

SOCIO-CULTURAL FACTORS INFLUENCING WOMEN'S  
REPRODUCTIVE HEALTH (WRH) IN KATOLO SUB-  
LOCATION, KISUMU DISTRICT

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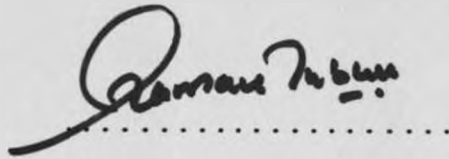
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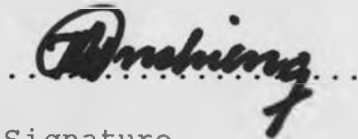
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## Dedication

I dedicate this work to my wife Mumbi, and to all Kenyan women and men battling tirelessly to emancipate and empower women .....indeed fighting for a just human society!

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## Abstract

This study examined some of the factors influencing women's reproductive health (WRH) in Katolo sub-location of Kisumu district, Kenya. It was prompted by a recognition that women's health is of utmost importance for the socio-biological survival of humankind. Women bear children, care for them, and socialise them into a community's desired habits. They, in turn, mature into adults, parenting future generations.

The focus of the study was socio-cultural factors which influence community WRH in Katolo, including customary beliefs and norms. The overall aim was to generate empirical data on the subject, which could hopefully serve as a basis for designing pragmatic intervention programmes, and probably provoke further inquiry into the problem.

Four hypotheses were formulated to guide in identifying and analysing the factors impinging on WRH in Katolo. Education and health awareness, customary beliefs and practices, and women's reproductive autonomy, were examined as the key variables explaining the WRH situation in the area. These were analysed in the context of *socialisation* and *gender* perspectives revealing the role of cultural ideology in sustaining certain cultural arrangements which impinge on community health.



Data collected from 98 women respondents were analysed electronically using the SPSS package. Interviews were also held with groups and key informants.

The key findings of the study were that; first, age at marriage had a bearing on women's knowledge and perceptions on reproductive matters, including associated illnesses. Older women age were more knowledgeable on such illnesses than younger women. Yet, the latter had higher chances of being victims of those illnesses. Second, women in Katolo perform heavy duties during pregnancy, including digging, weeding, carrying heavy loads and walking long distances. They do not perceive such duties as health hazards, for they have little or no option than to contend with a situation of 'absentee' male spouses. Third, women are affected by cultural beliefs as regards their nutrition and health. To some extent, food taboos determine their feeding habits during pregnancy.

Fourth, women in Katolo are fairly gender sensitive. They however, have little autonomy over crucial decisions affecting their sexuality and fertility. They also have little or no say on whether or not to provide equal education opportunities to their children.

Finally, the majority of women in Katolo do not use modern family methods largely because of 'fear' of their male spouses. They also poorly utilise modern child delivery, and instead utilize the services of TBAs.

The studies most overriding recommendation is that there is need to design and implement pragmatic and comprehensive programmes targeting WRH, to alleviate the scenario portrayed in the study. It calls for a concerted efforts by all stake holders - the government, NGOs and the community to improve WRH and general community health in Kenya.

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## List of abbreviations/acronyms

- AIDS - Acquired Immunodeficiency Syndrome
- CMA - Commonwealth Medical Association
- DHS - Demographic and Health Survey
- EPM - Energy-Protein-Malnutrition
- FP - Family Planning
- GOK - Government of Kenya
- HIV - Human Immunodeficiency Virus
- KMA - Kenya Medical Association
- MCH - Maternal and Child Health
- PID - Pelvis Inflammatory Disease
- STDs - Sexually Transmitted Diseases
- TBAs - Traditional Birth Attendants
- UNDP - United Nations Development Programme
- UNICEF- United Nations Childrens' Fund
- WHO - World Health Organization

# CHAPTER ONE

## BACKGROUND TO THE STUDY

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### 1.1 Background information

According to the World Health Organisation (WHO), health constitutes the complete physical, mental and social well-being of an individual person and not merely the absence of infirmity or disease (WHO,1992). Reproductive health is, therefore, not just the absence of disease or disability, but a condition in which the reproductive process is accomplished in a state of complete physical, mental and social well-being (WHO,1992). It relates to the health of individuals during their reproductive ages (15-45 years). According to Koblinsky et al. (1993), reproductive health is the ability to choose to have sex, to enjoy sexual relations without fear of infection or unwanted pregnancy, to regulate fertility without risk of unpleasant or dangerous side effects and to go safely through pregnancy and child birth. In a similar vein, Mati (1993) conceives the scope of reproductive health as that which confers three basic elements:

... the ability to reproduce, regulate fertility and to enjoy healthy sexual relationships; success in reproduction, survival, growth and healthy development of infants; and safety in fertility regulation and pregnancy - child birth should be achieved without health hazards and sex need not be a high risk activity (Mati, 1993:17).

Whichever notion of human reproductive health one may wish to adopt, it should be noted that it hinges upon an individual's health-life condition in the period preceding reproductive age. As the Commonwealth Medical Association (CMA) observes;

Reproductive health does not only relate to the health of women and men in their reproductive ages (15-45), but is a continuum just as the foundation of health in adult life is based on conditions in infancy, childhood, adolescence and even perinatal period (CMA, 1993:7).

The concern on women's health issues is underscored by women's unique role in socio-biological reproduction of society and their special health needs engendered by this role. Moreover, women's health is also a vital component in the global's present and long-term development goals including improved health and well-being of the future generations of children, women and men (CMA, 1993).

Women's reproductive health (WRH), is threatened by a myriad of complex factors including bio-medical, environmental, economic, political and socio-cultural factors. These factors which operate at both household and community levels pose great health risks not only to women, but to their children and the larger community.

The World Health Organisation (WHO, 1992), estimates that among 150 million women who become pregnant each year, half-a-million

die from pregnancy related causes. Unsafe abortion alone kills about 200,000 women, 99% of them in developing countries. About 60 million suffer long-lasting debilitating effects or "reproductive morbidity" which include infertility, maternal depletion syndrome, sexually transmitted diseases (STDs) including HIV/AIDS and other life-long physical disabilities. It is also estimated that, for every one woman dead of a reproductive problem, fifteen others live with varying degrees of morbidity (Mati,1993).

Some of the immediate bio-medical causes of these phenomena are well-known and have been widely documented. According to the Commonwealth Medical Association (CMA), these include haemorrhage, sepsis, obstructed labour, dystocia, eclampsia and anaemia (CMA, 1993:13). Other bio-medical causes are septic abortions, nutritional deficiency disorders, youth and old age pregnancies, inadequate care during and after delivery as well as persistent harmful traditional medical practices (GOK-UNICEF 1992:59).

A scrutiny of these problems, however, indicates that a number of non-medical factors, including environmental, political, economic and socio-cultural factors underlie this grave situation. Among the non-medical factors, socio-cultural factors are of great significance, not only to women's reproductive health (WRH), but also to the health of the general community.

Recent studies in Kenya touching on women's and children's health indicate that socio-cultural factors are among the major determinants of maternal and child health (Kuria, 1989; K'Okul, 1991; CMA, 1993; KMA, 1993; Paltiel, 1993). These socio-cultural factors include customary beliefs and practices.

## 1.2 Statement of the problem

Socio-cultural factors are said to be some of the major community health determinants, usually acting behind biomedical and other non-medical factors. This probably holds true, because a people's social organisation and individual attitudes are bound to influence every aspect of their life, including health behaviour.

It is well-known that certain cultural beliefs and customs underlie people's health perceptions, health-seeking practices, nutritional and sanitation patterns as well as their sexual and reproductive behaviour. They may impinge on certain social actions, interactions and relations which bear upon community health including women's reproductive health. Marriage customs may, for instance, touch on women's maternal age, reproductive decisions and family size which are major determinants of WRH.

This study sought to investigate some of the socio-cultural factors that influence WRH in Katolo sub-location, Kisumu district. The need to focus on this community arose from the



fact that, the Luo people, of whom the Katolo community is part, are said to harbour certain beliefs, customs and practices which impact negatively on their health (Suda, 1993; Ayiemba, 1993). On the basis of such information, it was assumed that beliefs, customs and practices inherent in the Luo culture could as well be influencing WRH. The study basically addressed the following questions :

- What socio-cultural factors (including beliefs, customs and practices) impact negatively on WRH in the Katolo community?
- To what extent do cultural values affect women's health perceptions, awareness and practices, and with what implications on WRH?
- In what way do socio-cultural values impinge on women's sexual and reproductive autonomy and with what consequences on WRH?

### 1.3 Purpose, objectives and scope of the study

#### 1.3.1 Purpose of the study

The basic aim or purpose of this study was to generate information on impediments to WRH among the Katolo people as part of the wider Luo community who are said to harbour certain beliefs and practices which impinge on their health. It is only

by generating such information that viable health projects could be conceived and implemented in the area. The study also aimed to contribute generally to the scanty knowledge available on the subject.

The study was carried out among the people of Katolo. They are part of the wider Luo community and other culturally related ethnic groups occupying the east Kano region of Nyando division, Kisumu district. Katolo sub-location consist of six villages, namely, Sare, Yogo, Kinasia, Olasi (Charare), Olasi (Orucho) and Holo.

### 1.3.2 Objectives of the study

The overall objective of the study was to identify and examine some of the factors which influence women's reproductive health (WRH) in the Katolo community. The specific objectives were to:

- Identify some of the socio-cultural factors (including beliefs, customs and taboos) which impact negatively on women's reproductive life in Katolo.
- Examine the extent to which socio-cultural factors influence the health perceptions and behaviour of women in Katolo and their consequences on WRH.

Investigate the relationship between socio-cultural factors, women's sexual and reproductive autonomy and its implications on WRH.

### 1.3.3 *Scope of the study*

This study was carried out among the people of Katolo. They are part of the wider Luo community and other culturally related ethnic groups occupying the East Kano region of Nyando division, Kisumu district. Katolo sub-location consist os six villages, namely Sare, Yogo, Kinasia, Holo, Olasi (Charare) and Olasi (Orucho).

### 1.4 *Rationale for the study*

This study centred on the health of girls and women during their reproductive age (15-45) as a matter of development concern. The health of women is critical from the perspective of their productivity and enhancing their role as contributors to national development and survival of their children (GOK-UNICEF, 1992: 127).

The need to undertake research in an area like this one stems from the fact that women reproduce populations through birth and care of children to perpetuate humankind. By thinking about their health, therefore, one is addressing a matter of global importance. In essence, it is a concern on a "human resource" - a vital component in development. For this reason, promotion,

and sustenance of good community health is an aspect worth consideration for any community that wishes to develop holistically.

The focus on socio-cultural factors which influence WRH is a pertinent and worthwhile undertaking, especially in the developing countries where some communities are said to have certain traditional values which are inimical to health promotion programmes (GOK-UNICEF, 1992). Some studies have shown that certain beliefs and customs prevalent in some communities are incongruent with their present health needs. Patriarchy attitudes for instance, impinge on women's health as they provide strong grounding and ideological justification for gender inequity.

Globally, the trend is towards a commitment on "health for all" by the year 2000, a requisite to having a future healthy global work-force. Amid a myriad of complex psycho-somatic disorders and pandemics, there is need to rethink some aspects of community cultural heritage which hamper gender equity in all aspects of community life, including health. Persistent cultural traditions which impact negatively on women's health conditions require to be done away with. More importantly, there is dire need to shed away pseudo-scientific perceptions which still keep human communities in the labyrinths of poverty, ignorance and disease.

It was hoped that this study would generate pertinent information regarding socio-cultural determinants of WRH, contributing to the scanty knowledge available on the subject and provide a departure point for further investigation into the problem.

### 1.5 Problems encountered in the study

The following were identified as problems and constraints in this study:

*Finances:* This was the main problem at the initial stage of the study. It took over a year between the proposal for this study was written and approved to the time the researcher went to the field for data collection. This was, however, solved by a grant provided by the University of Nairobi Deans' Committee on recommendation of the Director of the Institute of African Studies. Transport, which was initially an anticipated problem, was solved by coincidence. One of the study's supervisors was carrying out research in the same place. The combined research undertakings gave the researcher the advantage of having an institutional vehicle for local running in Katolo, and also solved most of the logistical problems that could have befallen the exercise.

*Health problems:* The researcher was compelled to go back to Nairobi for treatment and recuperation from a serious malaria attack in the middle of the data collection stage. Although this problem was anticipated as the place was a malaria zone, the attack still happened despite a prior inoculation against such ailments.

*Language:* This was not quite a big problem since the researcher used local personnel as assistants, one of whom he spent most of the time with. Yet there is always a limitation in fully grasping issues when they are communicated in a language other than one's own. Most of the respondents and participants in the study, however, understood the Kiswahili.

#### 1.6 Definition of terms

*Socio-cultural factors:* Cultural beliefs (perceptions, attitudes, knowledge), customs and practices.

*Women's reproductive health (WRH):* The health state of women of ages 15-45 years enabling safe motherhood.

*Negative health behaviour (NHB):* Attitudes, perceptions, beliefs and practices which may negatively affect health.

*Positive health behaviour (PHB):* Attitudes, perceptions, beliefs and practices which may promote health.

*Reproductive health problems:* Illnesses and other hazards associated with motherhood.

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## CHAPTER TWO

### LITERATURE REVIEW AND THEORETICAL FRAMEWORK

#### 2.1 Literature review

The literature reviewed in this section is drawn from pertinent medical, sociological and population-based studies touching on maternal and child health (MCH), women's health, fertility, family planning, and sexually transmitted diseases (STDs), including HIV/AIDS. It is mainly focused on non-biomedical determinants of women's reproductive health and socio-cultural factors in particular.

Broadly, women's reproductive health, lies within the realm of women's health which has to do with the entire range of issues that touch on women's illness, sickness, disease, wellness and wellbeing as well as those activities of prevention, diagnosing, healing, caring, and curing (Koblinsky et al., 1993). The reproductive health of women is at best perceived in a "woman's life-span approach" (Paltiel, 1993; World Bank, 1993). This is because WRH is determined by health conditions in the entire period that precede a woman's reproductive age (CMA, 1993; KMA, 1993).

Following a 'woman's life-span' approach, the key issues regarding WRH include, among others, women's nutritional



behaviour, sexual and reproductive behaviour, access to and effective use of modern health and family planning services, and women's vulnerability to both infectious and communicable diseases. Because women are likely to be afflicted by a myriad of ailments during their entire life-span, it follows that every health-related aspect of their life bears on their reproductive life and health.

During their reproductive age, women are under constant health threats associated with both their socio-biological role and their roles in community life. Their increasing and double work-loads in rural households engender excess stress and perpetual fatigue on them. This is because whether women are pregnant or not, they have to draw water, fetch firewood, cook and tend for children, which immensely contribute to what is referred to as "the women's burden of disease" (World Bank, 1993). The excess workloads placed on women may be appreciated in the context of men's drift to urban centres for employment and the sexual division of labour as ascribed by cultural tradition.

There is the common belief that women are usually healthier than men and, therefore, live longer, a belief further buttressed by the fact that girls are born with a biological advantage over boys (NCPD & DHS, 1989; Bervazian, 1993; CMA 1993). In developed countries, for example, males have higher

mortality than females at all ages. The infant mortality rate stands at 63 per 1000 live births for males and 54.3 per 1000 live births for females. This means that in early childhood, the female child has greater survival chances (NCPD & DHS, 1989).

It has, however, been established that women are more sickly than men throughout their life-span (World Bank, 1993). They also experience more sickness and disability at an earlier age than men (KMA, 1993). Studies conducted in Malaysia, Bangladesh, Jamaica and United States, reveal that women's problems begin earlier in life and persist longer in old age with the result that women suffer more from both acute and chronic non-fatal diseases (Strauss et al., 1992). It has been established that most women of child bearing age have poor nutritional status, and so may suffer endemic infectious diseases.

The early onset of health problems among women emanate from, first, their biological nature and their special health needs during reproductive age and, secondly, the social, political, economic and cultural contexts in which they are born, raised and perform expected roles. This fact is acknowledged in most medical and population-based studies (CMA, 1993; KMA, 1993; GOK/UNICEF, 1992). According to CMA (1993), for example, health-related gender differentials are determined by a

complex of biological, environmental, socio-economic and cultural factors.

Nevertheless, great emphasis has been placed on the view that women's reproductive systems make them more susceptible to a variety of medical conditions and diseases regardless of whether they become pregnant or not (CMA, 1993; KMA 1993). The pre-eminence that has been given to biomedical determinants of women's health inherent in medical literature, further tend to obscure some of the basic explanations to WRH which largely lies on the non-medical factors, and socio-cultural ones in particular.

It would probably be sheer naivety to attribute WRH problems solely on women's biological nature and biomedical factors with little or no cognisance of the political, economic and socio-cultural contexts. Anecdotal evidence indicate that socio-cultural factors underlie, and actually do aggravate women's life-long vulnerability and threats to their general health (KMA, 1993).

## **2.2 Factors influencing WRH**

The biomedical and environmental determinants of human health, including WRH, have considerably and competently been tackled by several medical and population-based studies in both local and international circles e.g. Manguyu (1993), CMA (1993), World Bank

(1993), KMA (1993), FHI (1994), etc. Other non-biomedical determinants, other than socio-cultural ones, have had a fair treatise in sociological and other social science studies. In the latter, environmental, political and socio-economic factors have had a greater emphasis e.g., Kuria (1989), K'Okul, (1989), WCK/UNICEF, (1992) Khasiani (,1992 Wamahiu, (1992) and K'Oyugi (1992).

This study primarily focused on socio-cultural determinants of WRH, an area which at the time of the study, was only peripherally treated in the available literature. A closer scrutiny of biomedical factors reveal their socio-cultural dimension for, behind them, are beliefs, customs and practices, which are core to a comprehensive understanding of not only WRH, but a broad range of community health issues.

### **2.2.1 Malnutrition**

Malnutrition simply means insufficient food intake, either by quantity (in terms of calories or joules) or quality (in terms of whether the food taken is a balanced diet or not - a diet that contains all the requisite nutrients that a human body requires), and in the right proportions (K'Okul, 1991). A balanced diet usually includes carbohydrates, proteins, vitamins plus micro-nutrients or trace elements such as boron, calcium, magnesium, iodine and cobalt. The broader view of malnutrition considers

other environmental factors detrimental to good health (K'okul 1991:5).

Malnutrition among women (whether in childhood, adolescence or in reproductive age), hampers their productivity, increases their susceptibility to infections and contributes to numerous debilitating and fatal conditions (World Bank, 1994). In this way, malnutrition has a direct influence on WRH. Yet, the immediate factors underlying malnutrition may be environmental, political, economic and, in essence, socio-cultural.

It is estimated that about 450 million women in the developing countries are stunted due to - protein energy malnutrition (PEM) during childhood, which places them at risk of obstructed labour (World Bank, 1993). Over 50% of the pregnant women are anaemic, about 250 million suffer the effects of iodine deficiency (WHO, 1992) and millions suffer blindness due to vitamin A deficiency, even though the exact number is unknown (Leslie, 1991).

Among the major causes of malnutrition in a community for example, are inadequate food supplies, its inequitable distribution, lack of nutrition awareness, and customary taboos. Women's malnutrition, in particular, hinges upon socio-cultural factors which stem directly from certain customary beliefs, norms and practices.

### 2.2.1.1 Socio-cultural causes of malnutrition

A World Bank report (1990) indicates that widespread malnutrition is a characteristic of the developing countries causing incidences and severity of health problems. Some studies have attributed malnutrition to poverty, as well as economic and technological backwardness of developing countries, while the fact is that malnutrition is a symptom of existing social inequalities (Kwofie, 1983; Sicoult, 1983; CBS/ UNICEF, 1984). Poor nutrition is not a product of economic factors, but socio-cultural ones as well. According to Luikj (1974:60) "to a large extent socio-cultural factors determine the nutritional status, for patterns of food use and habits depend on the cultural heritage of a society to which an individual belongs".

Certain studies have indicated that religion, superstition and taboos concerning foods are common and have a bearing on the nutritional status of mothers and children (Luikj, 1974 Kuria, 1989; GOK/UNICEF 1992; K'Okul, 1993; Nduati, 1992). According to Luikj (1974), for example, among many ethnic groups in East Africa there are special foods for pregnant women in order to safeguard against trouble during pregnancy. Among the Maasai, certain foods are prescribed for pregnant women which has implications for the baby's weight at birth and the post-natal health of both (Kuria, 1989). A pregnant Maasai woman is advised to avoid fatty foods, to drink cow blood, sour milk and lots of water, and (in some cases) to vomit after a heavy meal in the

belief that this makes delivery safer for both herself and the baby (GOK/UNICEF, 1992:32). Among the Abasamia of Western Kenya, pregnant women are not allowed to feed on pork, chicken, eggs or milk, for they are believed to cause sterility (K'Okul, 1991). The denial of highly nutritious foods to adolescent girls and women in adherence to certain community cultural beliefs and customs has negative implications for WRH as well as the neonatal health of the *paupera pair*. Medical studies point out that women require higher nutritional intakes than men in adolescence to enable them cope with the health demands during pregnancy and lactation. It is during adolescence that girls increase their nutritional needs due to their growth spurt associated with puberty and the onset of menstruation (World Bank, 1993). Inadequate diet at this time can jeopardize their health and physical development with life-long consequences including iron-deficiency (World Bank, 1994). This may also engender cephalopelvic disproportion, leading to obstructed labour and other pregnancy complications which may, in turn cause, women life-long morbidity.

Other beliefs and customs rationalise inequitable food distribution within the family, with females being fed less than males. The result is health and nutritional status differentials between the sexes. A study conducted in Kisumu (UCLA & U.O.N, n.d.) revealed the existence of discrimination against adolescent girls, with mothers giving more food to male children of

comparative ages on the pretext that boys require and demand more food than their sisters. It was also observed that during food scarcity, feeding the male members of the household became a priority to the detriment of the females. This leads to stunting of females, a condition that bears negatively on their reproductive life, including delivery of low birth weight babies later in life (Nduati, 1992).

Differential food and nutritional intakes as patterned and rationalised by persistent cultural beliefs and customs, therefore, explain gender health and nutritional differentials between sexes in most communities in the developing world.

Although, according to GOK/UNICEF(1992), there seems to be no male bias in food distribution in Kenya at statistically significant levels, several other studies have pointed out this bias (Wamahiu, 1992; Manguyu, 1993; UCLA & U.O.N, n.d.). Studies conducted in Asia and the Near East also indicate that women are more likely to suffer from nutritional deficiency (iron-deficiency anaemia, energy-protein- malnutrition and iodine deficiency) than men (KMA, 1993).

Other factors which contribute to malnutrition among women is their general lack of health and nutritional awareness which is closely associated with their lack of health and nutrition education (GOK-UNICEF, 1992; World Bank, 1993; K'Oyugi, 1992).



Persistence of certain traditional beliefs and perceptions has also militated against their knowledge-base in the areas of health, disease, sanitation and nutrition (GOK/UNICEF, 1992). Among the Abasamia, for example, the perceived causes of diseases such as marasmus, kwashiorkor and measles, is a breach of certain taboos or *chira* (K'Okul, 1991). Coupled with low levels of literacy, inadequate health information, education and communication systems and lack of general formal education in the rural areas, these beliefs buttress the prevailing ignorance on health and nutritional issues among women.

#### **2.2.2 Levels of education and health awareness**

About two-thirds of the world's illiterate population are women (CMA, 1993: 10). This can be explained by the fact that in many countries, little is expected of girls beyond the fulfilment of family duties. Certain cultural traditions, for example, bride wealth payment, exacerbate the 'burden' of a daughter, such that parents are less willing to invest on girls' education. In some Kenyan communities, girls are married-off upon the first signs of puberty, thereby denying them an opportunity to pursue higher education.

According to Onyango et al. (1990), the explanation for the low levels of education among mothers is a historical phenomenon, as females have not been involved in high level education since the colonial era (Kayongo & Onyango, 1984). Low levels of education

among women has also been attributed to teenage pregnancies, early marriages and gender discrimination (Wamahiu, 1992).

Lack of basic education among girls leaves them unprepared to find employment outside poorly paid, insecure and often exploitative world of casual work (CMA, 1993). It also perpetuates their ignorance on sexual, nutritional and family health education and renders them for early sexuality and motherhood together with the attendant reproductive health problems. Research has shown that health, sanitation and nutritional behaviours have a positive correlation with educational levels. Education is a crucial determinant of marital age, family size, fertility, adoption of family planning services, etc. (GOK-UNICEF, 1993; World Bank, 1993c; FHI, 1994). All these have an influence on women's reproductive health.

Whatever the reasons for the low levels of education among women, it plays a significant role in the way they perceive and tackle matters of health, disease, nutrition and sanitation, all of which have implications for their reproductive health. Studies have further indicated that, educated women utilize ante-natal, family planning and health services more readily than the uneducated ones (Wamahiu, 1992; Nduati, 1992; K'Oyugi 1992; FHI, 1994). Research has shown that girls who have attended school especially upto secondary level, are more likely to adopt positive health behaviour such as delayed marriage and child

bearing, small family size, use of health care facilities and appropriate child health-care (Schulz, 1989).

The implications of lack of basic education and persistence of certain beliefs can be understood if one appreciates the fact that, in the developing countries, 20-30% of married women wish to avoid pregnancy without using contraception (Westoff & Cchoa, 1991). It is estimated that one child in every five births is through unwanted pregnancy. About 40-60 million women resort to abortion for unwanted pregnancy, globally accounting for 125,000 - 200,000 female deaths annually (Rosenfield, 1989; Dixon & Muller, 1990; WHO, 1992).

### **2.2.3 Gender discrimination**

Gender discrimination is a major factor influencing women's health and WRH is particular. According to CMA (1993), girls are born with a biological advantage over boys which, in a number of countries, is cancelled out by the social disadvantages suffered by women and girls. In reference to women's reproductive health, gender discrimination is viewed by CMA as:

... a complex phenomenon [which acts] on the health of girls and women in a variety of ways: e.g. through culturally deep-rooted differential feeding practices, additional burden of work inside and outside the home and through the absence of provision for their special needs particularly in reproductive health...women suffer and die because they are neglected as children; married too young; poor and illiterate, underfed and overworked; subjected to harmful traditional practices, denied equal social, legal

and economic status; and because they are excluded from decision-making (CMA, 1993:9 & 13).

From an earlier discussion on malnutrition, it is observed that girls and women are discriminated against in regard to adequate nutrition and health-care (World Bank, 1993). In communities where boys are more valued than girls, boys receive more preventive care and more attention the sooner they get ill' while girls receive less food and less nutritious foods than boys (Ravindran, 1986).

Nowhere is gender discrimination most manifest than where there exist selective abortion of female fetuses and female infanticide. In some South East Asian countries, the sex of the foetus is detected through ultra- sound equipment and amniocentesis (Heise et al. 1993). In Bombay India for example, only one out of 8,000 abortions is performed on a male foetus (Ravindran, 1986).

#### **2.2.4 Sexual and reproductive autonomy**

Among most communities in the developing world, women have little or no say in matters regarding their sexuality and fertility. They lack basic rights within the family and society in most African communities. It is the men, for example, who dictate the timing and terms of coitus, and women may not have the right to refuse intercourse with their partners or demand the use of condoms or other contraceptives (Ascadi, 1993). A study

conducted in Kinshasa on gender roles' in family planning, revealed that men initiate most major fertility and family planning decisions, including the use of contraceptives. The results of the study indicated that the adoption and the successful use of contraception within marriage depends largely on the men's desire to stop childbearing (UNDP/WHO/World Bank, 1994:7).

The negation of women's sexual and reproductive rights hinge upon cultural attitudes and customs such as patriarchy which are further buttressed by laws that have been fashioned in accordance with cultural traditions. Among some communities, women are beaten or otherwise abused when they do not comply with men's sexual or child-bearing demands. This has an impact on family planning use and the incidence of STDs with implications on women's reproductive health. Globally, most women are not empowered by enacted law or by culture to be in control of their sexuality, health and reproduction (Heise et al., 1993). In Guatemala, for example, the law gives husbands the right to prohibit wives from even working outside the home. Divorce is illegal in Chile even on extreme circumstances of abrogation of the woman's rights (Heise et al., 1993). This lack of women's autonomy over their sexuality exposes them to the dangers of sexually transmitted diseases (STDs), including HIV/AIDS, reproductive tract infections (RTIs) and increased cases of unsafe abortions.

### 2.2.5 *Early sexuality and maternal age*

It has been observed that in many parts of the developing world, especially in rural areas, girls marry shortly after puberty and are expected to start having children immediately, such that most women become mothers before the age of 20 years (CMA, 1993). According to the Commonwealth Medical Association, "those who start bearing children early generally have more children at shorter intervals than those who embark on parenthood later" (CMA, 1993:11).

Most often, late marriage means postponement of child bearing, permits longer schooling for girls and minimizes exposure to the risks associated with child-bearing, premarital sex, unwanted pregnancies and sexually transmitted diseases (Westoff & Achoa, 1991). According to a World Bank report (1993), young women are at particular risk of HIV/AIDS infection. Today, young women (between 15-25) account for 70% of the HIV infected females world wide (World Bank, 1993).

Studies conducted in western Kenya ( Wamahiu, 1988; Ayiemba, 1993; Suda, 1993) found that between 46% and 65% of teenage girls have had sexual intercourse at least once. In Kisumu, it was observed that girls at the age of 14 years and below had already conceived their first babies (DHS, 1992). The risks of early sexuality and child-bearing include risks of STDs infection,

septic abortions, perforated uterus, ectopic pregnancy, infertility and death (Nduati, 1992). Pregnancy related risks include toxemia, anaemia, excessive bleeding, nutritional problems, and cervix perforation and obstructed labour due to cephalopelvic disproportion (Manguyu, 1989).

The vulnerability of young women to STDs, the risk of pregnancy-related complications, septic abortions and the associated debilitating effects are a formidable threat to WRH. According to Njau (1993), early sexuality and pre-marital pregnancies can be explained by personality and socio-cultural factors within the context of the communities in which teenagers live.

#### **2.2.6 Marriage practices**

Some studies have observed that certain persistent marriage practices are likely to affect WRH through exposure to STDs and HIV/AIDS (Suda, 1993). Practices such as polygyny, concubinage, levirate and sororate marriages as well as arranged marriages for teenage girls have implications for spread of disease (GOK/UNICEF, 1992; Suda 1993). These practices for example, place the Luo community in a vulnerable position to infection of STDs and HIV/AIDS (Suda, 1993:11). In the case where a deceased wife is replaced by her sister as a matter of custom among the Luo, if she had died of HIV/AIDS condition, her sister would meet the same fate.

### 2.2.7 Health beliefs and perceptions

Certain traditional medical beliefs and health perceptions account for the spread of disease among some communities in the developing countries. In Kenya, traditional beliefs about the causes of disease persist to a greater or lesser degree in different ethnic cultures (GOK/UNICEF, 1992). According to this same source:

some of these beliefs and practices... are consistent with scientifically acknowledged causes and treatment of disease. Others by contrast, make the control of preventable diseases difficult...(GOK/UNICEF 1992:31).

It is these beliefs and perceptions, for instance which sanction and justify certain practices which have a bearing on WRH. According to GOK/UNICEF, in Nyanza Province;

... a woman must, when her husband dies, "marry" an in-law or another man who is expected to help the family of the dead man remain intact... If the man dies from an illness resulting in heavy weight loss (such as AIDS), and if this illness cannot be related to a known disease, people will attribute it to *chira* and because *chira* is not considered contagious or transferable, one of the man's relatives, or some other man, will still 'inherit' his wife (GOK/UNICEF 1992:32).

The belief that certain diseases are caused by *chira* enhances ignorance and pseudo-scientific perceptions on health and disease. It hampers the knowledge base on diagnostic and prophylactic measures to certain ailments.



### 2.2.8 Access to, and utilisation of health-care services

Several factors, including traditional beliefs and customs inhibit women's use of available health care services. Modern health services help promote WRH through maternal and child health-care and family planning (MCH/FP) services. However, traditional customs which govern the care and nutrition of pregnant women impose obstacles on the utilisation of prenatal health services (KMA, 1993:173).

Admittedly, the major factors which limit women's access to modern services also include poor infrastructure, inadequate health services focused on women as a special category, poverty and discrimination of young and unmarried women (GOK/UNICEF, 1992).

Population-based studies indicate that women are generally less likely to utilise available health services because of their workload (which limits the amount of time devoted to seeking health care), poverty, and physical distance from health facilities (Gay, 1993:167). The quality of services offered is yet another factor which hampers women's utilization of health-care services. For example, health systems in most countries ignore infertility, STDs, adolescent health, female circumcision, violence, occupational health, and provider-client relationships (Gay, 1993).

Women's lack of empowerment and control is a key determinant of WRH. This is closely associated with the low status accorded to women among most communities in the developing countries. According to Gay (1993), socio-cultural factors influence the women's ability to make and act on decisions with regard to their use of health services.

### 2.3 Theoretical framework

This study adopted the gender and socialisation perspectives in an attempt to identify and examine some of the key issues pertaining to women's reproductive health among the Luo community of Katolo sub-location, Kisumu district. It is evident from the literature reviewed in this chapter that certain socio-cultural factors negatively influence women's health in most communities in the developing world. These factors may not be understood outside the social structures which nurture and sustain them.

The conceptual and analytical value of these perspectives in a study such as this one is underscored by the fact that, human behaviour (including perceptions, attitudes and practices), are essentially conditioned by culture. The various aspects of culture themselves are acquired through learning processes, which may collectively be termed as *socialisation*. It is probably important to understand the terms *socialisation* and *gender* before we proceed to demonstrate their usefulness to the study.

### 2.3.1 Socialisation

According to the *International Encyclopaedia of Social Sciences*, socialisation is "the process by which culture is transmitted from one generation to the next, or how a new person is added to the group and becomes an adult capable of meeting the traditional expectations of his [her] society for a person of his their sex and age" (1968:545).

In other words, socialisation is the process through which an individual learns to become a member of society, through both formal and informal induction into social roles (Smith, 1986). Through socialisation, individuals are inculcated into the values, norms, mores (in essence the total life) of the community in which they belong so that they are able to function within it by performing the roles expected of them. Norms, mores and values constitute aspects of culture and since it is culture that is transmitted through the socialisation process from one generation to the next, it is imperative too, to briefly comment on its meaning.

The classical meaning of the concept of 'culture' is offered by E.B. Tylor (1871) who regarded it as "... that complex whole which includes knowledge, belief, art, morals, customs or any capabilities and habits acquired by man as a member of society". Going by this definition, culture is an acquired rather than a biological phenomenon. The process of socialisation is the core

to acquisition of knowledge, beliefs, art, morals and customs through both formal and informal non-biological mechanisms. American Anthropologists prefer to use the term 'enculturation' in reference to socialisation, particularly when addressing issues of 'culture and personality'.

### **2.3.2 *The gender perspective***

The term 'gender' is a socio-cultural construct unlike 'sex' which is biological. As Oakley (1972) puts it:

To be a man or a woman, a boy or a girl, is as much the function of dress, gesture, occupation, social network and personality as it is of possessing a particular set of genitals (Oakley, 1972:158).

The gender perspective recognises 'gender' as the key principle that organises social arrangements, actions and even cognition (Hess & Ferree, 1987). These socio-cultural arrangements, actions and cognition include roles, perceptions and beliefs as well as self-images. They all constitute parts of a community's culture. They are understood and internalised by community members through nurturance and socialisation.

### **2.3.3 *Relevance of the perspectives to the study***

An individual's health behaviour is part and parcel of general community behaviour acquired through learning. As such, medical beliefs, perceptions and practices are acquired through socialisation. Cultural conditioning, which is achieved through socialisation or 'enculturation' is what makes individuals (men

and women) to take up their culturally ascribed roles and statuses without questioning. In this respect, the gender-role ideology which is nurtured through socialisation place both men and women in their respective ascribed positions in society.

Social scientists have pointed out that the socio-cultural environment determines behavioural patterns and roles among human beings. According to Wamahiu (1992), gender roles are socio-cultural roles allocated to individuals by society on the basis of their bio-cultural, rather than their biological characteristics. This allocation of roles by gender incorporates a system of unequal rewards in terms of prestige, wealth, power, authority and autonomy, which results in status disparity between men and women world wide.

The importance of these perspectives in understanding women's reproductive health lies in the assumption that gender health differentials emanate from certain cultural attitudes and practices. These are acquired through socialization and they place women in disadvantaged positions which bear on their welfare, including health.

The emergent theme from the reviewed literature is that women's health and nutrition during childhood, adolescence, reproductive age and beyond, is highly influenced by socio-cultural attitudes and practices. Traditional cultural beliefs, customs and

practices negate women the autonomy and control over actions that touch on their reproductive health. They hamper their knowledge-base in terms of health and nutrition, family planning, and other health-related issues. The fact that most women do not have equal access to formal education and that they are over-burdened with heavy workloads, inhibits their utilisation of available health services.

Through socialisation, most women internalise and accept as 'God-ordained', their low status in society such that they may not question, for example, why they have to eat less and low quality foods, be forced to marry early and bear many children and so on, to the detriment of their health. Actually, the role model presented to girls is that of a caring, self-sacrificing mother who is always at the service of others (Wamahiu, 1992).

It has been noted that girls internalise at home and within community negative self-images and values which are not conducive for their welfare, including health, education and even career aspirations (Wamahiu, 1992). Early marriages, for example, may be a result of the positive image portrayed for girls who make good wives and bring bride wealth to their parents.

The very basis for gender discrimination in most spheres of life, including health, emanates from the manner in which boys and

girls are brought up and the value attached to each. Among the Gikuyu community, for example, four ululations are done for a baby girl at birth and five for baby boy, indicating that there is more happiness when a boy (heir) is born than when a girl is born. It is so in most other societies (see for example, Mberia, 1974). Gender discrimination, therefore, has its underpinnings in communities' cultural dispositions. It is one of the identified factors which influence women's reproductive health.

#### 2.4 Study hypotheses, measurements and indicators

The following four hypotheses were formulated to guide the study:

H. *Socio-cultural factors have a negative impact on women's reproductive life*

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**Measurement:** What factors (e.g. beliefs, customs and taboos) negate WRH by touching on nutrition and health behaviour, fertility and reproductive decisions, utilisation of modern health care services? What influences women's health perceptions, awareness and practices, and with what implications on their reproductive lives?

**Indicators:** Presence of adolescent mothers, nutritional deficiency disorders, non-use or ineffective use of MCH/FP services, nutritional and health beliefs; prevalence of diseases associated with early maternal age and certain

traditional customary norms; early resumption of post-partum sex, pseudo-scientific perceptions on health and illnesses, including disease symptoms, prophylaxis and therapy.

H<sub>2</sub> *Negative health behaviour is more associated with old persons who adhere to traditional values than with young persons who do not adhere to traditional values*

**Measurement:** What constitutes negative health behaviour in reference to reproductive health? Who are older persons who adhere to traditional values? Who are young persons who do not adhere to traditional values?

**Indicators:** Presence of health beliefs, perceptions and practices that negatively affect women's reproductive health (e.g. food taboos, gender-based wilful malnutrition, premature motherhood, promiscuity, early marriages, preference for traditional healers vis a vis modern medical practitioners).

H<sub>3</sub> *Individuals with high educational and health awareness levels are more likely to adopt positive health behaviour than individuals with low educational and health awareness levels.*



**Measurement:** What constitute high/low educational and health awareness levels? What constitutes positive health behaviour?

**Indicators:** Presence of persons with education beyond primary school and basic knowledge regarding common disease symptoms, causes, prophylaxis and treatment. Also presence of people with little or no knowledge on common diseases symptoms, prevention or treatment.

H<sub>4</sub> *Women with control/autonomy over sexuality and fertility decisions are likely to have less reproductive health problems than women without control/autonomy over sexuality and fertility decisions.*

**Measurement:** What constitutes control/autonomy over sexuality and fertility decisions? What are reproductive health problems?

**Indicators:** Presence of women who make decisions over coitus, utilisation of MCH/FP Care, family size. Presence of pregnancy related health problems, e.g., premature pregnancies, obstructed labour, STDs and HIV/AIDS, and other debilitating conditions affecting WRH.

## CHAPTER THREE

### METHODOLOGY

#### 3.1 Site Selection

The choice to conduct a study among the Katolo community was based, first, on the consideration for funding which is usually a critical factor in any research undertaking. An on-going participatory action-oriented research (PAORA) project, headed by the then Research Fellow at the Institute for Development Studies, Dr. R.N.O K'Okul, agreed to affiliate the study to the Katolo Maternal and Child Welfare Organisation (KAMACHO) such that, the researcher did not have to seek for a study permit and to deal with other logistical matters to get to Katolo.

#### 3.2 Site description and community background

Katolo sub-location is situated in Kisumu district, Kenya (see Map 1). The district, which is in Nyanza Province of western Kenya, covers an area of about 2,600 km<sup>2</sup>. It is administratively divided into eight divisions, namely Maseno, Winam, Muhoroni, Mtwani, Upper Nyakach, Lower Nyakach, Kadibo and Nyando divisions (see Map 2).

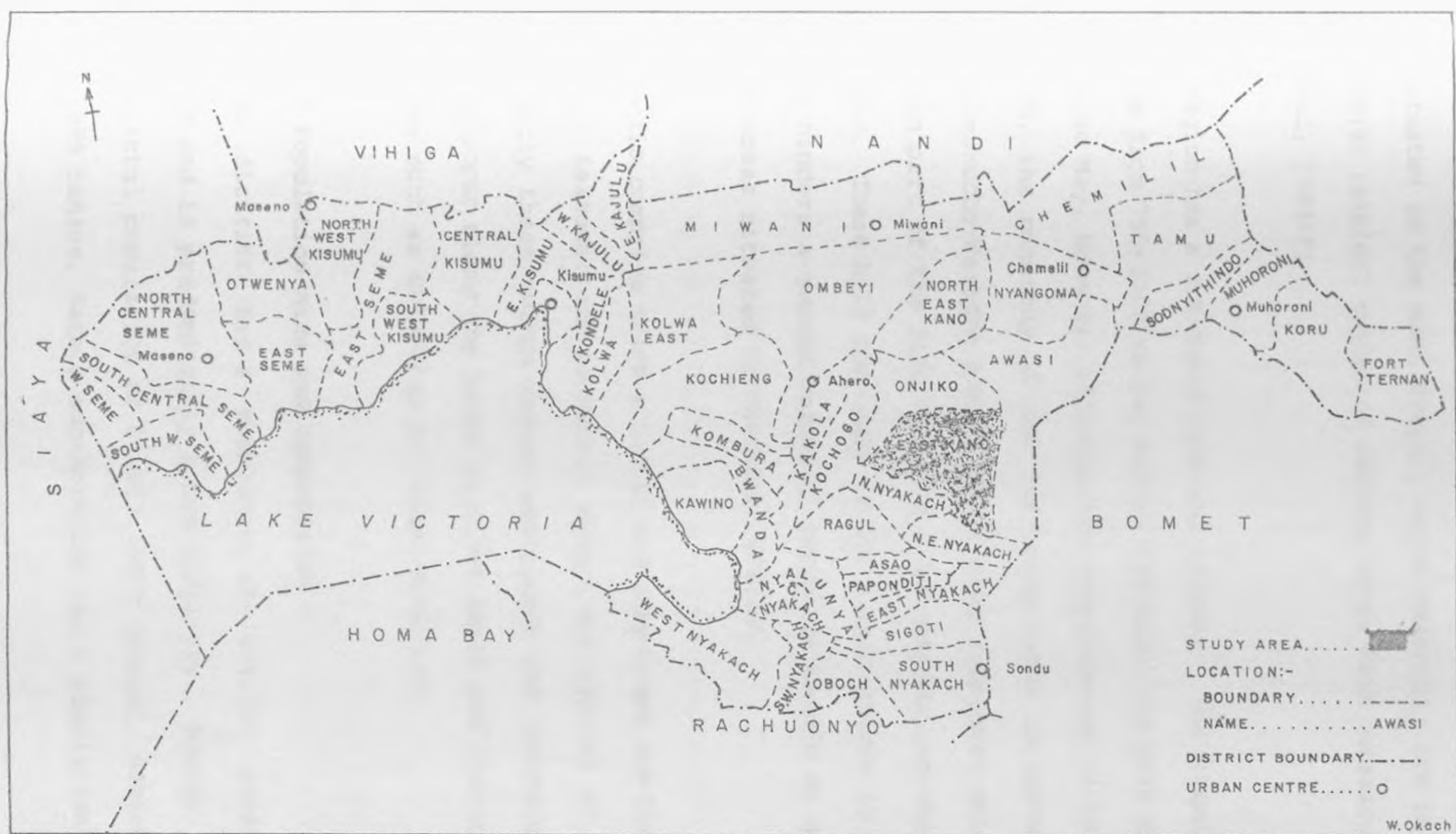
##### 3.2.1 Topography, climate and soils

Katolo sub-location falls in Nyando division, which borders Kericho district to the East, Nyabondo plateau to the south,

# MAP 1



LOCATION OF KISUMU DISTRICT IN KENYA



MAP 2

Nandi escarpment to the North and Lake Victoria to the West. It is situated in the Kano Plains, which generally lie in the high potential rainfall region of western Kenya with occasional floods (K'Okul, 1993:5).

The region has a sub-humid tropical climate. The annual rainfall varies from 750-2100 mm per annum, reaching its peak during mid March to May. However, although the sub-location is in the Kano plains, the monotony of the low-lying lands is broken by the Cmuono-Orucho-Waradho and Minyonge hill complexes which extend to form part of the Rift Valley relief complex and the Nyabondo plateau. These hill complexes create a rain-shadow in the area, which hinders a second rainfall regime in Katolo as enjoyed by other areas situated in the Kano plains.

The soils comprise thick alluvial and clay-loams and black-cotton soils. Seasonal and permanent swamps are typical of the area. Presently these swamps remain wastelands and undeveloped. They mostly occur along the banks of river Awach and the area's main streams such as Holo-Yogo and Olasi-Nyaljigo.

### **3.2.2 Population size and composition**

Kisumu district has a population of 664,086 people (1989 Census and is predominantly a Luo territory. Nyando division has a total population of 94,977 (1989 census). According to the 1989 census, Katolo sub-location has a population of 5,591

people, constituting 6% of the total Nyando division population (CBS, 1994). Katolo sublocation comprises six villages namely, Sare, Yogo, Kinasia, Holo, Orucho(Charare) and Orucho (Olasi).

### 3.2.3 Land use

The major economic activities on land include small-scale farming of cereals -rice, sorghum, millets and maize; root crops -cassava and sweet potatoes, and pulse varieties of beans, cow peas, lentils and groundnuts. Livestock farming in the region consist of rearing cattle, sheep, goats, donkeys, poultry and bee-keeping. Animal products, mainly used for subsistence, include beef, milk, ghee, blood, eggs and honey.

Land is yet to be consolidated and therefore is fragmented and owned along tribal lines. There is, thus, a limitation in terms of output engendered by this type of agrarian system. Bush furrowing is indeed practised in the region, which has led to massive destruction of the original tree canopy and bush land. There is remarkable non-use of modern fertilizers and other aspects of modern agricultural practices. Technological level is thus still rudimentary, with the hoe and machete as the main production tools in the community.

#### 3.2.4 Socio-economic infrastructure

The Katolo community (comprising Katolo and Acheho sub-locations), is poorly served in terms of transport and communication networks, educational facilities and health care services. During the rainy season, most areas are inaccessible due to the quality of existing rural access roads and the geological nature of the region. Katolo sub-location, for instance, has five primary schools (Sare, Kinasia, Olasi, Yogo and Holo), and one secondary school. School enrolments are extremely low, while school drop-out rate is high among girls from standard four onwards.

There are four access roads which traverse the sub-location; Odenya road from Waswa through Kinasia health centre, to Gabsorok; Otho Rakuon/Thurgem/Store Pamba road; Awasi/Olasi/Gabsorok road and Awasi/Kuth-Awendo/Katito roads. However, there is today conspicuous absence of any road networks in the region. The areas are utterly inaccessible by motor vehicles during the rainy season. There are numerous churches and one marketing centre (Wang'eno), and a big market, Katito (outside the sub-location) situated at the junction of the Sondu-Ahero-Kisumu tarmac road.

Services such as telecommunications and electricity are absent, not featuring even in Katito market, although they have reached neighbouring Wawidhi location, less than ten kilometres away.

There is however piped water at various points in the sub-location, the most notable being water kiosks provided by the KWAHO and UNICEF projects. At the time of the study very few of these were in operation.

### *3.2.5 Problems of development in the area*

Problems hampering development in the region include cultural conflicts, erratic climate (engendering intermittent droughts and flooding), diseases (malnutrition, chira, HIV/AIDS and malaria) and under-development. These problems affect every sector, including availability and utilisation of health care services. Other problems include poor crop and animal husbandry practices, marketing constraints, inadequate water supply, high incidences of malaria, environmental degradation, poor physical infrastructures and the persistence of harmful traditional beliefs and practices (GOK/UNICEF 1993).

### *3.2.6 The community*

Kano plains region (including Katolo), is inhabited by a conglomeration of six heterogenous cultural communities, with the Joluo forming the cultural majority (K'Okul 1993:11). Minority cultural groups include the Luo Abasuba, *Wawidhi*, *Waswa* and *Wagunga*; the *Abaluyia*, *Kabar*, *Kakmie*, *Watombori*, *Kamagaga*, *Kasae*, *Koguta* and *Ramogi*; the *Kisii Sidho* and *Wangaya*, the *Kipsigis*, *Jimo*; and the *Maasai*, *Kamswa* (K'Okul, 1996)-see table 3.1. The



original Joluo were well settled and established in the Kano plains by the 18th century.

Therefore, Katolo sub-location is inhabited by the Luo who are the indigenous people of the region and non Luo in migrants. To be specific, the Katolo community today is made up of the Nyikwa-Tolo Luo (about 80%) as the single dominant cultural group and non-Katolo settler cultural minority groups constituting about 20% of the population (K'Okul, 1996).

Table 3.1 Ethnic groups presently in Katolo sub-location

Cultural groups	Cultural communities	Lineage group
<u>Luos</u> *Indigenous ~In Migrants	*Jokatolo ~Agoro, ~Kanyakwar, Kabodho, *Asembo	Jok-Owiny, Joka-Jok (Alego) Jok-Omolo
<u>Non-Luos</u>  Suba  Luhya (Wamundha or Abamunda)  Gusii  <u>Kipsigis</u>	Wawidhi, (Kawamoya, Kimira, Kobongo, Wamundhi, Kamba)  Koguta, Ramogi, Kabar, Kasae, Kakmie  Sidho Jimo	Kasgunga, Riemy  Kabras, Banyole, Lugori Kisii Kalenjin

Notes: 1. Kawamoya and Kimira are some cultural clans. Kimira is simply a teasing name meaning 'a child born out of wedlock (Kimirwa).

2. Abaluyia in Katolo are referred to as the Wamundha distorted from the Luyia word Abamunda, meaning people from the same stomach.

3. Jo-katolo were originally the same cultural stock with Kagan, Kanyanda, Kodia, Gem; and are brothers to Angagi, Bup, Odiegi, Kameji, Waguya, Sabim (Kasagam) and Racham. Some of these clans were found co-existing with the Nyikwa-Tolo.

### 3.3 The community's health and nutrition situation

#### 3.3.1 Morbidity situation

- **Malnutrition:** According to K'Okul (1995), three types of protein-energy-malnutrition (PEM) were observed. These included *cultural chira* (marasmus), *cultural akuodi* (kwashiorkor) and *akuot-ledho* or kwasio-marasmic conditions (K'Okul, 1995:77). Indeed, malnutrition ranked number twelve in Katolo according to data available at the local dispensary. As indicated in the literature review section, malnutrition has negative implication for WRH as it leads to stunted growth and anaemia among other problems. In essence, malnourished persons will easily succumb to illness.

What is most intriguing about *chira*, *akuodi* and *akuot-ledho* conditions, and pertinent to this study is perhaps the way in which their causes and treatment were perceived. *Chira* in Katolo, is for example treated as punishment resulting from breaking customary norms (*kweche-Luo*) and taboo (*muma*). *Akuodi*, which was detected among several pre-school children in the 1995 study, is usually associated with *nawi* i.e. sorcery, superstition or witchcraft. *Akuot-ledho* which mostly affect an infant whose mother becomes pregnant too soon, is also somehow associated with *chira* and *akuodi*.

- *Micronutrient deficiencies:* The 1995 K'Okul study also revealed that deficiencies of vitamins A, B-complex, vitamin C, folate, and iron, selenium, zinc and calcium were common in Katolo. Such deficiencies have drastic health implications on an individual's later reproductive life.
- *HIV/AIDS:* At the time of the study, funerals were observed every week, in most cases deceased persons being victims of illnesses akin to HIV/AIDS. What is not quite clear is whether what the community term *chira*, is not HIV/AIDS. According to local medical personnel, a few cases of HIV/AIDS had actually been observed in the area. According to K'Okul's (1995) study, several villagers in Katolo had died of HIV/AIDS between 1989 and 1995. It is therefore important to note that cases of HIV/AIDS have been observed in Katolo, the extent of which may only be established through a comprehensive of the subject study in the area.

### 3.3.2 *Common illnesses in Katolo*

As already stated, Katolo lies in the flood prone Kano plains where the numerous swamps are a breeding environment for disease causing organisms. Common diseases include malaria, diarrheal diseases, respiratory infections, skin infection and other communicable diseases. Table 4.1 presents a comprehensive scenario of morbidity in Katolo. The figures attest to the

fact that adult females are most affected in terms of morbidity unlike the are under-five females.

In spite of the small figure indicated on STDs, the health personnel at the Kinasia dispensary observed that gonorrhoea and other mild STDs are common in the community but are largely treated traditionally. Most people in the community therefore do not go for treatment of these diseases at the health centre. Eye infections also seem to be a serious problem in spite the small figure of cases. From data obtained from a mobile clinic operating in the area, there were 1,200 cases of eye infection cases, including cataracts, during the period between August 1994 and January 1995 (see Table 3.3).

The Majority of eye patients with cataracts were usually adults above 30 years, while those with vitamin A deficiency disorder were largely children. All severe cases for both conditions were usually referred to appropriate hospitals for operation or further treatment, while mild cases were immediately treated.

**Table 3.2 Top 15 diseases reported at Kinasia dispensary between February 1994 and August 1995**

Disease	<u>No. of patients</u>								TOTAL	%
	< 5yrs. Children				Adults					
	Male	%	Female	%	Male	%	Female	%		
Malaria	555	17.7	391	12.5	1001	31.9	1189	37.9	3136	100
Circulatory diseases	202	13.8	314	21.5	386	26.4	561	38.3	1463	
Diarrheal diseases	146	22.2	87	13.2	227	34.5	197	30.0	657	
Respiratory diseases	262	24.2	87	8.0	373	34.5	359	33.2	1081	
Dental disorders	-		25	7.8	114	35.5	182	56.7	321	
Skin diseases	56	21.5	25	9.6	87	33.3	93	35.6	261	
STDs gonorrhoea, syphilis HIV/AIDS	-		-		55	33.9	107	66.0	162	
Eye infections/ cataract	19	23.8	24	30.0	29	36.3	8	10.0	80	
Anaemia	9	14.8	13	21.3	24	39.3	15	24.5	61	
Urinary tract infection	-		-		15	29.4	36	70.5	51	
Parasitic infection	17	39.5	3	7.0	14	32.6	9	20.9	43	
Malnutrition (emra, akandi)	20	64.5	8	25.8	-		3	9.7	31	
Mental disorder	-		-		11	44.0	14	56.0	25	
Pneumonia	7	28.0	2	8.0	10	40.0	6	24.0	25	
Disease of puerperum child birth	-		-		-		18	100.0	18	
Ear infection	7	41.2	2	11.8	7	41.2	1	5.8	17	
Other	65	24.1	55	20.4	40	14.8	110	40.7	270	
<b>TOTAL</b>	<b>1,365</b>		<b>1,036</b>		<b>2,393</b>		<b>2,908</b>		<b>7,702</b>	

Source: K'Okul R.N.O. (1996), Food security in Rural Kenya IDS University of Nairobi

**Table 3.1** Eye infection, vitamin A deficiency and cataract disorders in Katolo, Aug. 1994-Jan.1995

Eye operation	Number of patients with...				
	Visits	Infection Complaints	Cataracts (Mild)	Cataracts (Severe)	Vitamin A deficiency disorder (mild)
1st visit	500	337	18	24	4
2nd visit	258	117	15	101	25
3rd visit	107	86	15	4	2
4th visit	120	95	9	10	6
5th visit	90	56	11	20	3
6th visit	75	56	7	10	2
7th visit	50	13	-	36	1
<b>TOTAL</b>	<b>1200</b>	<b>816</b>	<b>75</b>	<b>205</b>	<b>43</b>

**Source:** *Katolo camp mobile eye clinic (ran jointly by KAMACHO, MOH, Lions Club and Kenya Society for the Blind)*

Treatment for vitamin A disorder included the use 'International Unit' vitamin A oral doses or water miscible vitamin A intramuscular dose which was either orally administered or injected. According the then resident doctor, 2mg of beta carotene was equivalent to 1mg of retinol. It was understood that absorption of dietary carotene in the intestines is uncertain, which in most circumstances is no more than a third become available to the body. Hence 6mg of dietary beta

carotene was to be taken as dietary equivalent of 1mg of retinol. In essence, this was only an approximation, since in advising on vitamin A of a diet in a community like Katolo where diets are largely vegetarian, it is most appropriate to recommend the sources and intakes of carotene separately. This is because animal products which are a rich source of retinol are rarely available to majority of people in the community due to poverty. The dominant source of carotene in the community are the indigenous green vegetables which are available seasonally.

At the Mobile Eye Clinic camp, the recommendation for pre-school children was 300mg of retinol per day, particularly through breast feeding, while 750mg of retinol was recommended for adults. These figures were based on amounts necessary only to restore normal levels of retinol among those suspected to be from homes where the diet did not contain retinol or carotene - a typical situation in the area between 1991 and 1994 drought periods (K'Okul, 1996). The resident doctor had also formulated these therapies on the basis of observed incidences of xerophthalmia/

karotomalacia, night blindness and photophobia, conjunctival xerosis, bitot's spots, corneal xerosis and ulcerations as well as retinol levels in the blood of affected persons.

'From the foregoing discussion, one would get the 'feel' of the health and nutrition situation in Katolo, contributing enormously to also our understanding of WRH situation in the community, which cannot be isolated from other aspects community health. The pertinence of this section would probably make more sense after reading chapter five.

### 3.4 The study design

This study was designed along the participatory action-oriented research approach (PAORA) tradition. PAORA is an approach which deviates from positivist or classical scientific research approaches. In the latter, the researched community is viewed as a mere object with the researcher being the 'expert'. The PAORA approach recognises the researched communities are 'experts' in the phenomena under investigation. Some of the core aspects of the approach are that:

◆

It is participatory in the sense that both the researcher and the researched community are in equal footing as 'experts' in their respective domains. This expertise is mutually shared during the research process.



The approach empowers the researched communities by imparting awareness regarding the phenomena or problem(s) under investigation; emphasizing the need to address the identified problem(s), and suggesting practical strategies to address them.

Data collection techniques lay emphasis on 'informal' interviews which may not intimidate respondents or participants in both groups and/or personal interview situations.

The research process is an exciting experience devoid of tension which is inherent in interactions between 'elites' and say, common rural villagers. It, thus, generates detailed data, which is probably 'most authentic', regarding the research problem.

PACRA has been used by many scholars in the developing countries under different names for example, Chambers (1980), Kassam and Mustafa (1982), Chitere and Mutiso (1991), and K'Okul (1991).

In a study like this one, where the author was interested in a holistic understanding the situation of reproductive in Katolo, such an approach was ideal as participants were able to confide with the researcher in matters pertaining to their sexual behaviour. It would have probably been rather tricky if a purely positivistic approach was adopted.

### 3.4.1 Sampling

The population universe from which a sample was drawn were inhabitants of Katolo sub-location. The sample was in the first instance determined purposively, and also largely in subsequent steps for the following reasons:

- The research design required that women of reproductive age be interviewed. Such a category of women would not have been identified through straight forward random sampling.
- The study envisaged interviewing key informants, or those perceived to have special information regarding our subject of interest. They included elderly persons, outside the reproductive age bracket who were conversant with traditional beliefs and customs and other qualitative data. Thus random sampling would again not have been appropriate for this.
- It was also required that information be elicited from community health workers, e.g., nurses, public health personnel and family planning health officers, a category of participants who were not amenable to random selection technique.

Respondents and other participants were arrived at through multi-stage sampling. A list of all households in the six villages by cultural groups in Katolo was compiled as the first

step in our sampling (see Table 3.4). This was done with the help of the research assistants and village elders (*milango* or *kidhedhe*). Among the enlisted households, were pregnant breast-feeding women and/or those who had under-five years children. From a list of over 250 individuals in this category, the rotary method was applied to randomly select 100 respondents. Only one respondent was picked from each of the households.

Table 3.4 Distribution of respondents by village and cultural group

Village	Cultural group	Frequency	Percentage (%)
Sare	Katolo	17	17
Kinasia	Katolo, Kimira Wawidhi	17	17
Yogo	Katolo, Kimira	17	17
Holo	Katolo	17	17
Olas	Katolo, Koguta, Jimo, Kobong'o, Wamundhi, Kabcdho	16	16
Charare	Katolo	16	16
<b>TOTAL</b>	<b>17</b>	<b>100</b>	<b>100</b>

**Notes:** Katolo major clans are; Komenya, Kanyangi, Kauma, Kathum, (Tolo Ajwang'), Kakwany, Waguya, Bup, Ramogi and Kamenji. However, both Ramogi and Kameji are still extremely small clans and assimilated among the Kokongo (Kanyangi) and Kaloo (Komenya) respectively. The Nyikwa Tolo alone comprise nine (9) Clans and 122 sub-clans. At the time of sampling, all the current Katolo inhabitants identified themselves as Jo-Katolo amidst cultural conflicts. This is what prompted me to investigate 'who is who' in Katolo. I even thought that the stated cultural groups were Katolo clans. I was wrong.

### **3.5 Data collection**

#### **3.5.1 Research instruments**

A standard questionnaire had been prepared before going to the field to solicit for data pertinent to the study. It was designed to benefit the core aspects of the study objectives (see Appendix). It carried questions which sought information regarding background characteristics of participants, their maternal and family planning histories; their knowledge, perceptions and experiences in health issues pertaining to reproductive health; their knowledge and attitudes regarding traditional beliefs, customary norms and practices, as well as access and utilisation of the various types of health care and family planning services. The instrument was pre-tested during the first two days in the field to establish its efficacy in eliciting the data required and also in estimation of the time field work would take.

#### **3.5.2 Interviews**

Interviews for this study were conducted on the basis of themes and questions contained in the standard research instrument. Structured interviews were largely deployed as the schedule was administered by the researcher with the help of the two assistants. This was necessarily because most of the participants had only elementary level of education. Since the instrument had many open-ended questions, it elicited rich data regarding the topic of study through 'participatory discussions'.

Unstructured interviews were carried out particularly to cross-check information and to enrich data solicited through other methods. Focused group interviews, informal discussions and follow-ups were held with community members in a participatory fashion. Indeed two group interviews were held for this study. It was especially in those group interviews that consensus views regarding most of the community's beliefs, customary norms and practices were obtained.

### 3.5.3 *Library research*

Library research went on throughout the period of this study . Prior to visiting the field, intensive library research had been carried out in the University of Nairobi libraries, the World Bank Library, UNICEF Library, Centre for African Family Studies, National Council on Population and Development library and other NGOs resource centres. Such readings focused on both the theoretical and substantial issues pertinent to the study. Preliminary data on the site of study was also obtained at this stage. In the field, health records, especially those on antenatal clinic attendance, contraceptive use and anthropometric measurements, were studied.

### 3.6 *Data analysis*

Collected information has to be systematically organised for the researcher to make sense out of the raw data. This necessitated the use of statistics. According to *Hinkle et al.* (1982),

statistics include the theory and procedures used for the purpose of understanding data. Such procedures are the mathematical calculations for summarising and organising the data as well as the high order statistics for making inferences or generalisations. Field data collected for this study was largely electronically analysed using the Statistical Package for the Social Sciences (SPSSPC+). Descriptive, deductive and inductive statistics were used to analyse data obtained on variables pertinent to hypotheses which guided the study. Cross-tabulations were used as a basis for determining relationships between the relevant variables, basically in a bivariate fashion.

According to Nie et al. (1970), cross-tabulations are joint distributions indicating the respondents' score in one variable as against another or other variables. These tables are summarised by certain statistics which show the relationships between the variables of interest. The measure of relationship adopted in this study was the chi-square statistic in which the significance of relationships was determined at 0.01 level of significance (see chapter four).

## CHAPTER FOUR

### DATA DESCRIPTION AND ANALYSIS

#### 4.1 Socio-demographic background of respondents

##### 4.1.1 Age of respondents

All the respondents on whom the survey questionnaire was administered were women. The majority (49%), were in the age bracket of 15-25 years. Another 33.7% fell in the age category of 26-35 years, while 15.3% were in the 36-45 years age bracket (see Table 4.1).

Table 4.1 Percentage distribution of respondents by age

Age bracket	Number of respondents	Percentage (%)
15-25	48	49.0
26-35	33	33.7
36-45	15	15.3
Missing	2	2.0
TOTAL	98	100

##### 4.1.2 Marital status

As regards marital status of respondents, a sizeable proportion of the women (60%), were widowed. Of these, most of them were found in Sare, Charare and Olasi villages constituting 19%, 19% and 17% respectively. Another 39% were married, while only a mere 3% were single (see Table 4.2).

Table 4.2 Distribution of respondents by marital status and village

Village	Single		Married		Widowed		TOTAL N=98
	n	%	n	%	n	%	
Sare	1	(5.3)	7	(36.8)	11	(57.9)	19 (19.4)
Charare	-	-	8	(47.0)	9	(53.0)	17 (17.3)
Yogo	-	-	10	(62.5)	6	(37.5)	16 (16.3)
Kinasia	2	(12.5)	4	(25.0)	10	(62.5)	16 (16.3)
Holo	-	-	10	(66.6)	5	(33.3)	15 (16.3)
Olasi	-	-	6	(42.9)	8	(57.1)	14 (14.3)
<b>TOTAL</b>	<b>3</b>	<b>(3.1)</b>	<b>46</b>	<b>(46.9)</b>	<b>49</b>	<b>(50.0)</b>	<b>98 (100)</b>

#### 4.1.3 Number of children

The majority (62.2%) of respondents had an average of 1-3 children, a fact which can partly be explained by a relative high parity in the area, considering that most of them fell in the 'young' category. Another 28.6 % had 4-6 children, while only a mere 9.2% had seven children and above (see Table 4.3). Considering the health situation in Katolo, it is likely that the infant mortality rate is relatively high, for one would have expected a larger percentage of the women to have had over seven children at the age of 45 years.



Table 4.3 Distribution of respondents by number of children

Number of children	No. of respondents	Percentage (%)
1-3 children	61	62.2
4-6 children	28	28.6
7 and above	9	9.2
<b>TOTAL</b>	<b>98</b>	<b>100</b>

#### 4.1.4 *Occupation of respondents*

Over a half of the respondents (65%) were peasants and housewives some of whom also supplemented their means of livelihood with small scale hawking activities. Only one primary school teacher was interviewed in the entire survey sample. Over 30% of the respondents also worked in other peoples farms when they were not occupied in their small land pieces.

#### 4.1.5 *Educational level of respondents*

Among the respondents interviewed, the majority (74%) had attained formal primary education, while only a mere 8% had no formal education at all. Another 17% had attained secondary level of education ( see Table 4.4).

Table 4.4 Distribution of respondents by level of education

Educational level	No. of respondents	Percentage (%)
No Formal education	8	8.2
Primary level	72	73.5
Secondary level	17	17.3
Missing	1	1.0
<b>TOTAL</b>	<b>98</b>	<b>100</b>

#### 4.1.6 Maternal and health histories of respondents

Maternal and health histories of respondents in Katolo revealed that a sizeable number of them experienced several problems associated with child-delivery and motherhood. It was observed that most of them had married and/or conceived at below 20 years of age, something that was pernicious to their reproductive lives.

As such, about 82% of the respondents had experienced problems relating to reproduction and delivery. *Rariu* or 'god of the stomach' (as it was literally perceived by the community), was mentioned by most women as a problem which afflicted those who defied certain traditional taboos relating to pregnancy. These included miscarriages, still-births, haemorrhage and amenorrhoea as cited by over 48% of the respondents. Another 21% reported that they had suffered persistent fatigue, dizziness, back-aches, oedema and partial blindness. The nexus between defying tradition and WRH is discussed in great detail in various sections of this chapter.

## 4.2 Discussion of the major findings

### 4.2.1 Socio-cultural factors and women's reproductive life

A number of studies have shown that certain socio-cultural factors are associated with poor women's health and WRH in particular (Kuria, 1991; GOK-UNICEF, 1992; Nduati, 1992; CMA, 1993 etc.). Among major factors cited in these works are traditional cultural beliefs and customary practices. The latter include marriage practices, nutritional taboos, as well as certain attitudes which stem from the cultural milieu within which individuals have been nurtured and socialized. Social-cultural factors influencing WRH in Katolo were examined by addressing the four aforesaid hypotheses, which guided this study.

This section deals with our first hypothesis that *'socio-cultural factors have a negative impact on women's reproductive life'*. Among the factors isolated for examination were certain customary beliefs and practices. Marriage practices were seen to have a bearing on age at marriage, which in turn influenced the level of women's knowledge and awareness regarding certain reproductive diseases. The overall observation was that certain socio-cultural factors not only influence WRH, but also the general community health knowledge/awareness, attitudes and practices.

## 4.2.2 Marriage practices and health awareness

### 4.2.2.1 Awareness of eclampsia.

It was observed that to some extent, women's level of health awareness was determined by age at marriage. It was for instance, established that women below 20 years of age were not aware of the condition of eclampsia.

Eclampsia is a condition which usually occur towards the end of a pregnancy. It is caused by the presence of poisonous substances in the blood and manifests itself in extreme high blood pressure and convulsions in the victim. It is a severe manifestation of toxemia of pregnancy, associated with fits and coma, damaging body tissues. Awareness of such a condition would compel an affected person to immediately take appropriate health measures, like visiting the nearest health delivery facility.

The fact that majority of respondents below the age of 20 years in Katolo (67%) were hardly aware of this condition is worrying mainly for two reasons; one, because they are very young mothers, just beginning their motherhood term and two, because inappropriate action may lead to grave consequences including death. This scenario is further worsened by the fact that most of the respondents (74%) had married at the age between 14 and 20 years.

Data obtained from Kanisia dispensary evidenced that most women, (about 46%) enter motherhood below the age of 20 years (see Table

4.5). About 33% of those below 20 years who attended MCH/FP clinic between January and June 1995 were already in their second pregnancy. Another 11% and 9% were in their third and fourth pregnancy respectively (see table 5.1). This means that they may have started their motherhood at the age of 13 or 14 years. Medically, such young girls are at risk of developing complications during pregnancy and delivery.

Table 4.5 Percentage distribution of gravid number by women's age

Age	Number of times ever pregnant						Total
	1	2	3	4	5	<5	
15-20	46% 25	33% 18	11.1% 6	9.3% 5	- do -	- do -	100% 54
21-25	- do -	19.4 7	33.3% 12	13.8% 5	25.0% 9	8.3 3	100% 36
26-30	- do -	20.0% 4	20.0% 4	35.0% 7	15.0% 3	10.0% 2	100% 20
31-35	- do -	- do -	- do -	- do -	- do -	100% 6	100% 6
36-40	- do -	- do -	- do -	- do -	- do -	100% 2	100% 2
41-45	- do -	- do -	- do -	- do -	- do -	100% 2	100% 2
TOTAL	25	29	22	17	15	13	120

Source: Kinasia dispensary MCH/FP clinic

Another implication of early marriage, and therefore early maternal age, is that women are denied the opportunity to pursue higher formal education which could be core in enhancing their reproductive health knowledge and awareness.

#### 4.2.2.2 Awareness of anaemia

It was further observed that women who were married below the age of 20 years, therefore entered their motherhood early, were relatively ignorant of the manifestations of anaemia as compared to their elderly counterparts.

Women between 21 and 25 years of age, and between 35 and 35 years of age constituted 70% and 69% of the sample respectively. A fair percentage (40%) of those between the age of 26 and 30 years were also aware of this condition. A sizeable proportion of those below the age of 20 years were not found to be aware of the condition.

Yet according to biomedical studies, mothers below the age of 20 years, who are usually in their first or second pregnancies, are at most risk of being anaemic. One reason for this could be their inexperience to nurse a pregnancy, coupled with the increased nutritional demands of their bodies, especially during the first pregnancy in readiness for foetal growth and delivery. It may be argued that, this is an age when women should be most aware of their bodily nutritional needs in the context of being at risk of life long maternal morbidity.

Another way of trying to understand the scenario would be to assume that mothers below the age of 20 years are most likely to have dropped out of school before attaining basic secondary education. In such circumstances, their knowledge base for basic reproductive health conditions is limited. Most studies have, for example, linked low levels of educational achievement among girls with early maternal age and the attendant health problems (GOK-UNICEF, 1993; World Bank, 1993; FHI, 1994). This could, therefore, explain why most mothers below the age of 20 years were unaware of health conditions which are pertinent to their reproductive health.

#### **4.2.2.3 Awareness of pregnancy complications**

This study also established that early marriage, which necessarily meant early maternal age, influenced women awareness of pregnancy complications. These included awareness on cause of obstructed labour, dystaxia, etc.. Dystaxia refers to the difficulties controlling voluntary movements under labour pains.

It was observed that 65% of the respondents below the age of 20 years were not aware of certain reproductive-related problems such as obstructed labour and dystaxia etc. These conditions are usually caused by anaemia due to malarial attack and under-nutrition during pregnancy. About 35% of respondents who seem to have been aware of the conditions may either have experienced the problems or learnt from older mothers.

#### 4.2.3 Duties performed during pregnancy and WRH

One assumption of the study was that women's performance of certain duties during pregnancy, jeopardize their reproductive life and safe motherhood. In most cultures, household duties are divided along gender lines, such that roles are dichotomized into women's and men's domains.

In Katolo, typical household duties include digging, weeding, harvesting, carrying loads, collecting firewood, fetching water, cooking, childcare, washing and herding. In this study, these duties were classified as either 'heavy', 'moderate' or 'light' for purposes of analyzing their impact on WRH (see Table 4.6). Duties such as carrying heavy loads, digging, fetching firewood and water were arbitrarily accorded more weight than cooking, weeding, herding, washing and tending children. It was assumed that performance of 'heavy' or 'all' duties by women during pregnancy would be detrimental to their reproductive health.



Table 4.6 Women's workload categories during pregnancy

<u>DUTIES</u>	<u>WEIGHED CLASSIFICATION</u>		
	Light	Moderate	Heavy
<b>Farmwork:</b> Digging			*
Weeding			*
Harvesting			*
Heavy loads			*
<b>Childcare:</b> Washing	*		
Nursing	*		
Weaning	*		
<b>Household:</b> Cooking	*		
water		*	
Wood fuel		*	
Food	*		
<b>Marketing:</b> over 20kg loads			*
Food basket		*	
<b>Herding:</b> Grazing		*	
Watering	*		
fodder			*

KEY

\* Indicate the category under which a task falls

When performance of 'heavy' or 'all duties' by women was cross-tabulated with whether they experienced any pregnancy problems, for example, say abdominal pains, miscarriage or other forms of maternal morbidity, the result was as presented in table 4.7.

Table 4.7 Performance of all duties by pregnancy problems

Perform all duties	Pregnancy problems		
	Yes	No	ROW TOTAL
Yes	32.0% (n=9)	69.9% (n=19)	28.6% (28)
No	15.7% (n=11)	84.3% (n=59)	71.4% (70)
<b>COLUMN TOTAL</b>	20.4% (20)	79.6% (78)	100% (98)

$\chi^2=2.38875$

df=1

p>0.01

contingency coefficient = .18110

Table 4.7 indicates the association between performance of both 'heavy', 'moderate' and 'light' duties and pregnancy problems. This is shown by the chi-statistic of 2.38875 and a contingency coefficient of .18110 at 0.01 level of significance. The 84% women respondents who performed both light and heavy duties during pregnancy do not seem to have experienced any problems, while 16% who experienced problems complained of back-ache and haemorrhage during pregnancy. Both heavy duties (such as farmwork) and light duties (such as washing), had a negative effect on their reproductive health. This is in line with studies which link women's reproductive problems with performance of heavy duties during pregnancy and performance of normal household duties by women with the 'women's burden of disease' (World Bank, 1992).

This finding could only suggest that ordinarily, women do not associate health difficulties during pregnancy with their performance of certain culturally ascribed household duties. This is certainly so because, the strains and fatigue engendered by performance of heavy duties during pregnancy medically have implications on women's health.

It has been globally observed that women, irrespective of whether they are pregnant or not, must attend to children, fetch firewood and water, till land and cook for their husbands (UNICEF, 1992). In most cases, women have performed certain duties, not necessarily because such duties fall within their cultural domain, but because children have attended school and husbands are simply 'absent' from the households and these duties must be performed-anyhow in the absence of appropriate technology.

It may further be argued that women's failure to link certain pregnancy problems with their indiscriminate performance of all household tasks during pregnancy hinges upon their 'cultural conditioning, or the manner in which they have been socialized. It would therefore not be expected that women would complain of what they culturally perceive as a 'God-ordained' arrangement. This argument fits the gender socialization perspective - the guiding conceptual framework of this study.

Among the Luo of Katolo, therefore, women still have to till land using the traditional hoe (*rahya* or *nyaimbo*), carry heavy loads on their heads, fetch water and firewood, and walk long distances to the market to procure essential household items even during pregnancy. It was, for instance, observed that a majority of the respondents (65.9%) in this study performed heavy duties during pregnancy.

#### 4.2.4 Cultural beliefs, customs and WRH

##### 4.2.4.1 *Beliefs relating to food*

Traditional cultural beliefs and customs play a significant role in shaping peoples' perceptions and behaviour in all aspects of life, including health and nutrition. In some communities for instance, beliefs and customs rationalize the manner in which food is distributed, determining the differential gender nutritional intakes within families. Earlier studies in Western Kenya and Nyanza Provinces reveal that the practice of giving more food to males than their female counterparts is prevalent (Nduati, 1992; Wamahiu, 1992; Manguyu, 1993; UCLA & UON, n.d).

Among the Abasamia, certain taboos proscribe some protein foods for pregnant women as they are perceived to cause sterility (K'Okul, 1991). In the Maasai community, eggs, fresh milk, meat and fatty foods are not to be taken by pregnant mothers as they are said to engender difficult delivery (Kuria, 1989). In Katolo, similar beliefs exist, which not only influence nutritional intakes amongst

pregnant women, but also determine gender-based nutritional habits. These beliefs consequently influence WRH.

One major finding in this study was that certain beliefs in Katolo influence the nutritional intakes of females, especially pregnant women. A cross-tabulation of the prevalence of food taboos and whether there are special foods meant for pregnant women yielded the results presented in Table 4.8.

Table 4.8 Existence of food beliefs/taboo by foods prescribed for pregnant women

Food beliefs/taboo	Whether foods proscribed for pregnant mothers		
	Yes	No	ROW TOTAL
Yes	62.5% (n=10)	37.5% (n=6)	100% (16)
No	33.3% (n=31)	66.7% (n=50)	100% (81)
COLUMN TOTAL	42.3% (41)	57.7% (56)	100% (97)

$\chi^2=2.29786$  df=1 p>0.01 contingency coefficient=.17909 Missing observations=1

From the table, it is evident that there is a relationship, albeit a weak one, between the two variables as indicated by the chi-square statistic of 2.2978 and a contingency coefficient of .17909. This finding is in accord with the gender perspective that women are nutritionally disadvantaged by culture among most communities in the developing world (Kwofie, 1983). The observation also concurs with certain studies which indicate that religion, superstition and taboos regarding food bear negatively on the

nutritional status of mothers and children (GOK/UNICEF, 1992; K'Okul, 1993).

Medical studies indicate that women demand higher nutritional intakes than males during adolescence to cope with their health demands during pregnancy and lactation (World Bank, 1993). The consequence of inadequate diet for women places them at risk of life-long reproductive health problems including iron deficiency anemia, obstructed labour due to cephalo-pelvic disproportion and low birth weight babies (Nduati, 1992).

Data elicited from a group interview and key informants indicate that in Katolo, there are a myriad of beliefs which impinge on the nutritional intake of females, especially pregnant mothers. It was observed that most women harbour the belief that male children deserve more and better food than female children because they are ostensibly expected to perform heavier or harder tasks in the household. The most intriguing finding is perhaps that concerning the consequences of non-adherence to these beliefs - *chira* or disaster. The concept of *chira* which is more profoundly treated in a later section in this work, seem to be a generic name for not only most causes of 'thinning' ailments, but also a consequence of most forms of socially unacceptable behaviour. A woman may, for example, suffer the wrath of *nyasach mon* (god of the womb) i.e., pelvic inflammatory disease (PID) or *sigeta*, because of eating certain proscribed foods during pregnancy. It may also result from

frequent births under careless attendance where the cervix does not respond appropriately, and indulging in certain non-acceptable sexual practices.

The cause of *sigeta* is not clear as explained by Katolo women. The condition is characterized by severe abdominal pains during menstruation or having sexual intercourse during menstruation. Katolo women claimed that the disorder is inherited along maternal lines, and escalated by promiscuous habits, which are not culturally acceptable. A man was, for instance, not allowed to indulge in copulation when a woman was menstruating. The 'modern man' does not care, and the problem is more severe among girl-children who indulge in premature sex.

Prevalence of beliefs/taboo relating to food in Katolo, were cross-tabulated with not taking milk and fish during pregnancy to examine whether or not there was a relationship. The results are presented in Tables 4.9 and 4.10.

Table 4.9 Food taboos by whether pregnant women take milk

Food taboos	Whether pregnant women take milk		
	Yes	No	ROW TOTAL
Yes	27.7% (n=13)	72.3% (n=34)	48.0% (47)
No	13.7% (n=7)	36.3% (n=44)	52.0% (51)
<b>COLUMN TOTAL</b>	20.4% (20)	79.6 (78)	100% (98)

$\chi^2=2.12874$

df=1

p>0.01

contingency coefficient =.17020

Table 4.9 illustrates an interesting phenomenon in Katolo. It was observed that 27.7% of the respondents who believed in food taboos took milk during pregnancy, while 72.3% did not take milk. There is a common belief that milk exacerbates STDs infection, and the fact that STDs rank number seven in the community morbidity patterns and affected 66% of females depict why milk is not popular (see chapter four). Pregnant women also do not take fish, for this ostensibly cause stomach pains, nausea and other pregnancy-related problems, while certain fish species (*seu* and *kamongo* - *bagrus* and *docmac*) are believed to influence evil spirits (*juogi*).

Most respondents however did not accept that the refrain from taking such foods during pregnancy on account of traditional beliefs. But a significant relationship between the prevalence of food taboos in the community and whether pregnant women take fish was still observed as shown in Table 4.10.



Table 4.10 Food taboos by whether pregnant women take fish

Food taboos	Whether pregnant women take fish		
	Yes	No	ROW TOTAL
Yes	33.3% (n=8)	66.7% (n=16)	24.5% (24)
No	16.2% (n=12)	79.5% (n=62)	75.5% (74)
<b>COLUMN TOTAL</b>	20.4% (20)	79.6% (78)	100% (98)

$\chi^2=2.12874$

df=1

$p>0.01$

contingency coefficient = .17020

The relationship between food taboos and whether pregnant women take fish is shown by a chi-square value of 2.12874 and a contingency coefficient of .17020 at 0.01 significant level. It was observed that 66% of the respondents did not take fish during pregnancy, even though they contended that no taboos proscribed fish on pregnant mothers. A type of fish, *fulu* (*Hapochronious species*), is despised for it is believed to harbour tape worms, while *mbuta* (Nile Perch), predated even on human beings.

One could, therefore, conclude that although there are certain beliefs which generally proscribe certain foods on gender lines, one will have to probe more deeply to get straightforward facts. Chicken, game animals and certain animal organs, such as *agok*, *nyamala*, *lep* and *adundo*, are still proscribed for males, while *nyarogno* and *thuno* are proscribed for females. These findings

corroborate observations made in other developing countries. It was evident from data obtained through group interviews that according to tradition, only women beyond menopause in Katolo are allowed to eat chicken or *gueno* without any adverse consequences. Women among the Luo also do not eat *lep* or cow's tongue, which also applies to young unmarried men, while adult men may comfortably eat the heart, thigh and back of chicken.

Other beliefs prohibit women to pick fruits during menstruation lest the fruit tree withers. Girls do not eat testicles of any animal lest their breasts disappear. There is also a belief that men's testicles would swell if they ate kidneys.

#### 4.3 Negative health behaviour and WRH

This section addresses the hypothesis that '*Negative health behaviour is associated with old persons who adhere to traditional values rather than with young persons who do not adhere to traditional values*'. One of the basic assumption was that old persons in any community are relatively conservative and therefore likely to uphold and cling to traditional cultural values than young persons. Some of these values (beliefs and customs) could be inimical to their health. Going by this premise, it was expected that older women would be less keen to utilise modern health care facilities, including attending ante-natal clinics, delivering children in hospital, using modern family planning methods, be

gender insensitive in the general care of their children and perhaps zealously observe existing nutritional beliefs. In essence, all these would constitute negative health behaviour.

In this study, 'old' women were taken to be those falling in the age category of 35 years and above, whilst those between 14 and 34 years were considered to be 'young' adults. Data were elicited on the relevant variables, which were cross-tabulated to determine the relationship between age and negative health behaviour. The results of these cross-tabulations are discussed in the rest of this section.

#### ***4.3.1 Women's age, nutritional beliefs and WRH***

Several studies that have been carried out among some Kenyan communities reveal that certain nutritional beliefs have a negative influence on general community health including WRH (e.g. K'okul, 1991; Kuria, 1989; Barvazian, 1993. GOK/UNICEF,1992). On this basis, this study also sought to ascertain whether women of different ages equally observe such nutritional beliefs or even beliefs which touch on their sexual behaviour. In this respect, it was expected that younger women would loosely observe such beliefs and therefore enjoy a relatively better reproductive health life than older women.

Data on whether respondents ate foods proscribed by community norms when they were pregnant were cross-tabulated with their age categories. The results were as shown in Table 4.11.

Table 4.11 Age category of respondents by whether they observed food taboos

Age category	Whether observe food taboos		
	Yes	No	ROW TOTAL
Young	25.0% (n=17)	75.0% (n=51)	84.0 (68)
Old	7.7% (n=1)	92.3% (n=12)	16.0 (13)
COLUMN TOTAL	22.2% (18)	77.8% (63)	100% (81)

$\chi^2 = 1.02264$      $df=1$      $p > 0.01$     contingency coefficient = .15106    Missing observations = 17

It is discernible from Table 4.11 that there was a relationship between adherence to food taboos by both young and old women as depicted by a chi-square statistic of 1.02264 and a contingency coefficient of .15106 at 0.01 level of significance. This

observation provide support to the findings of other studies already cited. One explanation for this scenario could be the fact that there were more respondents below the age of 35 years in the sample (see Table 4.12).

Table 4.12 Distribution of respondents by Age

Age bracket	Number of respondents	Percentage (%)
14 - 20 years	19	19.4
21 to 30 years	52	53.0
31 to 40 years	21	21.4
41 to 45 years	6	6.2
<b>TOTAL</b>	<b>98</b>	<b>100</b>

Indeed, only 15% of the respondents in the study were beyond 35 years old. As such, it could perhaps have been possible to have had more older women adhering to food taboos if the composition of

the sample was balanced in terms of age. Table 4.12 may thus be said to represent a lop-sided picture -that more young women (25%) observe food taboos as compared to older women who accounted for a mere 8% of the sample.

Another possible explanation for the scenario could be the arbitrariness in which the line between 'young' and 'old' was drawn. The focus of the study having been women of reproductive age (15-45 years), the dividing line between 'old' versus 'young' adults may not have been appropriate. Further, the ordinary usage of the term 'old' in most communities preclude persons below 45 years which is menopausal entry age in the context of women's reproduction.

The observation presented in Table 4.12, however, may not be ignored because it certainly reveals one important fact pertinent to the study - that women's nutritional behaviour is probably influenced by certain cultural beliefs in Katolo.

Data got from group interviews and key informants support this latter position. There are a significant number of taboos in Katolo. Pregnant women, for instance, are required by tradition to

shun fatty and protein foods such as fish, mutton, beef and eggs. The same sources also indicated that younger women are likely to defy such proscriptions than older women as, apparently, nothing happens to them during pregnancy or after delivery when they eat such foods. However, if a mishap occurs relating to child birth the community may attribute this to non-adherence to nutritional taboos as prescribed by cultural tradition. These nutritional beliefs which are prevalent in Katolo negatively influence the reproductive life of women irrespective of their ages and whether, some women defy them or not. This observation is in keeping with the gender perspective that certain nutritional beliefs or taboos target women in certain communities, often adversely affecting their reproductive health.

#### *4.3.2 Utilisation of modern family planning methods*

A major assumption in this study was that older women (34 years and above) were more likely to disregard the use of modern contraceptives and methods of family planning than their younger counter parts between the age of 15 and 34 years. Respondents were asked whether they used any contraceptives to prevent pregnancy and why they did or did not use them. Irrespective of their ages 76% of the responders did not use any contraceptives to prevent pregnancy (see Table 4.13).

Table 4.13 Distribution of respondents by use of contraceptives

Use contraceptives	No. of respondents	Percentage (%)
Yes	22	22.4
No	76	77.6
<b>TOTAL</b>	<b>98</b>	<b>100</b>

The majority of the respondents (77.6%), irrespective of their ages indicated that they either abstained from sex or used natural family planning methods, which they otherwise termed 'rhythm'. To a large extent, the adoption of this method was not because of adherence to certain traditional beliefs but other social factors dealt with elsewhere in this study.

Most women who did not use modern contraceptives to prevent pregnancy gave a variety of reasons, including the fear of their male spouses, being shy (especially young mothers) or having not been aware that there are any safe artificial family planning methods.



Table 4.14 Use of 'rhythm' by fear of male spouse

Fear male spouse ?	Use 'rhythm ?		
	Yes	No	ROW TOTAL
Yes	72.7% (n=8)	27.3% (n=3)	12.5% (11)
No	37.7% (n=29)	62.3% (n=48)	87.5% (77)
COLUMN TOTAL	42.0% (37)	58.0% (51)	100% (88)

$\chi^2=3.52426$      $df=1$      $p>0.01$     contingency coefficient =.22870    Missing observations =10

Table 4.14 above depicts a relationship between the use of natural family planning ('rhythm') and the fear of male spouses as indicated by the chi-square value of 3.5246 at 0.01 significance level and a contingent coefficient of .22870. It would, therefore, appear that the use of 'rhythm' by women in Katolo (irrespective

of their ages) does not hinge upon adherence to traditional values, but to a large extent, the fear of their male spouses and other factors. This negates our hypothetical claim that older women observe cultural values more, and that these values adversely affect their health more than that of their younger counterparts.

Yet, women's fear of their male spouses which strongly influences their family planning behaviour could be said to stem from some cultural arrangements which have placed women in a subordinate position. The fear of their male spouses could be interpreted as some adherence to cultural values - that they must 'respect' the position of their husbands who they explicitly obey or clandestinely disobey!

Observations made in Katolo were also in line with the gender perspective on the view that women do not exercise or enjoy their reproductive autonomy since they cannot make crucial decisions regarding their reproduction (Bervazian, 1993). A study carried out in Zaire found that it is the men who determine the time of coitus, including making major fertility decisions (UNDP/WHO/World Bank, 1994).

### 4.3.3 Family planning methods and distance to FP facilities

The above scenario is further supported by the fact that women use natural family planning (rhythm) even in areas where family planning services are reasonably near. Table 4.15 show the results of a cross-tabulation between use of 'rhythm' and whether family planning services were far among Katolo women.

Table 4.15 Use of 'rhythm' by whether FP facilities are far

Use rhythm	Family planning services far ?		
	Yes	No	ROW TOTAL
Yes	21.4% (n=3)	78.6% (n=11)	14.3% (14)
No	9.5% (n=8)	90.5% (n=76)	85.7% (84)
COLUMN TOTAL	11.2% (11)	88.8% (87)	100% (98)

$\chi^2 = .72109$

df=1

p>0.01

contingency coefficient = .13083

It is evident from Table 4.15 that only about 21% of the respondents used 'rhythm' as a family planning method on account of living far from family planning services, against about 79%

were not using 'rhythm', yet family planning services were not stationed far from their homes. Another 91% of the respondents were not using 'rhythm', seemingly on account of certain factors other than distance. This observation implies that use of family planning services in Katolo was not determined by distance, but by other factors that may warrant further investigation. Suffice to say that, irrespective of whether distance to health facilities where family planning services were available had an influence on the type of family planning method used by the respondents, their use of 'rhythm' or non-use of modern family planning services constitute negative behaviour.

It would appear from this scenario that women who used 'rhythm' as a family planning method did so by default, and not by any conscious effort to do so. In essence, what emerged from group interviews, is that most women in Katolo were not using contraceptives to prevent unwanted pregnancies, a behaviour that cut across women of all ages. These practices amount to negative reproductive health behaviour.

Although these observations do not seem to support our hypothesis as stated, they persuasively suggest that rural women, irrespective of their age, do subscribe to certain values (cultural or otherwise) which prevent them from making use of the

available modern family planning services. The latter argument is buttressed by the results of the cross-tabulation presented in table 4.16.

Table 4.16 .0 Use of modern FP services by whether Healthy facility is far

Use modern FP services ?	Whether health facility is far		
	Yes	No	ROW TOTAL
Yes	4.5% (n=1)	95.5% (n=21)	22.4% (22)
No	25.0% (n=19)	75.0% (n=57)	77.6% (76)
COLUMN TOTAL	20.4% (20)	79.6% (78)	100% (98)

$\chi^2=3.22553$

df=1

p>0.01

contingency coefficient = .20717

It is evident from Table 4.16 that although about 96% of the respondents indicated that modern family planning facilities are not stationed far from their homes, only about 5% make use of them, while a staggering 75% do not make use of them against the 25% of respondents who indicated that family services services were far.

This scenario concurs with studies done elsewhere which attribute non-adoption of modern family planning services to low levels of education, women's lack of sexual and fertility autonomy and other socio-cultural factors. A key factor which befits the gender perspective is that women, by the very magnitude of their workloads in the household may not find time to even seek health care, leave alone family planning services (Gay 1993). It has also been witnessed that traditional customs may impose obstacles to utilization of health services (KMA, 1993).

#### ***4.3.4 Utilisation of child delivery services***

One important finding in this study is that about 90% of the respondents were not using modern child delivery services, ostensibly because they did not have problems during delivery. The non-use of modern delivery services was considered as negative health behaviour. As shown in Table 4.17, about 79% of the respondents indicated that the hospital where delivery services could be available was not far, yet only a mere 11% made use of the facility. According to data elicited from the group interview however, the nearest maternity facility for this community is about 8 kilometres away in Katito. It is accessed through a bumpy road usually impassable during rainy seasons. This is relatively a short distance, but not for a woman in labour pains in an area where

there are no public transport facilities and people are generally poor. According to Gay (1993), one of the major factors that hamper women's access to modern health care is poor infrastructure.

It was, however, apparent from data elicited in groups interviews and key informants that there were several local experienced and skilled traditional birth attendants (TBAs) who have had basic training to assist mothers to deliver children from the Ministry of health. They provide delivery services to the community.

It is largely the availability of TBAs in Katolo which best explain why most women do not deliver in hospitals rather than their age or attachment to traditional cultural values. A cross-tabulation of whether maternity hospital is far and whether the respondents delivered in hospital (Table 4.17) illustrates this view.

The contents of the table indicate that there was no significant relationship between delivery in hospital and whether a facility was far. It would appear that with the trust the community have on TBAs, the distance to the maternity was not an issue regarding their behaviour as pertains to where they delivered their children.

Table 4.17 Whether maternity hospital is far by delivery in hospital

Hospital far?	Do you deliver in hospital?		
	Yes	No	ROW TOTAL
Yes	11.1% (n=1)	88.9% (n=8)	9.2% (9)
No	21.3% (n=19)	78.7% (n=70)	90.8% (89)
Column Total	20.4% (20)	79.6% (78)	100% (98)

$\chi^2 = .08541$

df=1

p>0.01

contingency coefficient=.07316

About 90% of the respondents did not use maternity services since they felt they had no problem during delivery (see Table 4.18).



Table 4.18 Non-use of child delivery services by having no problem during delivery

Problem during delivery	Deliver in Hospital		
	Yes	No	ROW TOTAL
Yes	22.2% (n=2)	77.8% (n=7)	9.2% (9)
No	10.1% (n=9)	89.9% (n=80)	89.9% (89)
Column Total	11.2% (11)	88.8% (87)	100% (98)

$\chi^2 = .29455$

df=1

p>0.01

contingency coefficient=.11012

#### 4.3.5 Gender sensitivity and WRH

Gender sensitiveness of the respondents was examined with a view to determining the impact of gender perceptions on reproductive health. It was assumed that respondents who were not gender sensitive (e.g., discriminated against their female children on

provision of education) demonstrated negative health behaviour. When the age category of respondents was cross-tabulated with whether they would have preferred to educate male or female children, the results were as in Table 4.19.

Table 4.19 Age category of respondents by gender preference on education provision

Age category of respondents	Gender preference in education provision			
	Boy	Girl	Both	ROW TOTAL
Young	81.8% (n=27)	90.6% (n=29)	75.0% (n=12)	83.8% (68)
Old	18.2% (n=6)	9.4% (n=3)	25.0% (n=4)	16.2% (13)
COLUMN TOTAL	40.7% (33)	39.5% (32)	19.8% (16)	100% (81)

$\chi^2 = 2.12074$  df=2 p>0.01 contingency coefficient = .15073 Missing observations =17

It is evident from the table that there is an association between the ages of responders and sex preferences in providing education. Only 25% of 'old' respondents would have preferred to give both sexes equal opportunities in education against 75% of the 'young' respondents. Yet one might take into consideration that majority of respondents were in the category of 'young' respondents. It was expected that the 'young' respondents with higher education levels would have liberal views about education provision to both gender. This supports the hypothetical position that 'young' persons are more likely to practice positive health behaviour than the 'older' persons. The significant relationship is depicted by a chi-square statistic of 2.12074 and a contingency coefficient of .15073 at 0.01 level of significance.

#### 4.3.6 *Health perceptions and attitudes*

Data on health perceptions and attitudes were elicited mainly from the group interviews, particularly focusing on how such perceptions and attitudes may hamper health awareness and therefore, affect badly on WRH. The relationship between respondents' age and their health perceptions was determined by cross-tabulating their perception on causes of certain locally familiar children illnesses with their age. Table 4.20 shows results of the cross-tabulation of respondents' perceived cause of *marasmic* condition in children age group of respondents.

Table 4.20 Age category of respondents by perceived cause of marasmus (mosquitoes)

Age category of respondents	Perceived cause of marasmus (mosquitoes)		
	Yes	No	ROW TOTAL
Young	18.8% (n=8)	83.2% (n=60)	34.4% (68)
Old	30.8% (n=4)	69.2% (n=9)	16.0% (13)
COLUMN TOTAL	14.2% (12)	85.2% (69)	100% (81)

$\chi^2=1.79897$

df=1

p>0.01 contingency coefficient =.19269

Missing observations =17

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It would appear from table 4.20 that, comparatively, a fair percentage (31%), of respondents in the 'old' category perceive mosquitoes as the cause of *marasmus* among children, against a mere 11% in the 'young' respondents category. This implies that pseudo-perceptions on causes of diseases mainly affect the older persons, presumably with low education and health awareness levels than younger persons. There is thus a certain level of relationship between age and perceptions on health, if the chi-square value of 1.79897 and a contingency coefficient of .19269 at 0.01 level of significance are anything to go by.

The general observation is however, that the majority among both age categories of respondents, did not perceive mosquitoes as the cause of *marasmus*. This is shown by 88% and 69% of the 'young' and 'old' respondents respectively. Indeed, this agrees with information gathered from the group interviews attributing *marasmic* condition among children to malnutrition, which is actually the right cause.

Yet, another view which emerged from group interviews is that there are health and illness conditions which are purely explained by the cultural code, and for which remedies are found in the same code. Measles in Katolo is, for example, was perceived to be caused by *nundu*, a strange wind which blows from Lake Victoria during the night, accompanied by evil spirits whose voices are clearly audible. It may cause mysterious deaths to children. The community refers to the wind as *nyawawa*, as this (they believe), would

prevent it from striking members of their households. These beliefs cut across respondents of all ages in Katolo. The findings corroborate those of studies conducted elsewhere in Nyanza Province. According to Mairura (1995) for example, measles is as a result of *chira* (misfortunes that may befall a family) - a belief that when a child has a big stomach, a big head, weak legs and sunken eyes, it is a result of an evil eye. Other beliefs which touch on reproductive health included some evil power or *juogi* which may cause still births. *Juogi* has such immense powers that it (he) can even stagnate the growth of a foetus. In Katolo, *nyasach mon* is the equivalent of this power.

#### 4.4 Educational/health awareness levels and WRH

##### 4.4.1 Educational level and health awareness

This section deals with the hypothesis that '*Individuals with high educational/health awareness levels are more likely to adopt positive health behaviour than those with low educational/health awareness levels*'. In this study, persons who had attained formal secondary education and above, were considered to have attained a high educational/health awareness level. Those with elementary primary education or no formal education at all were considered to have low educational/health awareness levels. Positive health behaviour envisaged having perceptions, attitudes and practices which have a bearing on sustenance or promotion of good health including effective use of MCH/FP services, modern child delivery

services, appropriate nutritional intake, having married or delivered children at an appropriate age, and being empowered in terms of making reproductive health decisions.

From the data, it was observed that only a small proportion among the respondents had attained formal primary and secondary education, constituting 19.4% and 33.3% respectively (see Table 4.21). About 81% of the respondents had not attained primary education while 68% had not attained secondary education. When the educational level of the respondents was cross-tabulated with use of modern family planning methods, the results were as presented in Table 4.21.

Table 4.21 Level of education by whether practice modern family planning

Education level	Use of modern family planning services		
	Yes	No	ROW TOTAL
No formal education	25.0% (n=2)	75.0% (n=6)	8.2% (8)
Primary	19.4% (n=14)	80.6% (n=58)	74.2% (72)
Secondary	33.3% (n=6)	67.7% (n=11)	16.5% (17)
COLUMN TOTAL	22.7% (22)	77.3% (75)	100% (97)

$\chi^2=5.12761$  df=4 p>0.01 contingency coefficient =.22407 Missing observations =1

It can be observed from the table that there is a significant relationship between the respondents' educational levels and use of modern family planning services as shown by the chi-square statistic of 5.12761 and a contingency coefficient of .22407 at 0.01 significant level. It would appear that the use of modern family planning methods increase with increase in the level of formal education as shown by 33.3% of the respondents who attained secondary education and above, against 19.4% of respondents who were using modern family planning methods with primary level education.

This observation befits our hypothesis that *'individuals with higher educational levels are likely to adopt positive health behavior than those with low level education'*. Adoption of modern family planning methods constitute positive health behaviour. These observations would further imply that those with a higher educational level would relatively have smaller families and also enjoy adequate nutritional intakes. Both of these constitute positive health behaviour. These findings corroborate other studies conducted elsewhere in the developing countries, which link maternal age, family size, fertility, and better nutrition with individuals' education levels (GOK-UNICEF, 1992; World Bank 1993c FH1, 1994). Other studies have also indicated that educated women utilize ante-natal, family planning and health services more readily than uneducated Women (Nduati,1992; K'Oyugi, 1992).



#### 4.4.2 Educational/health awareness and health behaviour

It was assumed in this study that individuals with a relatively higher educational level had also a higher level of health awareness, and were therefore, likely to exhibit positive health behaviour. An examination on how respondents perceived the causes and treatment of common nutritionally associated illnesses such as *marasmus* and *kwashiorkor* was carried out. When the level of education and perceived treatment of *kwashiorkor* and *marasmus* conditions were cross-tabulated, the results were as presented in Table 4.22.

It would appear from the table that a majority of the respondents with primary level of education (82.6%), perceived 'adequate food' or 'appropriate nutrition intake' as the remedy for *kwashiorkor* condition. There was thus a positive relationship between the correct perception on the remedy of *kwashiorkor* - *marasmus* conditions and whether or not the respondents had formal education as indicated by the chi-square value of 5.64616 and a contingency coefficient of .23453 at 0.01 significant level (Table 4.22).

Table 4.22 Perceived treatment of kwashiorkor by level of education(adequate food)

Perceived treat..Of kwas.  marasmic condition	Level of education			ROW TOTAL
	None	Primary	Secondary & Above	
Yes	4.3% (n=2)	82.6% (n=38)	13.0% (n=6)	47.4% (46)
No	11.8% (n=6)	66.7% (n=34)	17.5% (17)	52.6% (51)
COLUMN TOTAL	8.2% (8)	74.2% (72)	17.5% (17)	100% (97)

$\chi^2=5.64616$  df=4 p>0.01 contingency coefficient = .23453 Missing observations =1

The smaller number of respondents with secondary level of education can be explained by the few responses in this category which constituted only 17.5% of the sample size as opposed to 74.2% responses observed in the category of those with primary level of education. The data largely attests to the positive relationship between level of education (and level of health awareness) and the correct perception on the remedy or treatment of kwashio-marasmic conditions. This observation supports the hypothesis as stated and also corroborates other studies which have related level of education with positive health perceptions and practices.

According to Schultz (1989) for example, girls who have attended school especially up to secondary level are more likely to adopt positive health behaviour such as delayed marriages and child

bearing, small family size, use of health care facilities and adopt appropriate child care.

#### 4.4.3 Level of education and place of child delivery

Another way in which health behaviour was assessed vis a vis education was cross-tabulating education level of the respondents and their utilisation of child delivery practises. Results of cross-tabulating the two variables are presented in Table 4.23.

Table 4.23 Respondents' level of education by place of child delivery

Level of education	Place of child delivery		ROW TOTAL
	Hospital	Home/other place	
None	25.0% (n=2)	75.0% (n=6)	8.6% (8)
Primary level	42.0% (n=29)	58.0% (n=40)	74.2% (69)
Secondary and above	62.5% (n=10)	37.5% (n=6)	17.2% (16)
<b>COLUMN TOTAL</b>	44.1% (41)	55.9% (52)	100% (93)

$\chi^2=9.65422$  df=8 p>0.01 contingency coefficient =.30667 Missing observations =5

From Table 4.23, a relationship between delivery in hospitals, which constitutes positive health behaviour and educational level of respondents can be discerned. About 62.5% who had secondary level education had delivered in hospital, whilst 37.5% of the respondents delivered at home or elsewhere. This again supports our

hypothesis as stated, for delivery in hospital constitute positive health behaviour and was related with level of education. A similar observation has been made by other studies (World bank, 1993a; KMA, 1993).

#### 4.4.4 Health awareness and positive health behaviour

It was discerned from the data that there was a negative relationship between awareness of certain health conditions and the practice of family planning. A cross-tabulation of awareness of pregnancy complications and practice of family planning is presented in Table 4.24.

Table 4.24 Awareness of pregnancy complications by practice of family planning

Whether aware of pregnancy complications	Practice family planning		
	Yes	No	ROW TOTAL
Yes	68.2% (n=15)	31.8% (n=7)	22.9% (22)
No	50.0% (n=37)	50.0% (n=37)	77.1% (74)
COLUMN TOTAL	54.2% (52)	45.8% (44)	100% (96)

$\chi^2=1.58513$  df=1 p>0.01 contingency coefficient =.15160 Missing observations=2

It is evident from the table that there is an association between respondents' awareness of pregnancy complications and adoption of modern family planning. This implies that, to some extent, family planning is determined by awareness of pregnancy complications as depicted by a chi-square value of 1.58513 and contingency coefficient of .15160 at 0.01 level of significance.

This partially supports the assumption inherent in the hypothesis that the level of health awareness has a bearing on the practice

of family planning or adoption of positive health behaviour. It is evident from the table that 68.2% of the respondents who were aware of pregnancy complications practised family planning as against 31.8% who did not practise family planning on account of being unaware of pregnancy complications. This observation is in line with findings of other studies which indicate that the health awareness level of individuals, play a significant role in shaping their health behaviour (K'okul, 1991, K'Oyugi 1993).

Data elicited from other sources indicated that most women in Katolo harbour pseudo-scientific perceptions regarding certain health conditions, a fact attested to by their knowledge base on the cause and treatment of certain common illnesses and health conditions. This could partly be attributed to their low levels of education, a characteristic of rural populations globally, of which women constitute the majority. Indeed, individuals' educational levels have a direct influence on their health awareness.

These observations befit the gender perspective - that women are disadvantaged as pertains to provision of education among most communities. This becomes a major impediment for women to acquire a level of education which may equip them with the

requisite health awareness level to respond positively to their health needs. Being illiterate undermines women's knowledge base in matters pertaining to health, buttressing certain cultural attitudes which negate them good health. It would thus be quite appropriate to conclude that educational and health awareness level is a major determinant of women's reproductive health.

#### 4.5 Women's autonomy and reproductive health

In this section, WRH is discussed in the context of women's autonomy, as regards making sexual and fertility decisions and acting on the basis of such decisions. The guiding hypothesis was that *'Women with autonomy in sexual/reproductive decisions are likely to experience less reproductive health problems than those without sexual/reproductive autonomy'*. The basic premise on which this discussion hinges is that, in most African societies, women do not have autonomy in the sphere of sexuality and fertility.

According to Ascadi and Ascadi (1993), men dictate the timing and terms of coitus, as women do not have the right to refuse intercourse with their partners or demand the use of condoms or other contraceptives.

In the study, women's sexual/reproductive autonomy refer to the ability and freedom of women to make choice decisions regarding whether or not to adopt modern family planning methods to prevent unwanted pregnancies and their capacity to choose when to have intercourse with their partners

#### 4.5.1 *Sexual autonomy, family planning and reproductive health*

Among the salient factors identified in Katolo which negate women autonomy in the realm of sexuality and fertility, were cultural beliefs and practices, fear of their male spouses, burden of workloads in the household (based on ascribed gender roles) and educational levels. These factors were found to stifle women's autonomy in utilisation of modern reproductive health care systems, which adversely affected their reproductive health behaviour.

Data elicited from respondents indicate that women who used modern contraceptives to prevent unwanted pregnancies were those who somehow defied community values and attitudes, who also happened to have a relatively higher level of education and health awareness. Autonomy in the study was thus treated at two levels - one, where women do not observe "oppressive" traditions as influenced by their age and educational levels (and health



awareness) and two, where they defy the whims of their male spouses, albeit clandestinely.

It was observed that most women in Katolo use natural family planning to prevent unwanted pregnancies. It is important to note that although they cited other reasons that hamper their adoption of modern family planning methods, the most glaring fact is that most of them feared their male spouses (see Table 4.25).

Table 4.25 Use of natural family planning ('rhythm') by fear of male spouses

Fear of male spouse	Use of natural family planning ('rhythm')		
	Yes	No	ROW TOTAL
Yes	72.7% (n=8)	27.3% (n=3)	12.5% (11)
No	37.7% (n=29)	62.3% (n=48)	87.5% (77)
COLUMN TOTAL	42.0% (37)	58.0% (51)	100% (88)

A significant relationship between women's fear of their male spouses and their use of a 'rhythm' (or non-use of contraceptives)

can be observed in the table, shown by a chi-square statistic of 3.5246 at 0.01 level of significance and a contingency coefficient of .22870. Women's fear of their male spouses, thus, denies them sexual or fertility autonomy, constituting an impediment to ideal reproductive health. As evidenced by the data, about 73% of the women respondents were using natural family planning, rather by default than by any conscious effort to control their fertility.

This observation corroborates other studies which link ineffective use of modern family planning methods with poor male co-operation in fertility control ( Oyosi, 1995). A study in Zaire also revealed that men initiate most major fertility and family planning decisions, including contraceptive use (UNDP)/WHO/World Bank, 1994). This implies that women's autonomy in matters of sex and, by extension that of their fertility and reproductive decisions, hinge upon the whims of their male spouses.

What the constriction of sexual/reproductive autonomy for women means is that, they do not have a say over their fertility and family size, which may engender a host of health-related problems. Indeed, their lack of sexual autonomy makes them vulnerable to sexually transmitted diseases (STDs), unwanted pregnancies and other related maladies, including maternal depletion syndrome. It was observed that young women below the age of 25 years were

already in their third or fourth pregnancies, suggesting very close spacing of children.

These findings in Katolo thus support the basic tenet of our hypothesis, and also befit the gender perspective that males, to a large extent, influence the reproductive health of women as they control their sexuality.

#### *4.5.2 Cultural factors, autonomy and reproductive health*

The emergent theme from most studies is that women's lack of autonomy in reproductive matters is basically a function of social and cultural factors. In essence, women's fear of their husbands to engage independently in family planning initiatives, hinge upon certain attitudes which are nurtured and reinforced by culture. Patriarchal social arrangements, typical of African families, presuppose male dominance in most domains of social life. This includes the control of women by men in most aspects of their lives including health behaviour, within the broader context of social consensus and normative expectations. According to Heise et al. (1993), no culture or enacted law empower women to be in control of their sexuality, health or reproduction globally. This implies that 'normal' women should not be in control of their lives including making crucial decisions, such as using contraceptives, without the consent or tacit approval of their male spouses.

The findings in Katolo indicate that women in that community too, are bound by certain cultural norms which dictate their use or non-use of modern contraceptives, or in what style (whether open or clandestine) they may use such facilities.

Data obtained through group interviews and key informants indicated that certain cultural beliefs and customs (which 'must' be observed), influenced women's reproductive health behaviour and consequently their general health. There are, for instance, several strands of *chira* which are perceived to adversely affect those who defy certain customary practices. Such practices, which 'liberated' women would defy, include *ng'ando yimbo* (resumption of post-partum sex within four days in case of delivering a baby boy, and 3 days for a baby girl), as they explicitly indicated. The fear of such consequences negate women the autonomy to make decisions regarding what is best for them on sex and fertility matters. The danger of engaging in sex before full recovery of the uterine wall include women's susceptibility to a myriad of reproductive tract infections including STDs and HIV/AIDS.

In other words, women cannot enjoy sexual autonomy in the context of cultural norms which govern their lives including health behaviour. They are, for instance, compelled by such norms to marry early and bear many children as expected by society. Research has shown that women who start childbearing at puberty, generally bear

more children, and at shorter intervals than those who begin parenthood at a later age (CMA, 1993). This fact agrees with findings in Katolo, where about 54% of the respondents in the age bracket of 21-25 years had had 1-3 children and those in the age bracket of 26-30 years had had 4-6 children or more.

Further evidence indicates that 65% of the women interviewed were married at an age below 20 years (see Table 4.26). This cannot be attributed to their 'free choice' as community expectations are pressure enough to bring about this scenario. Moreover, the community is also responsible for the denial of educational opportunities to girls, which leave them with no option than to engage in other 'businesses' or to start motherhood at an early stage in life.

Table 4.26 Distribution of respondents by age at marriage

Age at marriage	No. of respondents	Percentage (%)
14-20 years	64	65.3
21-25	18	18.4
26-30	5	5.1
Missing observations	11	11.2
TOTAL	98	100

The observation that most women marry too young on account of lacking autonomy or control over the lives is not unique of Katolo. Similar findings have been observed by other studies globally. Among major health threats associated with women marrying too early is exposing them to risks associated with childbearing (Westoff & Achoa, 1991). These include unwanted pregnancies, STDs, perforated uterus, ectopic pregnancies, and even death (Nduati, 1992). The risks directly related to pregnancies include toxemia, anemia, excessive bleeding and obstructed labour.

The findings in Katolo support our hypothesis and augers well with the gender perspective that women have always had a 'raw deal' in society on account of being denied autonomy through social sanction. In Nyanza Province, under which Katolo sub-location falls, practices such as wife inheritance are prevalent. Where women have no option other than being placed under 'caretakers' upon the demise of their husbands. A study conducted by GOK/UNICEF (1992), indicated that a woman 'must marry' their men 'in-laws' or other male relatives upon the death of their husbands, failure to which *chira* would befall them.

In conclusion, therefore, it would be plausible to submit that women's lack of autonomy or control over their sexuality and fertility, is basically a function of the socio-cultural contexts in which they are born, socialized and live, rather than mere

gender relations. Gender relations are themselves conditioned by culture. Thus, women's fear (or is it respect?) for their husbands vis-a-vis their reproductive health behaviour (such as adoption of family planning methods), should be seen in the wider context of socio-cultural factors.

## CHAPTER FIVE

### SUMMARY CONCLUSION AND RECOMMENDATIONS

#### 5.1 Introduction

In this final chapter, a summary of the salient findings of the study are presented. The conclusion and recommendations, which organically derive from the findings, provide some suggestions on the 'way forward' to improving WRH in Kenya. One important thing which should be borne in mind is that, women's health should be placed at the very core of the development agenda at the community, national and international levels. Such a realisation would make nations more committed to health programmes which, in turn, would enhance healthy populations and continued existence of human kind. Indeed, women's health ought to be a priority in national development, particularly because of their socio-biological role in society.

#### 5.2 The purpose, objectives and scope of the study

The basic purpose of this study was to identify and examine some of the socio-cultural factors which influence women's reproductive lives. The ultimate goal was essentially to generate empirical data on the impediments of WRH in certain rural setting - Katolo. This was seen as an important task as



it would certainly bring into light, some of the customary beliefs and norms which are inimical to good health. Such an revelation would further sensitize the government and other development agents who may wish to launch intervention health programmes in the area. The study recognised that promotion of positive health behaviour among women, would in turn enhance the health of their children and ultimately, that of future generations of their communities.

### **5.3 Community health and morbidity situation**

It was observed that the health situation in Katolo is relatively poor. Statistical figures obtained from local health facilities, key informants and documents attested to this fact. While malaria is the leading disease in the area, other preventable diseases, particularly relating to malnutrition and human behaviour, were also observed.

### **5.4 Summary of the major findings**

One most important finding in the study was the significant relationship existing between women's maternal age and their perceptions and level of knowledge on reproductive health and

illnesses. It was, for example, observed that although 77% of the women between the age of 31 and 35 years; and 60% of those over 41 years had knowledge on symptoms of illnesses relating to pregnancy and motherhood, 65% of those with 20 years and below had not.

Generally, women advanced in age were more knowledgeable as regards motherhood problems than their young counterparts. This is a worrying trend because most of such health problems affect young mothers. It is important for young mothers to have such knowledge to enable them take appropriate measures at the earliest signs of such sicknesses. It is extremely important as it was evident that most women in Katolo become mothers before the age of 20 years. Poor level of knowledge among women could be attributed to low levels of education which is engendered by early marriages.

Evidence also indicated that pregnant women perform virtually all duties in the households in Katolo. These included digging, weeding, fetching water and firewood, and tending children. Over 66% respondents performed these chores. About

84% indicated that their performance of these duties during pregnancy does not affect their health. They could not interpret the stress and fatigue engendered by such duties as health problems since they perceive them as their very own. They simply performed them irrespective of whether they lived with their husbands or not.

According to the data, women are nutritionally disadvantaged on account of certain persistent beliefs and practices. There are beliefs which proscribe foods such as fish and other nutritious foods for pregnant women as attested to by 63% of the respondents. Data from the group interviews indicated that there were a myriad of beliefs which target women's nutrition and therefore affect their reproductive lives.

Due to such beliefs, 72% and 66% of the respondents indicated that pregnant women do not take milk and fish during pregnancy respectively. There was a significant relationship between awareness of these taboos and abstaining from taking certain foods during pregnancy among the respondents. Awareness of these beliefs cut across women of all ages in the community, although this did not necessarily suggest their adherence to them.

Another interesting finding was that there was poor utilisation of reproductive healthcare services such as modern family planning and child delivery services. Most women, (over 78%) were not using contraceptives for fear of what might happen to them if their male spouses found out. They instead used 'rhythm' or the natural family planning method. Distance to the facility where family planning services were available was therefore insignificant to the rate of contraceptive use. Not even respondents' educational level seemed to have significantly influenced their use of modern family planning methods.

The majority respondents also did not attend hospitals for child delivery on account of having trusted TBAs or having no complications during delivery. Another factor which could partly explain the popularity of TBAs in the community, is that the nearest maternity facility is situated eight kilometres away from the villages. However, statistically, there was no significant relationship between the distance to the maternity hospital and the women's use of the facility.

As regards gender sensitivity, it was observed that about 75% of the 'young' and educated women were keen to provide equal educational opportunities to children of both sexes, against 25% of those grouped in the 'old' category. Yet, this finding

was not conclusive because there were fewer respondents interviewed in the latter category than in the former.

The respondents had correct perceptions on some of the illnesses prevalent in Katolo such as kwashiorkor and marasmus. This was indicated by 88% and 69% of the respondents among the young and old categories respectively. About 83% of the respondents indicated that adequate food is the remedy to these conditions. But there were other illnesses that the community perceived as being caused by *chira* such as measles and *rariu* which could only be explained and dealt with in the cultural code. For example only *manyasi* or concoctions such as *kagno* would cure such ailments.

Finally, it was observed that the absence of women's sexual and reproductive autonomy is essentially a function of cultural tradition rather than simple gender relations. About 73% of the women interviewed were using contraceptives clandestinely for fear of their husbands. Men controlled the fertility of their wives by virtue of the prevailing cultural arrangement rather than their whims to do so.

## 5.5 Conclusion

It is evident from the foregoing that, WRH in Katolo is influenced by certain socio-cultural factors' notably persistent cultural beliefs and practices. These affect women's nutritional and health seeking behaviour and their knowledge base in matters of health. They buttress their pseudo-scientific perceptions on causes and remedy of certain illnesses which threaten their reproductive life. The fact that young women are not aware of health dangers associated with early motherhood, is a worrying trend since they are at risk of life-long maternal morbidity.

Other threats to WRH in Katolo could be associated with women's poor use of reproductive health care services. At this rate, they are bound to produce many children at short intervals which augers badly for their health and that of their children. This is particularly so because women do not have the autonomy to take charge of their fertility. Large families would obviously mean poor family nutrition and poor reproductive life for Katolo community's subsequent generations.

## 5.6 Recommendations

From the findings of the study the researcher has suggested a few recommendations. One, in view of WRH situation in Katolo, there is need to design and implement an integrated health care intervention programmes. The programmes could be implemented in a primary health care (PHC) fashion so as to have as wide coverage as possible in this community. Such programmes should be comprehensive to include reproductive health education and services, maternal and child health, and family planning. They must go hand in hand with appropriate health education for the sake of sustainability. Moreover, such education will gradually extricate the community from the web of harmful cultural traditions.

Secondly, there is need for the government and other development agencies to focus their attention on uplifting literacy levels. Although the difficulties of introducing instant changes are appreciated, basic forms of infrastructure that could facilitate educational campaigns are lacking. In essence, education is the key to improving all spheres of community life including health behaviour.

Thirdly, something should be done to improve the community standard of living in Katolo. It is particularly important that the agricultural sector is invigorated through improved

roads, water and irrigation projects, land registration, and introduction of scientific farming methods. Because of the semi-arid nature of Katolo as a result of the rain shadow effect, water projects could improve crop yields and uplift the nutritional standards of the community. This would also improve general community health.

Improved standards of living would shift the community's efforts and preoccupation from activities relating to mere basic survival, to thinking about their welfare, including education and health. When education level of the community is uplifted, it would become receptive to new ideas which would gradually change their health perceptions positively. Enlightened people are 'liberated' people who would also realise that children, irrespective of their sexes require equal opportunities in all aspects of life. Increased access of girls to education would mean delayed marriage and future mothers who adopt appropriate health behaviour.

All these initiatives call for concerted effort from development actors including the government, NGOs and other development agencies. Above all, members of the community should be mobilized to participate in all projects aimed at improving their standard of living.



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# APPENDIX

## Women's Reproductive Health - Interview Schedule

Kisumu district, East Kano location, Katolo sublocation

### SECTION A: Biodata

1. Name.....Village
1. Sare                      4. Holo  
2. Kinasia                5. Olasi (Olusho)  
3. Yogo                    6. Olasi (Charare)
2. Sex                    1. Male                    2. Female
3. Age.....Religion
1. Christian  
2. Muslim  
3. Traditional  
4. Other (specify).....

4. Number of children.....

#### Number of children, Sex and Age

Number of children	Sex	Age

5. Marital status (Tick as appropriate)
1. Single                      4. Divorced  
2. Married  
3. Separated                5. Widowed

6. If married, state age at marriage.....years.

7. Level of education and number of years at school:



1. None formal education
2. Primary .....years
3. Secondary .....years
4. University .....years
5. Other .....years

8. Occupation.....

**SECTION B: Health, maternal age and family planning history**

9. At what age did you first get pregnant.....years

10. What health problems did you experience then and subsequent pregnancies

.....

.....

.....

.....

.....

11. Which of the following have you ever experienced? (Tick appropriately)

- |                    |        |
|--------------------|--------|
| 1. Vomiting        | Yes/No |
| 2. Severe bleeding | Yes/No |
| 3. Oedema          | Yes/No |
| 4. Headaches       | Yes/No |
| 5. Miscarriage     | Yes/No |
| 6. Pre-eclampsia   | Yes/No |
| 7. Other (specify) | Yes/No |

12. Have you had a problem since the your last delivery ?

1. Yes      2. No

13. If yes, please narrate nature of problem

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14. For how Long do you breast feed your children ?.....years

Child rearing calendar

Child	Age in months	Type of foods fed e.g. milk, porridge, sauce etc....

15. What do you do to avoid unwanted pregnancy (please narrate methods).

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.....

16. Where have you been delivering your children?

1. Hospital
2. At home
3. Other places (Specify ) .....

17. Why? Give reasons

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.....

18. What duties do you not perform during pregnancy?

.....

.....

.....

.....

.....

19. Who decides on what duties you should or not perform during pregnancy

1. Spouse
2. Myself
3. In-laws
4. Others (Specify) .....

20. Who assists you in the household chores during pregnancy

---

- 1. myself
- 2. My children
- 3. My spouse
- 4. Neighbours / Friends
- 5. Others ..... (Specify)

21. Do you attend-natal clinics?

- 1. Yes
- 2. No

22. If you do not attend why ? Give reasons?

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23. If you do, what happens in the clinic?

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24. What have you learned from attending ante-natal clinic?

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25. In your opinion, what do you think of having many children?

1. Advantageous

2. Not advantageous

26. Why? Narrate.

.....

.....

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.....

27. Whose wish was it to have these children?

1. Mine

2. Spouse

3. Grandparents

4. Others (Specify) .....

28. If none, whose? and why? Give reasons

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.....

29. Why do you breastfeed your baby that long/short period? (Refer to Q. 17) Give reasons:

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30. After delivery how long does it take you "TO CUT WEST". State exact days/weeks/months.

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31. What are your reasons for the answer above?

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.....  
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32. How soon do you resume your normal work after delivery?

..... (weeks/months/years)

**SECTION C: Economic status, food and Nutrition**

33. What is the total land size in acres/hectares owned by you?

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34. Of the total land owned by you , how much do you cultivate?

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.....  
.....  
.....

35. What do you do with crops you grow in shamba?

.....  
.....  
.....  
.....  
.....

36. How many of each of the following types of livestock does your household have?

Cows .....

Goats .....

Sheep .....

Poultry .....

Others ..... (Specify)

37. Mention what you ate yesterday

.....  
.....  
.....  
.....  
.....

38. After noon snacks

.....  
.....  
.....  
.....

39. Are there foods that you do not eat when you are pregnant

1. Yes

2. No

40. If yes, which ones, and why?

.....  
.....  
.....  
.....

41 Are there any special foods for mothers/pregnant women in this community?

1. yes

2. No

42 If yes, which ones and why?

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.....  
.....  
.....

**SECTION D: Health perceptions/awareness**

Have you ever suffered from any of the following? Please tick

- 1. Acute respiratory infections (yes/no)
- 2. Eclampsia (yes/no)
- 3. Malaria (yes/no)
- 4. Anemia (yes/no)
- 5. Pneumonia (yes/no)
- 6. Sexually transmitted disease (yes/no)
- 7. Pregnancy complications (yes/no)

44. What in your opinion are the cases of:

- 1. Measles .....
- 2. Kwashiorkor.....

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- 3. Marasmus.....
- 4 Diarrhoea .....
- 5. Typhoid .....
- 6. Schistosomiasis .....
- 7. Hook worm .....

45. How are each of them treated in the community traditionally?

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**SECTION E: Gender sensitization**

46. What would be your sex preference for a first-born?

- 1. Boy
- 2. Girl

47. Explain your preference above.

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.....

.....

48. In your opinion, among your children if you consider boys and girls, which ones deserve more food? .....

49. Give reasons for your answer

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.....

50 At what age would you like your daughter to get married? ..... (years).

51 Why would you consider such age as most appropriate?

.....  
.....

52 At what age would like your son to marry? ..... (years).

53 Give reasons for your answer (52) above

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.....  
.....

54 do you think there are problems associated with a girl marrying too early

- 1. Yes
- 2. No

55 If yes, mention them

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.....

56 Among your children, which ones would you prefer to educate if funds are scarce?

- 1. Boys
- 2. Girls

57 Give reasons for your answer above

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**SECTION F: Access to, and utilization of MCH/FP services**

58 How far is the nearest health facility? ..... (Kms.)

59 How often do you visit the health facility? .....( per month/year).

60 For what illnesses do you visit the facility? (Please list them)

.....  
.....  
.....

61. Are there illnesses that you may not take to hospital?

1 Yes

2. No

62. If yes, which ones? (List them).

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.....  
.....

63. How do you tackle them. Please explain.

.....  
.....  
.....

64. Do you use any family planning method?

1. Yes

2. No

65 If yes, which one(s)?

.....  
.....  
.....

66 If no, what do you do to prevent unwanted pregnancy?

.....  
.....  
.....  
.....

67. Does your spouse/parents know about your use of the method in (66) above?

1. Yes

2. No

68 If no, what would happen if they/ he/she knew?

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.....  
.....

**SECTION G: Traditional beliefs and customs**

69 Are aware of any taboos which bar one not to attend hospital or eat certain foods?

1. Yes

2. No

70. Indicate them in the table below

Hospital	Eating certain foods

71 What would happen if one went to hospital/ate proscribed foods. Please narrate

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.....  
.....

72. What is said to have happened:

a) If a person dies of an illness which emaciates his/her body?

.....  
.....

b) If a child become skinny/swells stomach/sunken eyes/shriveled skin?

.....  
.....

c) If a person in a homestead has mental disorder?

.....  
.....

d) If a child has measles/kwashiorkor/marasmus?

.....  
.....

e) If a girl is never married?

.....  
.....

f) If a man is never married?

.....

73 Are there people who go to traditional healers for treatment?

1. Yes

2. No

74. At what stages and for what illnesses do they consult them? Please narrate.

.....  
.....

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75 In your opinion and/ or experience do you think that traditional healers are more effective than modern doctors

1 Yes

2 No

76. Give reasons for your answer.

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