothers posing for a photograph at the Nango clinic after antenatal check-up