

**INFLUENCE OF CULTURAL TRADITIONS ON THE REPRODUCTIVE HEALTH OF  
SOMALI WOMEN REFUGEES IN NAIROBI COUNTY, KENYA**

**BY**

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## DECLARATION

This Research Project Report is my original work and has not been submitted for a degree or any other award in any other institution.

Sign.....Date.....

**Joseph Isuzi Akivaga Fedha**

**(L50/64511/2010)**

This Research Project Report has been submitted for examination with my approval as the University Supervisor.

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## **DEDICATION**

This Research Project Report is dedicated to my father, Peter Fedha, the pillar of our family.

## **ACKNOWLEDGEMENT**

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## **ABBREVIATIONS AND ACRONYMS**

UNHCR- United Nations High Commission for Refugees

WHO- World Health Organization

UNICEF- The United Nations Children's Fund

UNFPA- United Nations Population Fund

KNBS- Kenya National Bureau of Statistics

RCK- Refugee Consortium of Kenya

FGM- Female Genital Mutilation

PATH- Program for Appropriate Technology in Health

US- United States

HIV- Human Immune Deficiency Syndrome

AIDS- Acquired Immune Deficiency Syndrome

SACB- Somalia Aid Coordination Body

UNIFEM- United Nations Development Fund for Women

LMICs- Low- and Middle-income Countries

CPR- Contraceptive Prevalence Rates

USAID- United States Agency for International Development

NGOs- Non Governmental Organizations

## ABSTRACT

Approximately 1000 women die each day worldwide from pregnancy related causes, 99% of them in developing countries and more than 50% in sub-Saharan Africa (WHO, 2008) with most deaths concentrated around the time of delivery. The study set out to establish the influence of cultural traditions on the reproductive health of Somali women refugees in Nairobi, Kenya. The objectives of the study were to establish the impact of traditional birth attendants to maternal health among Somali refugees in Nairobi; to investigate the extent to which attitudes towards family planning and contraception among Somali refugee women in Nairobi has an effect on their reproductive health; to determine the influence of female circumcision on reproductive health among Somali women refugees in Nairobi; and to establish the influence of food taboos on reproductive outcomes among Somali women refugees in Nairobi. The study was conducted as a cross sectional survey. The target population was all Somali women refugees in Nairobi. Sample size was determined by use of Fischer equation ( $n=Z^2pq/e^2$ ). Snowball sampling was used in this study. Questionnaires were pre-tested at the School of Communication at Daystar University, Nairobi. Data was collected by the researcher over a period of four weeks by the use of self administered questionnaires from respondents who can read and write and also with the assistance of the researcher for those illiterate respondents. All questionnaires were edited and responses coded before data was entered into the computer by the use of the Statistical Program for Social Scientists (SPSS), version 11.5. Cross tabulation was the main method used for data analysis. After analysis, data was summarized and presented in form of frequency tables, percentages and proportions. 75% of the respondents reported reliance on the services of TBAs, most of whom are untrained, for antenatal care. 65.1% of the respondents reported complications before labor. Even with these complications, a considerable number of respondents, 39.1%, sought the help of TBAs instead of specialized care from hospital. 51.8% of the respondents reported to have delivered at home while 41% of those who delivered at home reported to have been assisted by TBAs. There is also a strong correlation between complications during labor and delivery and assistance place of delivery. In family planning, the use of contraceptives was found to be very low. Only 27% of the respondents reported the use contraceptives as compared to 56.1% of the respondents who reported not to be using contraceptives. Many women are exposed to high risk pregnancies that would be avoided through family planning. With regard to FGM, 91% of the respondents were circumcised. There was a strong correlation between birth complications and FGM. 62.9% of the respondents reported that they had experienced a complication in their reproductive history. As to food taboos, 70.8% of the respondents reported that in their pregnancies they had avoided some foods. Foods avoided include eggs, 96.8%; milk, 85.7%; red meat, 71.4%; white meat, 58.7%; beans, 33.3%; and other foods like groundnuts, cheese, fish, bread, cakes, banana, and potatoes, 20.6%. Most of these foods are livestock products which are major sources of proteins essential nutrients for the rapidly growing fetus and the mother. The study recommends that among the Somali refugee community should be trained to be able to recognize complications, and learn more reproductive health information. There also should be concerted and strengthened actions towards eliminating food taboos among Somali refugee women. Religious leaders should also be involved in disseminating messages especially against harmful traditional practices such as FGM and encourage their followers on the needs for family planning choices.

## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 Background of the study**

Maternal mortality and morbidity are some of the most important global health issues facing the world today. Worldwide, approximately 1000 women die each day from pregnancy and childbirth related causes (WHO, 2010). In addition, 99% of these maternal deaths occur in the developing world, with sub-Saharan Africa accounting for over half of these deaths (Ibid). The international community has committed to improving maternal health by 2015 with Millennium Development Goal (MDG) number five, which aims to reduce maternal mortality by three quarters and reach universal access to reproductive health care. Even with this commitment, many countries have failed to implement effective programs to reduce maternal mortality and morbidity, and women around the world continue to die or suffer from the complications of pregnancy and childbirth. There are many direct causes of the maternal health situation and a number of underlying factors at the individual, community, and countrywide levels. Complex socio-economic factors, culture, and tradition combine together at all levels to create high morbidity and mortality for women of reproductive age.

In conflict situations, reproductive health always does not receive the much needed attention it deserves as all efforts are usually directed to lifesaving humanitarian assistance. Since the outbreak of civil war in Somalia in 1991 an estimated one million people have died and nearly 50 percent of the population has been displaced (UNHCR & Women's Refugee Commission, 2011). The total breakdown of social services from a generation of war has virtually destroyed all maternal health facilities and has resulted in a detestable state of reproductive health care.

It is on the background of conflict, drought and famine, increased food prices, under-development, poor governance, limited humanitarian access, extreme food insecurity, water

shortages and acute malnutrition that thousands of Somalis, 80 percent of them women and children, flee their country to find food and shelter in Kenya, Ethiopia, and Djibouti. According to the United Nations Food Program, one in five women of childbearing age is likely to be pregnant in such a crisis situation. Sadly, providing emergency relief for millions of people over a prolonged timeframe puts the reproductive health care of pregnant women low on the priority list (Every Mother Counts, 2011).

According to The United Nations High Commissioner for Refugees (UNHCR), complications during pregnancy and childbirth are the leading causes of death and disability among women of reproductive age in developing countries. To make matters worse, in crisis settings, the risks of dying from pregnancy-related causes are even higher. More than 60 percent of the world's maternal deaths occur in 10 countries, nine of which are experiencing or emerging from armed conflict. (WHO, UNICEF, UNFPA & The World Bank, 2010).

Further, UNICEF cites that the lifetime risk in Somalia of maternal death in childbirth is one in seven women. This is one of the highest maternal mortality rates in the world. It compares to one in 2,100 women dying in childbirth in the United States – a 300 times difference in the maternal mortality (UNICEF, 2011). In Kenya, Maternal mortality is high, at 410 at 100,000 live births per year. About 14,700 women of reproductive age die each year from pregnancy and related complications while between 294,000 and 441,000 suffer from disabilities caused by complications during pregnancy and childbirth. This however cannot be compared to the Somalia case. There are many complex contributors to the high maternal morbidity and mortality in Somalia – including cultural traditions – which form the centerpiece of this research project.

While the majority of Somali refugees and asylum-seekers in Kenya live in designated camps, they often seek to make their way to urban areas to escape the harsh living conditions of

camps and search for better opportunities, especially given the protracted nature of the conflict in Somalia. (UNHCR, 2011)

The presence of urban refugees is not unique to Kenya; more than half of the world's refugees now reside in non-camp settings. Unlike the hundreds of thousands of refugees living in Kenya's camps, refugees residing in urban areas constitute a largely invisible population; little is known about their numbers, profile, status, location and livelihoods. For these reasons, targeting the urban refugee population in Nairobi is a major challenge. This difficulty is further compounded since refugees in Nairobi are often reluctant to come forward for support due to fear that they could be deported or sent to refugee camps, making service provision especially challenging. (Zetter & Deikun, 2010)

Reasons for coming to Nairobi vary, but most urban refugees report that they come to Nairobi in search of greater livelihoods opportunities and increased security. Many report feeling unsafe in Kenya's large refugee camps of Kakuma and Dadaab, where security incidents including rape and killings have been recorded. Many others report the frustration of having to live in camps where there is virtually no chance of employment and climatic conditions are harsh, and so they moved to urban areas to seek economic independence in the hope of a better life. (Sara, Samir & Pantuliano, 2010)

## **1.2 Statement of the Problem**

Cultural and religious traditions influence and often impede the reproductive health of Somali women. These traditions are evident in areas such as: childbirth, access to modern maternal healthcare, use of contraceptives, gender inequalities and female circumcision. Modern day Somalis; whether urban dwellers, pastoral nomads or farmers; are still bound by clan allegiance and male dominance (Deyo, 2012). Tradition has a large influence over women's roles in the clan hierarchy and the family.

Somali women are seen as vessels for bearing children and minimal value is placed on their health. According to the World Health Organization (WHO), only 2 percent of deliveries among the Somali take place in a health facility, supported by professionally trained staff. This means the average Somali woman gives birth at home with the help of a traditional birth attendant, or family and friends. This is largely driven by culture.

In the case of prolonged labor where a life-saving cesarean section is required, these procedures can only be performed with the approval of the woman's father-in-law or the husband. This gets very complicated in refugee camps as the men most often are absent. Many women die from this inability to obtain permission. Even in immigrant populations, there is strong resistance to cesarean sections based on the belief that the risks of multiple surgeries will lead to the inability to bear additional children or even death. The fear of infertility is driven by the high value placed on having large families by tradition and religious beliefs. In the refugee camps, women often care for as many as ten children in their family. Even among immigrant populations, where nuclear families and economic challenges are often the norm, couples feel significant peer pressure for the woman to bear many children (Deyo, 2012). As such, contraception and abortions are heavily discouraged in Somali tradition. As a result, many women give birth annually which is detrimental to their health, infant mortality is high, and dangerously low neonatal birth weights are all common in Somali society.

Female circumcision is a deeply ingrained custom in Somalia, practiced for centuries, with one of the highest rates of circumcision in the world at 98 percent. This practice is the most common reason for prolonged or difficult delivery and is one of the main causes of maternal mortality among Somali women.

### **1.3 Purpose of the Study**

The purpose of this research project was to find out how cultural traditions influence reproductive health choices of Somali women refugees in Nairobi County, Kenya. The study gathered suggestions from Somali women and men, for more culturally sensitive reproductive health programs that could be offered through Kenyan clinics and hospitals.

### **1.4 Research objectives**

1. To establish the impact of traditional birth attendants to maternal health among the Somali refugee women in Nairobi
2. To investigate the extent to which attitudes towards family planning and contraception among Somali refugee women in Nairobi has an effect on their reproductive health.
3. To determine the influence of female circumcision on reproductive health among Somali women refugees in Nairobi
4. To establish the influence of food taboos on reproductive outcomes among Somali women refugees in Nairobi

### **1.5 Research Questions**

1. Do traditional birth attendants have an impact on maternal health of Somali refugee women in Nairobi?
2. Does resistance to family planning and contraception affect reproductive health of Somali refugee women in Nairobi?
3. Does female circumcision affect childbirth among Somali women refugees in Nairobi?
4. Do food taboos affect reproductive outcomes among Somali refugee women in Nairobi?

### **1.6 Significance of the study**

The study is a major step forward in respectfully supporting the cultural traditions of Somalis in Kenya through the identification and subsequent development of culturally sensitive

reproductive health programs. These programs will enable these communities to “meet halfway” and build trust thus reducing the rate of maternal morbidity and mortality among Somali women.

The findings of this study will be useful to maternal health care providers who should more effectively support the cultural traditions related to the reproductive health of Somali immigrants and refugees so as to provide culturally competent care.

The ministry of health and sanitation can also use this study to understand the reproductive health needs of Somali women in Kenya. The UNHCR can also use the findings of this study to provide reproductive health education to Somali families for them to better understand the value of Western medicine

### **1.7 Limitations**

The biggest challenge was to have Somali women open up and share their thoughts on sensitive and personal topics related to their cultural beliefs. To address this, the researcher spent as much time as possible learning more about Somali culture. He also used a Somali research assistant who introduced me to Somali culture and lifestyles.

Given that some of the migrant Somali refugees in Nairobi are unregistered and illegally in Nairobi, it was difficult to win the confidence of these women as many of them fear that they would be repatriated back into the refugee camps if caught. To address this, the researcher used one of their most trusted confidants who introduced me to them. Interviewing the women in Somali language with the help of a translator helped the participants feel more comfortable talking about sensitive subjects. Also every participant had the option not to answer any question they do not wish to give personal information about. The researcher did not also ask for any participant’s name as to ensure their complete anonymity throughout the process.



## **1.8 Delimitations of the study**

The study was conducted in Eastleigh, Nairobi. Eastleigh is 3 Kilometers to the east of the Nairobi Central Business District. The estate is entirely a Somali zone with heavy Somali investments, many mosques and Somali schools. Nairobi is the Capital City of Kenya with a population of approximately 3,138,369 (KNBS, 2010). There are approximately 507, 540 Somali refugees in Kenya, 51% of whom are women. Official figures suggest there are around 46,000 refugees in Nairobi (UNHCR 2010), however unofficial estimates are nearer 100,000 (RCK, 2008).

This study grew out of an interest to research the cultural influences that relate to the reproductive health of Somali refugees in the camps at Dadaab, situated in northeastern Kenya. Due to the instability of the camps and the vulnerability of the population, it was not possible to conduct research in Dadaab at this time. Studying a more stable refugee population – immigrants in Nairobi – was deemed to be the preferred method for protecting human subjects and accomplishing the goals of the research.

## **1.9 Basic assumptions of the study**

It was assumed that Somali refugees in Eastleigh maintain a network and I got through the network through snowballing.

## **1.10 Organization of the study**

The study is organized into Chapters one to five. Chapter one is introduction which comprises background of the study, problem statement, purpose of the study, study objectives, research questions, significance of the study, delimitation and limitations of the study, assumptions of the study and definition of significant terms are discussed.

Chapter two reviews literature on traditional birth attendants, family planning attitudes, female circumcision, and food taboos and their influence on reproductive health of migrant Somali refugee

In chapter three, Research Methodology is presented. It comprises Research design, Target population, Sampling procedure, Methods of data collection, Validity of the instruments used, Reliability of the research findings and data analysis techniques.

Chapter four presents the data analysis, presentation, interpretation and discussions. The results are organized based on the themes of the study; traditional birth attendants, family planning attitudes, female circumcision, and food taboos and their influence on reproductive health.

Chapter five gives a brief summary of findings, conclusions and recommendations which will be based on the themes of the study; female circumcision, food taboos, family planning and traditional birth attendants and their influence on reproductive health.

### **1.11 Definition of Significant terms used in the study**

**Reproductive health-** a state of physical, mental, and social well-being in all matters relating to the reproductive system, at all stages of life.

**Culture-** the shared knowledge, values, traditions, languages, beliefs, rules and worldview of a social group

**Refugee-** any person who owing to well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, unwilling to return to it.

**Female genital mutilation-** is any surgical modification of the female genitalia, comprising all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or nontherapeutic reasons

**Maternal health-** the health of women during pregnancy, childbirth and the postpartum period

**Contraception-** use various devices, drugs, agents, sexual practices, or surgical procedures to prevent conception or impregnation (pregnancy)

**Maternal death-** the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

**Maternal Mortality Rate-** the number of maternal deaths in a period (usually a year) per 100,000 women of reproductive age (usually defined as aged 15-44 or 15- 49).

**Gender inequalities-** unequal treatment or perceptions of individuals based on their gender

**Obstetric complications -** disruptions and disorders of pregnancy, labour and delivery, and the early neonatal period

**Infant mortality-** the death of a child less than one year of age

**Cesarean section-** is surgery to deliver a baby

**Postpartum hemorrhage-** excessive bleeding following the birth of a baby

**Neonatal death-** the death of a baby within the first four weeks of life

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1. Introduction**

This chapter reviews literature on female circumcision, cultural beliefs and access to maternal health care, family planning and gender inequalities and their influence on reproductive health of migrant Somali refugee women in Nairobi.

#### **2.2. Role of traditional birth attendants in increased maternal mortality**

Approximately 1000 women die each day worldwide from pregnancy related causes, 99% of them in developing countries and more than 50% in sub-Saharan Africa (WHO, 2008) with most deaths concentrated around the time of delivery. An estimated 2.65 million stillbirths occurred in 2008 worldwide (Lawn et al. 2011) while 3 million new-borns do not survive the first month of life worldwide annually (WHO, 2006). Skilled assistance during childbirth, readily accessible appropriate care in case of complications and effective postnatal care within the first 24 hours of delivery are strategies that can improve perinatal outcomes for mothers and babies (Fillipi et al. 2006) A key strategy to reducing maternal and neonatal deaths is the ‘health-centre intrapartum care strategy’, where qualified skilled workers manage labor, effectively manage complications and are supported with effective referral systems for specialized care when needed, and an effective postnatal care package (Koblinsky, Matthews, & Hussein, 2006)

A significant proportion of mothers in developing countries still deliver at home unattended by skilled health workers (Montagu et al. 2011). In Kenya, maternal mortality rate has not reduced over recent years, and may even have increased from an estimated 380/100000 live births in 1990 to 530/100000 live births in 2008 (WHO, 2008). Although a number of factors may have contributed to this, including improved identification of maternal deaths, health

facility delivery remained low at 44% and 42.6% in the early 1990s and in 2008 respectively (KNBS and ICF Macro, 2010).

In *Global report on preterm birth and stillbirth: Delivery of interventions* (Cesar & Craig, 2010), sociocultural barriers were identified in provision of preterm and stillbirth interventions. A cross-sectional study was carried out to assess experiences related to obstetric complication and seeking assistance from a skilled provider among women. It was found out that nearly half of the women who faced complications did not use skilled providers at the time of obstetric complications. Cognitive and cultural barriers were among the factors cited for not using skilled maternal care. (Worku, Yalew & Afework, 2013)

Skilled attendants during labor, delivery, and in the early postpartum period, can prevent up to 75% or more of maternal death. However, in many developing countries, very few mothers make at least one antenatal visit and even less receive delivery care from skilled professionals. A cross-sectional household survey to understand why women preferred home delivery even when facility based delivery is available at minimal cost in Ethiopia revealed that the most important reasons for not seeking institutional delivery were the belief that it is not necessary and not customary. Traditional birth attendants were seen as culturally acceptable and competent health workers. (Shiferaw et al., 2013)

An assessment of the role of traditional birth attendants in maternal health care in Edo State, Nigeria, Ofili and Okojie (2005) found that of the 45 TBAs interviewed, majority (62.2%) acquired their skills through apprenticeship with relation, while 8.9% had no training at all. The services provided by the TBAs ranged from ante-natal care, child delivery, treatment of infertility, management of threatened abortion, and circumcision of babies. Preparations used in the treatment of cord stump included methylated spirit, herbal preparations, dry heated sand, and engine oil. Some of the medications used (animal dung, flies, scarification marks, and cow urine)

to treat patients could serve as sources of infection. Methods of risk assessment during ante-natal care, management of delivery complications, record keeping among TBAs were found to be poor. Infection prevention methods used were also found to be poor, with more than half (51.1%) not using any form of preventive measures during procedures. This study has revealed that the practices of these TBAs are not safe.

Despite Malawi government's policy to support women to deliver in health facilities with the assistance of skilled attendants, some women do not access this care. A qualitative study to explore the reasons why women delivered at home without skilled attendance was conducted. It was found out that socio-cultural factors were among the factors that made women to deliver at home (Kumbani et al., 2013). These findings can be supported by a report of a systematic review to identify and analyze the main factors affecting the utilization of antenatal care in developing (Simkhada et al, 2008)

Almost 50% of women in low- and middle-income countries (LMICs) don't receive adequate antenatal care. Using a predetermined search strategy, Finlayson & Downe (2013) identified qualitative studies reporting on the views and experiences of women in LMICs who received inadequate antenatal care. 21 papers representing the views of more than 1,230 women from 15 countries were included in this study. The study shows a dissonance between programme design and cultural contexts that may restrict access and discourage women in accessing pre-natal and antenatal care. This shows that that there may be a misalignment between current antenatal care provision and the social and cultural context of some women in LMICs. Antenatal care provision that is theoretically and contextually at odds with local contextual beliefs and experiences is likely to be underused

A study was carried out in western Uganda to find out why during pregnancy and delivery women continue to choose high risk options leading to severe morbidity and even their

own deaths. The findings demonstrated that adherence to traditional birthing practices including the use of TBAs and beliefs that pregnancy is a test of endurance and maternal death a sad but normal event, are important factors. The use of primary health units and the referral hospital, including when complications occur, was considered only as a last resort. (Kyomuhendo, 2003)

Another qualitative study was conducted in Limpopo, South Africa to explore and describe the indigenous beliefs and practices that influence the attendance of antenatal clinics by women. It became clear that the indigenous beliefs and practices of pregnant women have an influence on their attendance of antenatal clinics. For example, factors such as fear of bewitchment cause delayed attendance of antenatal clinics. Women use herbs to preserve and protect their unborn infants from harm. They also trust the knowledge of traditional birth attendants, and prefer their care and expertise to the harsh treatment that they receive from midwives in hospitals and clinics who look down on their indigenous beliefs and practices. (Ngomane & Mulaudzi, 2012)

Place of delivery affects outcomes of pregnancies. In many patriarchal societies, access to safer places of delivery like hospitals and health centers is mediated by gender roles and relations within the household. A qualitative study in Tanzania was used to explore determinants of home delivery. The study revealed that tradition and cultures and the pattern of decision-making power within the household were perceived as key determinants of the place of delivery. (Mrisho et al, 2007). An ethnographic study to examine the social costs to women of skilled attendance at birth in rural Ghana revealed that most women delivered at home. Home delivery was found to raise a woman's status in her community, while seeking skilled attendance lowers it. (Bazzano et al, 2008)

In Zimbabwe even in areas with easy access to Western-type delivery care, the majority of women are cared for and delivered by traditional birth attendants who are members of their

extended family (Mutambirwa, 1985). To understand the social, cultural context of pregnancy, childbirth and subsequent maternal and child care and to use this information for the improvement of maternal and child-health care an anthropological investigation was conducted in Zimbabwe. This study established that certain aspects of childbirth such as obstetric complications, are intimately linked to traditional birthing practices like the use of TBAs

Botswanan women tend to consciously opt for home deliveries, even in areas where modern maternity care facilities are easily accessible. Approximately 40% of deliveries in Botswana occur outside of institutions (55% in rural areas and 23% in urban areas) and are generally assisted by traditional midwives. (Staugard, 1985) To gain more information on this phenomenon, the 175 identified traditional midwives in 2 health regions of Botswana were interviewed. A more intensive interview with 59 of these traditional midwives indicated that 81% had no contact with their clients during the prenatal period. 95% showed a total lack of knowledge of the female reproductive system, yet all were able to identify signs of a high risk delivery and willing to refer these cases to a modern health facility. As a group, Botswanan traditional midwives have specific conceptions regarding food taboos during pregnancy (e.g., avoidance of meat and eggs) that can place pregnant women at risk of protein deficiencies. Overall, these findings indicate that the traditional midwife in Tswana society cannot be regarded as a well-defined health worker, as is the case with traditional healers.

In a study to find out whether training traditional birth attendants (TBA) might have an impact on reproductive health in Lao PDR, it was found that an overwhelming majority of the women delivered at home, attended only by untrained individuals. During pregnancy and after delivery, the women claimed that they often suffered from edema of legs and feet, high fever and hemorrhages (Sirivong et al., 2003).



Choudhury N. & Ahmed M. (2011) carried out a qualitative study to collect data on maternal care practices during pregnancy, delivery, and post-partum period from women in ultra poor households in rural Bangladesh. The sample included both currently pregnant women who have had a previous childbirth, and lactating women. The study shows that women usually considered pregnancy as a normal event unless complications arose, and most of them refrained from seeking antenatal care. Financial constraints, coupled with traditional beliefs and rituals, delayed care-seeking in cases where complications arose. Delivery usually took place on the floor in the squatting posture and the attendants did not always follow antiseptic measures such as washing hands before conducting delivery. Following the birth of the baby, attention was mainly focused on the expulsion of the placenta and various manoeuvres were adapted to hasten the process, which were sometimes harmful.

The Indonesia Maternal Mortality Rate (MMR) of 420/100.00 live births remains among the highest in East Asia while coverage of births assisted by skilled providers is still low. Traditional beliefs have been a key factor associated with the choice between midwives or traditional birth attendants (TBA) and the low number of antenatal care visits in rural West Sumatra. Using focus groups Agus Y., Horiuchi S. & Porter S. (2012) found out that women followed the traditional beliefs and rely on TBAs rather than midwife who are more secure during pregnancy. Use of TBA was still dominant and women believed that following traditional beliefs led to a healthy pregnancy. In a study to compare the obstetric outcome of pregnancies attended by TBAs with that of pregnancies attended by obstetricians, Bodner et al. (2004) finds out that lower rate of episiotomies and perineal tears of all degrees were found in women attended by obstetricians.

Illiteracy levels and isolation among Somali women are high. Knowledge levels about the many health risks associated with pregnancy and childbirth are low and not informed by

modern medical practices. There is poor demand for, and strong mistrust of the preventive medical model. For example, only one out of four pregnant women seeks out antenatal care (Leigh & Sorbye, 2010). Social and cultural traditions associated with reproduction – such as marriage of adolescents as young as 15 years old, frequent and close pregnancies, and the home birthing tradition – all adversely impact decisions to seek reproductive health care until it is too late to save mothers or their children.

In Uganda high maternal mortality rates was found to be caused by poverty, common misconceptions about delivery and family planning, cultural and social factors, and traditional birth attendants (TBAs). Armstrong (2011) carried out a study aimed to determine the impact of traditional beliefs and TBAs on women's health and health-seeking behavior in Mbarara District, Uganda. The study found that common misconceptions surrounding the perceived complications of family planning cause large family sizes and also put women at a greater risk of mortality and morbidity. Many women also believed that going to the hospital is for those with complications and that there is no need to deliver in a health center if a woman has had a normal pregnancy or good deliveries in the past. There are also many cultural beliefs such as bravery associated with home deliveries and the lowered status of women in the society that pose challenges to improving maternal health.

### **2.3. Attitudes towards family planning and contraception**

Contraceptive prevalence is low in the African region despite considerable family planning programmatic efforts. To examine how community factors shape contraceptive use for married women in an entire region, comparing results across 21 African countries a Demographic Health Survey was carried out. After controlling for individual and household level factors, community level factors of demographics and fertility norms, gender norms and

inequalities, and health knowledge remain significantly associated with contraceptive use. (Miriam, Rob & Hamid et al, 2012)

Another demographic and health survey examined the role of community-level factors in explaining geographic variations in modern contraceptive use in 6 African countries- Kenya, Malawi, Tanzania, Burkina Faso, Ghana, and Ivory Coast. Significant associations were found between several community-level factors and reported use of modern contraceptive methods. The study shows that aspects of a community's sociocultural and economic environment appear to influence a woman's use of modern contraceptive methods. (Rob et al., 2007)

Widespread resistance to modern contraception is one factor associated with high fertility in Tanzania. A qualitative study to identify cultural barriers to modern contraceptive use in Matemwe village, Zanzibar, revealed that despite free and easy access to contraceptives, only 2% of Matemwe women participated in the village's family planning programme. Several factors were found to influence contraceptive use, including strong Muslim beliefs, male dominance over females (especially in polygynous relationships), and limited exposure to modern ideas via education and travel. Interviews indicated that in order to lower fertility in Matemwe, cultural barriers to family planning must be confronted. (Keele, Forste & Flake, 2005)

In a review to elucidate the religious and cultural influences on contraception, literature searches were conducted to identify religious teachings related to family, sexual relations, and family planning for Christianity, Judaism, Islam, Hinduism, Buddhism, and Chinese religious traditions. The review revealed that religious and cultural factors have the potential to influence the acceptance and use of contraception by couples from different religious backgrounds in very distinct ways (Srikanthan & Reid, 2008) Cultural factors are equally important in couples' decisions about family size and contraception.

A multilevel study to examine contextual effects of gender norms, communication, and social capital on family planning behaviors in Uganda showed that all of the four variables were significant predictors of family planning behavior. The authors found that gender norms as a contextual factor significantly interacted with the individual-level perceived benefit. (Paek et al, 2008). These findings are validated by another qualitative study on young people's views on childbearing in Uganda which showed that the following factors are responsible for high fertility: Sustenance of 'men's blood' through the male child; poverty, joblessness and child bearing, and other socio cultural issues- religion, kin, elders and child bearing". This illustrates that people's views on motivation for childbearing in Uganda are embedded in cultural norms and linked strongly to patriarchy, social respectability and women's sustenance. (Mirembe et al., 2010)

To evaluate the opinions and experiences of married women in southeastern Nigeria regarding their rights to contraception, a cross-sectional survey was conducted. The study reveals that 43.7% of women were unaware of their rights to contraception. Denial of contraceptive rights was reported by 43.4% women. In total, 54.9% women with unplanned pregnancies blamed denial of access to contraception for their pregnancies. Among the women who had used contraception previously, 61.9% reported that the decision to do so was taken by their spouse (Chigbu, Onyebuchi, Onwudiwe & Iwuji, 2013).

Using data from Ethiopia and Kenya Dynes, Stephenson, Rubardt, & Bartel (2012) examine how perceptions of community norms differentially shape contraceptive use among men and women. Men and women whose current number of sons is lower had lower odds of reporting contraceptive use. This is a cultural phenomenon in such a paternalistic society where there is prestige and honor to having many sons.

A qualitative and quantitative study to assess attitudes towards and perceptions about contraceptive use among married refugee women of Somali descent living in Finland, showed

that 73% of the respondents did not use contraceptives this was connected with religious beliefs and issues involving marital relations (Degni, Koivusilta & Ojanlatva (2006). Among men, Degni, Mazengo, Vaskilampi & Essen (2008) carried out a study to explore religious beliefs of Somali men residing in Finland that may influence their use of condoms. The study showed that 63% of the men avoided using condoms and were opposed to women's contraceptive use for religious reasons.

Somali are dominantly Muslims. Muslims believe that children are a gift from Allah, who will determine how many children a family will ultimately have. The more children a Somali family has, the more blessed they are. Further, both men's and women's status are based on their ability to produce children. According to Comersamy et al. (2003), a man's status is measured by his ability to produce children, particularly boys. Similarly, a woman's status is based on her level of fertility. The total fertility rate among the Somali population is between 5.7 and 6.7, irrespective of their geographical location. Estimated CPR is cited as around 1% (UNHCR, 2010) However, very limited quantitative information exists on use of contraceptives among Somali refugees residing in urban setting

The family structure in Somalia, rooted in both Islam and cultural tradition is patriarchal. For example, the Quran requires wives to be obedient to their husbands. When it comes to family decisions, the husband typically has the last say. Men head the household and women are subordinated to their husbands on most matters. As a result, most Somali women believe if they do not deliver babies for a few years, the husband will divorce her and marry another woman. Because 'Allah will provide,' husbands and wives do not discuss when they want to begin having children or how many children they wish to have. Modern birth control methods are against religious and cultural traditions in Somalia, and a World Health Organization (WHO)

2006 survey reported that only 1.2 percent of married Somali women used modern contraceptives.

Using contraception equates to voluntary infertility and has a significant impact on women's position in society. The only child spacing method that is sanctioned in the Quran is breastfeeding for extended periods of time up to two years – for the health of the mother, for the health of her new baby, and for the health of her future children.

In the refugee camps, there is also significant Somali resistance to family planning and contraception. The primary research report on reproductive health among Somali refugees in Dadaab (ESD & USAID, 2008) explored strong cultural traditions and beliefs that constrain family planning choices among refugees. The general consensus among women, men and religious leaders – consistent with the literature on Somalia – was that Allah determines the number of children that a woman has, and as a result, Somali women are encouraged to have children early and to have as many as possible. Somalis take great pride in having large families and feel that producing many children is necessary for clan survival.

For families who wish to practice family planning, most fear going against cultural norms or facing the social stigma that results from having fewer children. The women in the study agreed that those who do not have children or only have a few children are shunned. This study was supplemented by an assessment of the use of modern family planning methods among the refugee population in Dadaab (UNHCR, Dadaab Sub-Office, 2010). Consistent with the World Health Organization data from Somalia, the uptake of modern family planning methods was very low. Less than one percent of married women within the Dadaab refugee camps used family planning. Major reasons for this low uptake were: social, cultural and religious influences as key reasons and low levels of education among the women, and unequal power relations between men and women also are key drivers of low family planning use across the research.

While adeptly highlighting many of the critical cultural and religious traditions practiced by Somali refugees, the Dadaab UNHCR report in particular has several limitations. The report has little analysis of the data and no conclusions or programmatic actions to be taken. Also, the reproductive health coordinator in the camp who was not Somali conducted participant recruiting, which questions the validity of the sample.

Despite the strong religious and cultural resistance to family planning and contraception, it is critical to recognize the impact that large, closely spaced families have on the high maternal and infant morbidity and mortality rates in Somalia. Leigh & Sorbye (2010) cite evidence that maternal and child survival can be severely compromised if births are less than 24 months apart. Maternal and child health also are at risk if mothers give birth at too young an age. Given Somalia's extremely high fertility rates, the combination of early childbearing and women's closely spaced pregnancies results in the health of women and their children being severely endangered. According to Leigh & Sorbye (Ibid), if high-risk pregnancies could be avoided, the number of maternal deaths would decrease by one quarter. On a related note, if children are born at least two years apart, many child deaths could be avoided as closely spaced children are at a higher risk for disease.

#### **2.4 Female circumcision**

Female genital mutilation (FGM) is any surgical modification of the female genitalia, comprising all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or nontherapeutic reasons (WHO, 2008). As an ancient traditional practice in large parts of Africa, FGM is so deeply embedded in societies that practice it. It is a rite of passage to womanhood with strong, ancestral socio cultural roots. Rationalizations for the perpetuation of FGM/C include: preservation of ethnic and gender

identity, femininity, female purity/virginity and "family honour"; maintenance of cleanliness and health; and assurance of women's marriageability (UNICEF, 2010).

A study by PATH (2012) shows that in Kenya, 30% of women supporting continuation of the practice agree that FGM help to preserve virginity and avoid immorality. In Nigeria, similar rates (36%) were reported by women, while 45% of men supporting continuation of the practice agreed with this statement. FGM was believed to be proof of a girl's virginity, thereby improving the marriage prospects of unmarried girls who have undergone the procedure. In Côte d'Ivoire, "improved marriage prospects" was cited by 36% of women favoring continuation of the practice once married. FGM is also believed by some communities to ensure that a woman is faithful and loyal to her husband. For example, 51% of women in Egypt believe that FGM prevents adultery.

To identify the prevalence, perceptions, perpetrators, reasons for conducting FGM, and factors associated with FGM with regard to women's health, community-based cross-sectional house-to-house interviews were conducted among 858 females of reproductive age (15–49 years), in Kersa district, Ethiopia. In the study the main reason for the practice of FGM was reduction of female sexual hyperactivity. The majority of the respondents (92.3%) were themselves circumcised and 68.8% did not know of any health-related problems associated with FGM. The study concludes that some of the women knew about the negative reproductive health effects of FGM and some had also experienced these themselves. However, only a few had tried to stop the practice and the majority had taken no steps to do so (Wondimu, Yirga, Nega, Mengistu, & Arja, 2012). This may be attributable to the fear of becoming alienated from the cultural system and fear of isolation.

There are no known medical benefits to FGM, and it can be potentially dangerous for the health and psychological well-being of women and girls who are subjected to the practice



resulting in short- and long-term complications. According to Balogun et al.(2013), health problems of significance associated with FGC faced by most women are maternal and neonatal mortality and morbidity, the need for assisted delivery and psychological distress

Women with FGM are significantly more likely than those without FGM to have adverse obstetric outcomes. Risks seem to be greater with more extensive FGM. In a Demographic and Health Survey of 28, 393 women attending for delivery between at 28 obstetric centres in Burkina Faso, Ghana, Kenya, Nigeria, Senegal, and Sudan women with FGM, showed risks of caesarean section, postpartum haemorrhage, extended maternal hospital stay, infant resuscitation, stillbirth or early neonatal death and low birth weight . FGM is estimated to lead to an extra one to two prenatal deaths per 100 deliveries. (Banks et al. 2006). A study on female circumcision and obstetric outcomes by the World Health Organization (Lancet, 2006) cited these risks among women who had undergone FGM. It was also observed that risks increase with more extensive forms of female circumcision like infibulations.

In evaluation of female genital mutilation complications, Carcopino, Shojai & Boubli (2004) found out that health consequences directly depend on the severity of the initial mutilation. They are more severe in infibulated women. Pregnancy, childbirth and the obstetrical period are particularly dangerous for the mother and the child. Female genital mutilation contributes to childhood and maternal mortality and morbidity.

Maternal mortality in Tanzania is recorded at 300-400 deaths per 100,000 women. The main causes are hemorrhage, sepsis, rupture of the uterus, anemia, and others. The risk factors associated with the above causes include maternal height, age, child spacing, and number of births per woman; malaria and anemia; imbalance of energy and food intake; HIV/AIDS; women's workload; and female genital mutilation (FGM) (Mella P., 2003)

A cross-sectional study to evaluate the impact of female genital mutilation on parturition in India revealed that the mothers who required an episiotomy incision for foetal and maternal indications among the circumcised accounted for 43.0% whereas it was only 24.6% for the referent group. The mean duration of labour by conventional standards is prolonged in circumcised and non-circumcised groups. More complications in terms of perineal tears, bleeding, incontinence and febrile illnesses are registered for the FGM. (Hakim L., 2001)

A prospective case-control study to compare the sexual function of women with female genital mutilation (FGM) to women without FGM in a tertiary referral university hospital in Saudi Arabia reveals that sexual function in women with FGM is adversely altered. This adds to the well-known health consequences of FGM. The study recommends that efforts to document and explain these complications should be encouraged so that FGM can be abandoned. (Alsibiani & Rouzi, 2010)

In a study aimed to assess the prevalence of childbirth complications due to FGM in the province of Gourma, Burkina Faso, a cross-sectional study was conducted. Obstructed labor occurred in 29% of the cases, and a caesarean section was performed in 7% of the cases. Of all the normal vaginal deliveries, 24% required episiotomies, 18% experienced obstetric hemorrhaging, 20% had uterine retroversion and 3% needed blood transfusions. Among the newborns, 5% were resuscitated and 4% were stillbirths. (Ndiaye et al., 2010). The study is a clear show that FGM constitutes an important risk factor for complications during childbirth.

In another paper to examine the association between FGM and women's reproductive morbidity in rural Gambia, a cross-sectional community survey of 1348 women was conducted. Women who had undergone FGC had a significantly higher prevalence of bacterial vaginosis and a substantially higher prevalence of herpes simplex virus 2 (Linda M et al., 2001). The higher prevalence of HSV2 suggests that cut women may be at increased risk of HIV infection.

Somalia has one of the highest prevalence rates of female circumcision in the world, latest survey indicating that at least 98 per cent of women said they had undergone the process, and 80 percent undergo infibulation WHO, 2008). In a cross-sectional study by Mitike & Deressa (2009) in three refugee camps in Somali Regional State, Eastern Ethiopia, prevalence of FGM was with high intention of the parents to circumcise their daughters (84%). Almost all operations were performed by traditional circumcisers (81%) and birth attendants (18%). Clitoral cutting and narrowing of the vaginal opening through stitching were the two common forms of FGM reported by the respondents. This study is supported by another study by Gele & Sundby (2013) which shows that the support towards the persistence of the practice is profoundly high in Somalia. People are aware of the health and human rights effect of female circumcision, and yet they support the continuation of the practice.

According to public health experts and physicians (Inter Press Service, 2011), nearly all of the Somalis at Dadaab practice female circumcision. This practice is a major obstacle to maternal health and Dadaab gynecologists cited that women who have undergone female circumcision are twice as likely to die during childbirth and more likely to give birth to a stillborn child than other women who have not experienced female circumcision. Other studies in many African countries have linked female circumcision to increases in maternal and infant morbidity and mortality due to obstructed labor.

Long-term consequences of FGM include infibulations cysts, keloid scar formation, damage to the urethra resulting in urinary incontinence, pain during sexual intercourse, sexual dysfunction and difficult childbirth, difficult menstrual periods (UNICEF-Somalia/SACB-Health Sector/UNIFEM, February 2001). If the operation is conducted in unhygienic surroundings and/or using shared instruments, the victims are exposed to deadly infections like tetanus and HIV/AIDS.

Studies that are not conducted in medical settings tend to rely on women's reports of their experiences to measure complications, and while there may at times be no alternative to this approach, its limitations have to be taken into account. Self-reports of health symptoms or conditions are known to correspond only imperfectly to health professionals' assessments of morbidity, because perceptions of health vary a great deal with age, gender, and culture, and because socially defined expectations of health, pain, or discomfort influence the likelihood that women will report on what they feel (Khattab, 1992). Self-reports are especially unreliable given the numerous possible complications of FGC, and the lack of unified definitions to measure them. This study will ensure that every question is well explained to ensure that all questions are understood by all the respondents in the same manner. Standardized definitions will be used.

## **2.5. Impact of food taboos on reproductive outcomes**

Food taboos are a common practice of prohibiting certain food items for pregnant and/or lactating women or girls in general. Foods that are good sources of energy and protein are not allowed to be consumed by pregnant women for reasons such as difficult and prolonged labor due to fears of a large baby. Similarly sources of vitamins and minerals are restricted during pregnancy mainly due to the fear of offensive discharges during delivery and skin diseases on the body.

Maternal nutrition in pregnancy is an important reproductive health issue. It affects the growing baby and directly post-partum (Donahue et al. 2009). Calories, proteins, vitamins and other important food elements needed by the developing foetus and the growing child are provided by the mother. Adequate intake of certain food elements during pregnancy improves birth weight and labor spontaneity.

In many African societies, food taboos dictate the diets of females. These taboos often happen during their most critical reproductive times in their life, e.g., pregnancy. Among some

societies, females at menarche cannot eat fresh meat. They, also restrict fresh meat consumption for menstruating women. Research done on many different under or marginally nourished populations indicates that maternal nutritional health influences birth spacing significantly. Specifically, undernutrition causes longer postpartum amenorrhea (Spielmann, 1989). Poor maternal nutritional health does not prevent the fetus from surviving and growing. Yet mothers who do not consume many calories often have low birth weight infants. These infants are at high risk of dying because they have little to no fat reserves and they consume inadequate amounts of nutrition since the mothers cannot make insufficient amounts of milk.

Egwuatu (1986) has previously documented food taboos among pregnant women of Igbo tribe in Nigeria. Eating snails during pregnancy was believed to predispose the baby to excessive salivation and vomiting. Eating yam or 'fofoo' was believed to make the baby big and difficult to deliver, while eating of pig would make the baby spotted at birth.

In a study in Tanzania, sixty-nine percent of pregnant women reported food taboos. In that community, eating fish was believed to hurt the mother's abdomen and also cause late delivery; eating farm meat would make the child take on characteristics of farm animals. The high prevalence of severe anemia during pregnancy in that district was linked to malaria parasitemia, hookworm infections, and food taboos. (Marchant, 2002)

Due to food taboos, 26% of pregnant women in Indonesia also avoid fishes, meat, vegetables and chicken eggs. According to the women, eating fishes and other food from a river will cause difficulties during delivery because the fetus would be upside down in the womb, while eating chicken eggs will make them behave like chicken during delivery and would make the delivery last longer (Hartini, 2005). Similar food practices were also found among groups of pregnant women in India (Choudhry, 1997). Some of the women reported that eating certain

food items will cause prolonged and difficult labor. Others said certain food items will make the baby's head too large to fit through the mother's pelvis during delivery.

Studies conducted among 25 ethnic groups in central, eastern and southern parts of Ethiopia (Dawit et al 2005) have reported that food items that are white in color (e.g. milk, fatty meat, porridge, potato, banana, etc.), clean vegetables, colostrum and fruits are prohibited to be consumed by pregnant/lactating women and children. Hence, the diet of a pregnant woman is limited to food items such as 'teff,' bread made of sorghum, corn, etc. Only a few studies have been done on the different food taboos in Ethiopia. It is believed that certain food items which are white in color will be plastered on the body of the baby and cause labor difficulties and will also produce offensive uterine fluid (amniotic fluid) during delivery. In addition green vegetables, like green peppers, are believed to causes a bad odor in both the mother and the baby and make the newborn baby bald. Restricting the food of pregnant and lactating women and children may cause under-nutrition of the pregnant mother leading to increased risks in pregnancy and labor such as anemia and other micro-nutrient deficiency illnesses, and low resistance to infection.

In a paper on the influence of maternal nutrition on infant survival and growth and on subsequent fertility, Phillip (1982) notes that during pregnancy, modifications in the maternal hormonal system help maintain availability of nutrients to the fetus relatively independently of maternal nutrition. When maternal dietary deficiencies reach critical levels, the effectiveness of these mechanisms in maintaining fetal nutrition decreases. Studies have confirmed the correlation of severe maternal malnutrition and lowered birth weight, neurological disorders, impaired physical growth, mental retardation, and poor school performance.

Levels of low birth weight (LBW) and maternal malnutrition in rural Bangladesh are among the highest in the world. In a qualitative study to survey dietary practices among pregnant

mothers in Bangladesh served by a reproductive health and nutrition program, Shannon, Mahmud, Asfia & Ali (2008) establish that despite high levels of awareness of nutritional dietary requirements, 50% of the women reported reduced food intake during pregnancy. Dietary taboos and food aversions were widely practiced. Women consistently received the last and smallest food shares during mealtimes.

In another study to determine the nutritional status and reproductive health of Orang Asli women in Australia, Lim & Chee (1998) found that women's nutritional status was generally not satisfactory. Their mean iron intakes were very low. Food taboos and cultural practices are practised by the pregnant women during their confinement.

To assess the traditional postpartum practices and mother and child nutritional status a cross-sectional study was done in 41 randomly selected villages on the outskirts of Vientiane capital city, Lao PDR (Laos). Information was collected about pregnancy, delivery and traditional practices through a standardized questionnaire. Contrasting with a high antenatal care attendance (91%) and delivery under health professional supervision (72%), a high prevalence of traditional practices was found, including exposure to hot beds of embers (97%), use of traditional herb tea as the only beverage (95%) and restricted diets (90%). Twenty-five mothers (8.3%) were underweight. Mothers had insufficient intake of calories (55.6%), lipids (67.4%), iron (92.0%), vitamins A (99.3%) and C (45%), thiamin (96.6%) and calcium (96.6%). (Barennes et al. 2009).

In a study to examine some of the factors influencing women's reproductive health in Katolo sub-location of Kisumu district, Kenya, Kamau (2010) focused on socio-cultural factors which influence the community, including customary beliefs and norms. The study found out that women in Katolo perform heavy duties during pregnancy, including digging, weeding, carrying heavy loads and walking long distances. It was also found that women are affected by

cultural beliefs as regards their nutrition and health. To some extent, food taboos determine their feeding habits during pregnancy.

To understand social cultural factors that influence maternal nutrition among women in perinatal period attending Pumwani Maternity Hospital, Kiga (2010) notes that there are many factors that determine diet behavior among humans. In addition to personal preferences, there are cultural, social, religious, economic, environmental, and even political factors. In the study, 60% of women under study said cultural background influenced their food preference.

A cross-sectional study assessing the prevalence of food taboos during pregnancy, types of foods prohibited and the associations of some of the socioeconomic parameters to food taboos, was carried out in Hadiya Zone, Southern Ethiopia. Two hundred ninety five healthy pregnant women were included in the study. A questionnaire consisting of socioeconomic information, food taboo practice, types of foods avoided and reasons for avoidance was administered by trained nurses. The results indicate that 27% of the women avoided at least one type of food due to food taboos. Milk and cheese were regarded as taboo foods by nearly half of the women (44.4%). The reasons for avoiding foods include fear of difficult delivery, discoloration of the fetus and fear of abortion (Tsegaye, Muroki & Wamboi, 1998). The extent to which these food restrictions affect the nutritional status of women is not fully realized. These foods contribute entirely to the protein content of the diet and play an important part in the diet of pregnant women.

A qualitative comparative case study was conducted to compare and contrast food taboos and avoidance practices during pregnancy among indigenous Temiar women. It was found that consumption of seventeen types of food items was prohibited for a pregnant Temiar woman during the prenatal period. Fear of difficulties during labour and delivery, convulsions or harming the baby (such as fetal malformation), and twin pregnancy seemed to trigger many food



proscriptions for the pregnant Temiar women, most of which have been passed on from generation to generation. (Sharifah Z., Nilan P. & Germov J. 2012)

Maternal mortality in Tanzania is about 977 maternal deaths per 100,000 live births (WHO, 2008), with anemia amongst the five top causes of maternal deaths. In a study to quantify the problem of anemia amongst pregnant women in Kilombero valley, Tanzania, it was found that protein foods like fish and meat had the highest number of taboos during pregnancy. It was found out that these taboos which deter the consumption of protein rich foods exacerbate anemia among pregnant women. (Marchant et al. 2002)

## **2.6 Conclusion**

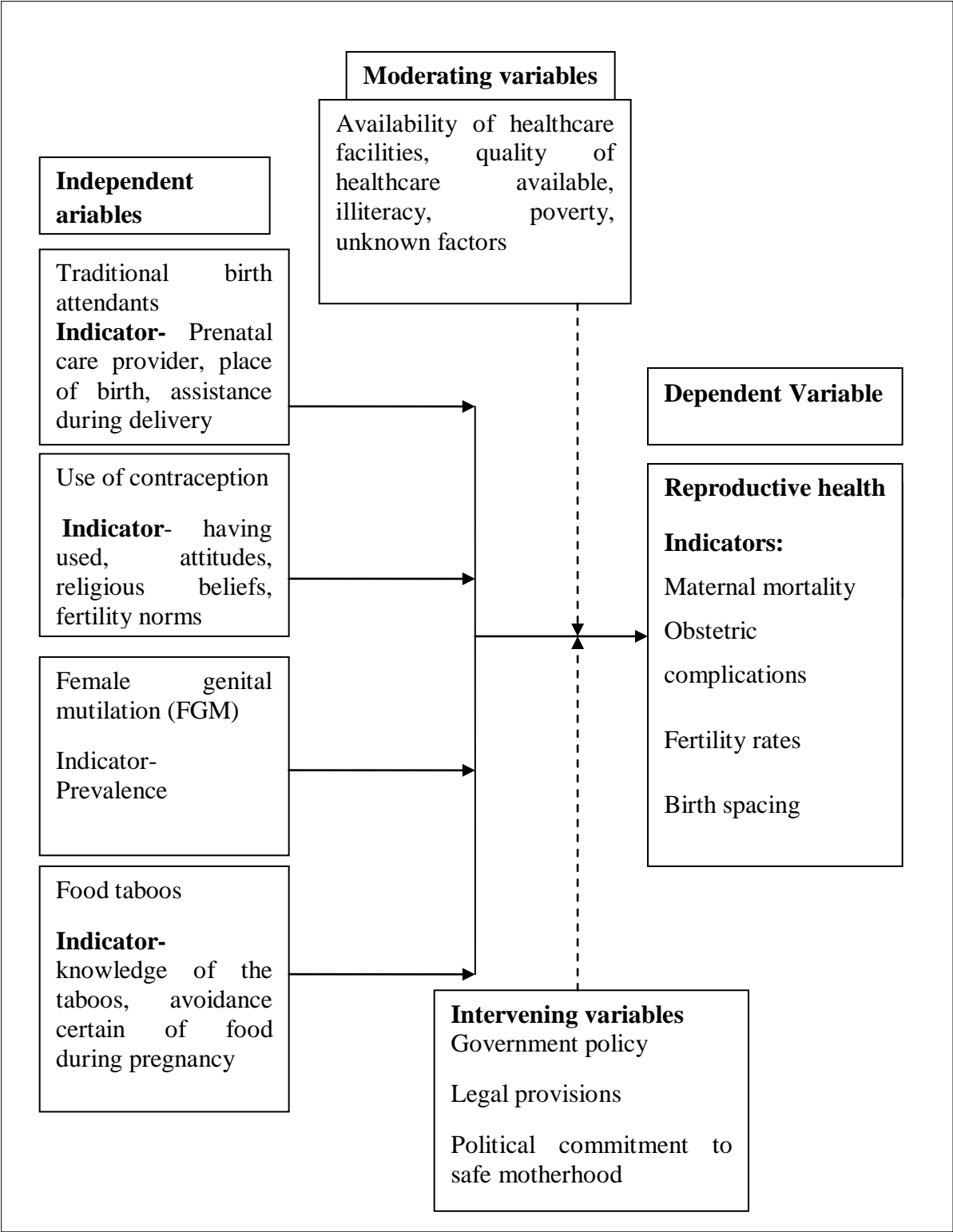
Skilled assistance during childbirth, readily accessible appropriate care in case of complications and effective postnatal care within the first 24 hours of delivery are strategies that can improve prenatal outcomes for mothers and babies. A key strategy to reducing maternal and neonatal deaths is the ‘health-centre intrapartum care strategy’, where qualified skilled workers manage labor, effectively manage complications and are supported with effective referral systems for specialized care when needed, and an effective postnatal care package. Literature has revealed studies that show that skilled attendants during labor, delivery, and in the early postpartum period, can prevent maternal death. However, in many developing countries, very few mothers make at least one antenatal visit and even less receive delivery care from skilled professionals.

Prevalence of contraceptive use is low in the African region despite considerable family planning programmatic efforts. This can be attributed to community level factors of demographics and fertility norms, gender norms and inequalities, and health knowledge. Religious and cultural factors have the potential to influence the acceptance and use of contraception by couples from different religious backgrounds in very distinct ways. Cultural

factors are equally important in couples' decisions about family size and contraception. Among the Somali, using contraception equates to voluntary infertility and has a significant impact on women's position in society. For families who wish to practice family planning, most fear going against cultural norms or facing the social stigma that results from having fewer children.

FGM is so deeply embedded in many African societies. It is a rite of passage to womanhood with strong, ancestral socio cultural roots. Reasons for continued practice of FGM include preservation of ethnic and gender identity, femininity, female purity/virginity and family honor; maintenance of cleanliness and health; and assurance of women's marriageability. According to the literature reviewed, FGM has been found to cause adverse obstetric outcomes. FGM has been found to cause obstructed labor, caesarean sections, episiotomies, obstetric hemorrhaging, uterine retroversion, blood transfusions and stillbirths.

On food taboos, available literature reveals that the practice of prohibiting certain food items for pregnant and/or lactating women or girls is a common practice the world over. Foods that are good sources of energy and protein are not allowed to be consumed by pregnant women for reasons such as difficult and prolonged labor due to fears of a large baby. Similarly sources of vitamins and minerals are restricted during pregnancy mainly due to the fear of offensive discharges during delivery and skin diseases on the body. Maternal nutrition in pregnancy is an important reproductive health issue. It affects the mother, and the growing baby. Food taboos often happen during women's most critical reproductive times i.e. pregnancy. The extent to which these food restrictions affect the nutritional status of women is not fully realized. These foods contribute entirely to the protein content of the diet and play an important part in the diet of pregnant women.



**Figure 1: Conceptual framework**

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

This chapter details the methods of data collection, analysis and presentation that were used in this study. It focuses on Research design, Target population, Sampling procedure, Methods of data collection, Validity of the instruments used, Reliability of the research findings and data analysis techniques used in the study.

#### **3.2 Research Design**

The study was conducted as a cross sectional survey. The researcher, with the help of a Somali research assistant (who also acted as a translator) administered the survey by reading out the questionnaire to the respondents. This design was favored because childbirth experiences could be quite painful, and the questions highly personal and sensitive to answer. The survey therefore helped the researcher to establish personal contact with the respondents and create an easy environment in which they felt comfortable to share their experiences. Second, this design was best for this study since follow-up was not necessary; the investigator met the respondents once and gathered all the information in one encounter.

#### **3.3 Target Population**

The target population of the study was the Somali women refugees in Nairobi. As earlier noted in this paper, there are approximately 46,000 Somali refugees in Nairobi, most of whom lived in Eastleigh. The targeted women are of ages between 18-55 years.

#### **3.4 Sample size and sample selection**

##### **3.4.1 Sample size determination**

The minimum sample size (**n**) required for determining the influence of cultural traditional beliefs on reproductive health among Somali women refugees will be calculated using the formula;

$$n = Z^2 pq / e^2 \quad (\text{Fisher et al, 1990})$$

Where **Z**= the value of the standard deviate at the 95% confidence level= (1.96).

**p**= the population proportion of Somali women who are circumcised = 92%  
(Wondimu et al. 2012)

**q** = 1-p

**e**= level of error allowable at the given level of confidence = 0.05

Therefore,

$$n = 1.96^2 (0.92 \times 0.08) / 0.05^2 = 108.5 = \mathbf{109}$$

For this study, a sample size of **109** was taken to be adequate representation of the population.

### **3.4.2 Sample selection**

A female Somali research assistant helped to randomly select the first participants. After the first participants are selected, the study used the snowball methodology to identify remaining participants. An important part of the recruiting process was the solicitation of informed consent

### **3.5 Methods of Data collection**

The researcher developed a questionnaire that was used to gather data from the respondents.

#### **3.5.1 Piloting of the study**

The questionnaires were pre-tested at the School of Communication at Daystar University, Nairobi over a period of two days, two weeks prior to embarking on the actual study. After pre testing, the data collection instruments were adjusted as appropriate to enhance the validity of the data collected.

### **3.5.2 Validity of the instruments used**

The validity of the instruments used for data collection was tested by a pre test of the questionnaires at the School of Communication at Daystar University, Nairobi Campus over a period of two days, two weeks prior to embarking on the actual study. Those questions that were not clear were modified in order to improve on the validity of the responses that were later obtained from the questionnaires.

As a way of improving the validity of the responses at the time of the actual data collection, the following measures were taken. First, to ensure confidentiality, all participants had the option not to answer any question they did not wish to give personal information about or to stop at any time. Secondly, the participants were not asked their names so as to ensure their complete anonymity throughout the process. Thirdly, care was taken not to lose the confidence of the respondents through ensuring that the questions were framed in a manner that was non-judgmental and not too intrusive into the personal life of the respondents.

### **3.5.3 Reliability of the instruments used**

The Test- retest method was used to test for the reliability of the instruments used in the study by implementing measurement instrument (questionnaire) at two separate times for each subject. The correlation between the two separate measurements was then computed with an assumption that there was no change in the underlying condition between test 1 and test 2. Data was collected and analyzed by the investigator to minimize error caused by different investigators.

### **3.6 Data Collection Procedures**

Data was collected by the researcher over a period of four weeks by the use of self administered questionnaires. The researcher first read the letter of transmittal to the respondent and clarified all the concerns of the respondents before administering the questionnaires. Then the researcher, with the help of the research assistant read each question on the questionnaire to

the respondents as he marked their responses appropriately. The literate respondents were given the questionnaires to fill by themselves.

### **3.7 Data analysis techniques**

All questionnaires were edited and responses coded before data was entered into the computer by the use of the Statistical Program for Social Scientists (SPSS), version 11.5. Cross tabulation will be the main method used for data analysis. After analysis, data was summarized and presented in form of frequency tables, percentages, and proportions.

### **3.8 Ethical considerations**

In this study research ethics were upheld. A letter of transmittal was used with every administration of the questionnaire to ensure full informed consent of the participants. For those who were not fluent in English, the consent form will be translated into Somali. Also, for those participants who were illiterate, the research assistant acting as the interpreter read aloud the letter of transmittal and confirmed consent orally, and then filled out the consent form in the presence of the participant. In addition to obtaining consent, the identity of the subjects was kept confidential through only providing brief descriptions of the clients and omitting their names or any other identifiers.

Some of the questions in the questionnaire may have been uncomfortable for some respondents to answer. It was made clear at the beginning of every interview that some of the questions could be embarrassing and that all the information provided would be completely voluntary and that the interview could be stopped at any time or a question skipped. At the end of every interview, respondents were compensated with a small gift such as a bar of soap, although they were not to know at the beginning that they would be receiving this gift so as to ensure voluntary participation.

**Table 3.1: Operationalization Table**

| Objective   | Variable  | Indicators                                | Measurement          | Measurement Scale | Data   |
|---|---|---|----------------------|-------------------|--------|
| To establish the impact of traditional birth attendants to maternal health  | Independent Use of TBAs in pregnancy and delivery | Visits to antenatal clinics               | No. of occurrence    | Ordinal           | Survey |
|   |   | Complications before labor                | No. of occurrence    | Ordinal           |        |
|   |   | Place of delivery                         | Name                 | Nominal           |        |
|   |   | Assistance during delivery                | Name                 | Nominal           |        |
|   |   | Complications during labor and delivery   | No. of occurrence    | Ordinal           |        |
|   |   | Post birth complications                  | No. of occurrence    | Ordinal           |        |
|   |   | Pregnancy outcome                         | No. of occurrence    | Ordinal           |        |
| To investigate the extent to which attitudes towards family planning and contraception affects reproductive health. | Level of contraceptive use                        | Child spacing                             | No. of occurrence    | Ordinal           | Survey |
|   |   | Use of contraceptives                     | No. of occurrence    | Ordinal           |        |
|   |   | Reasons for use of contraceptives         | No. of occurrence    | Ordinal           |        |
|   |   | Reasons for not use of contraceptives     | No. of occurrence    | Ordinal           |        |
| To determine the influence of female circumcision on reproductive health  | Female genital mutilation                         | Circumcised women                         | No. of occurrence    | Ordinal           | Survey |
|   |   | Age when circumcised                      |                      |                   |        |
|   |   | Perceived benefits of FGM                 | Names                | Nominal           |        |
|   |   | Reproductive problems associated with FGM | No. of occurrence    | Ordinal           |        |
| To establish the influence of food taboos on reproductive outcomes  | Food taboos                                       | Knowledge of food taboos                  | No. of occurrence    | Ordinal           | Survey |
|   |   | Avoidance of food                         | No. of occurrence    | Ordinal           |        |
|   |   | Reasons for avoidance                     | No. of occurrence    | Ordinal           |        |
|   |   | Foods avoided                             | Names                | Nominal           |        |
|   |   | Determiners of food to be avoided         | Names                | Nominal           |        |
|   |   | Number of times to feed in a day          | Number of occurrence | Ordinal           |        |
|   |   |   |                      | Ordinal           |        |



## **CHAPTER FOUR**

### **DATA ANALYSIS, PRESENTATION AND INTERPRETATION**

#### **4.1 Introduction**

This chapter presents the findings of the study on influence of cultural traditions on the reproductive health of Somali women refugees in Nairobi County, Kenya

It is organized based on the themes of the study; female circumcision, food taboos, family planning and contraception and traditional birth attendants (TBAs) and their influence on the reproductive health of Somali women refugees. The results are presented in tables and discussion is given after each table.

#### **4.2 Response return rate**

A sample size of 109 respondents was targeted based on Fisher et al, 1990 formula for sample size calculation. The researcher therefore administered 109 questionnaires to the respondents. However, 89 questionnaires were returned giving a response rate of 81.7%.

#### **4.3 Background characteristics**

The study sought the background characteristics of the respondents. These characteristics include age, religion and levels of literacy. Their responses are shown in table 4.1

Majority of the respondents (41.57%) were aged between 33-39 years. Only 2.25% of the respondents were below 18 years while 4.49% were above 53 years of age. 10.11% of the respondents were aged between 18-25 years while 14.61% were aged between 26-32 years. 19.10% of the respondents were aged between 40-46 years and 7.87% of the women were between 47-53 years old. This sample was appropriate for this study because a majority were within the reproductive age. Therefore it was believed that the respondents would give reliable and firsthand accounts of their reproductive experiences within the Somali cultural setup.

**Table 4.1: Background characteristics of respondents**

| Characteristics                    | No. of respondents | Percentage % |
|------------------------------------|--------------------|--------------|
| <b>Ages of respondents (Years)</b> |                    |              |
| Below 18 years                     | 2                  | 2.2          |
| 18-25                              | 9                  | 10.1         |
| 26-32                              | 13                 | 14.6         |
| 33-39                              | 37                 | 41.6         |
| 40-46                              | 17                 | 19.1         |
| 47-53                              | 7                  | 7.9          |
| Above 53                           | 4                  | 14.5         |
| <b>Totals</b>                      | <b>89</b>          | <b>100</b>   |
| <b>Religion of respondents</b>     |                    |              |
| Muslim                             | 85                 | 95.5         |
| Christian                          | 1                  | 1.1          |
| No response                        | 3                  | 3.4          |
| <b>Totals</b>                      | <b>89</b>          | <b>100</b>   |
| <b>Literary levels</b>             |                    |              |
| Literate                           | 41                 | 46.1         |
| Illiterate                         | 48                 | 53.9         |
| <b>Totals</b>                      | <b>89</b>          | <b>100</b>   |

Because religion is an important component of culture, the respondents were also asked to give their religions. 95.51% of the respondents were Muslims while only 1.12% were Christians. 3.37% of the respondents failed to give responses on their religion. These findings confirm the known fact that Somali are predominantly Muslim. As a cultural component of the

Somali community, Muslim influence will determine some reproductive choices of the Somali women thus having an impact on their reproductive health.

The respondents were asked if they had ever attended school and if so, the highest education level they had attained. Majority of the respondents (53.9%) were illiterate compared to 46.1% who could read and write. For those who had attended school, none had university education and a majority (90.2%) had primary level education only. Levels of literacy are known to influence the reproductive choices among women. This sample was appropriate for this study because a majority of the respondents are illiterate or semi-illiterate and therefore education does not influence their reproductive choices. This is the proportion that is deeply rooted in the practice of FGM, is likely to seek the services of TBAs, is likely to resist modern family planning practices and is likely to be swayed by food taboos during pregnancy.

#### **4.4 Traditional birth attendants**

The study sought to establish the impact of traditional birth attendants (TBAs) to maternal health among Somali refugee women in Nairobi.

##### **4.4.1 Pregnancy history of the respondents**

To begin with, the researcher sought to know about the reproductive history of the respondents. The respondents were therefore asked if they had ever been pregnant. Their responses are shown in table 4.2.

**Table 4.2: Pregnancy history**

| <b>Pregnancy history</b> | <b>No. of respondents</b> | <b>Percentage %</b> |
|--------------------------|---------------------------|---------------------|
| Ever been pregnant       | 83                        | 93.3                |
| Never been pregnant      | 6                         | 6.7                 |
| <b>Totals</b>            | <b>89</b>                 | <b>100</b>          |

A majority of the respondents (93.3%) had ever been pregnant in their life time. Only 6 women, 6.7% of the respondents, had never been pregnant. These findings show that the sample is suitable for the study because most of the respondents have had pregnancy experiences and their responses will be reliable in so far as their experiences with TBAs are concerned

#### 4.4.2 Pregnancy status

To ascertain their present pregnancy status, the respondents who reported to have ever been pregnant were asked if they were pregnant at the time of the study. Their responses are shown in table 4.3.

**Table 4.3: Pregnancy status of respondents**

| Pregnancy status | No. of respondents | Percentage % |
|------------------|--------------------|--------------|
| Pregnant         | 11                 | 12.4         |
| Not pregnant     | 78                 | 87.6         |
| <b>Totals</b>    | <b>89</b>          | <b>100</b>   |

Of all the respondents, 12.4% were pregnant at the time the study was carried out.

#### 4.4.3 Antenatal care attendance

To get responses on their health seeking behavior during pregnancy, pregnant respondents were asked if they attended antenatal care. Findings are shown in table 4.4

**Table 4.4: Antenatal care attendance**

|               | No. of respondents | Percentage % |
|---------------|--------------------|--------------|
| Attending     | 8                  | 72.7         |
| Not attending | 2                  | 18.2         |
| No response   | 1                  | 9.1          |
| <b>Totals</b> | <b>11</b>          | <b>100</b>   |

72.7% of pregnant women reported that they attend antenatal care. 18.2% of the pregnant respondents reported that they did not attend antenatal care. This could be attributed to ignorance given the high levels of illiteracy among the Somali refugee women. Some of these women are also in Nairobi illegally, having escaped from camps to search for better living in Nairobi. Therefore, they live underground lives, failing to make use of available healthcare systems with fear of repatriation back to the camps.

#### **4.4.4 Antenatal care provider**

To find out where the pregnant respondents got their antenatal care, the women were asked who they visited for antenatal care. Findings were recorded in table 4.5.

**Table 4.5: Antenatal care provider**

| <b>Provider</b> | <b>No. of respondents</b> | <b>Percentage</b> |
|-----------------|---------------------------|-------------------|
| Doctor          | 2                         | 25                |
| Nurse/midwife   | 4                         | 50                |
| TBA             | 6                         | 75                |
| No Response     | 1                         | 12.5              |

25% of the pregnant women who sought antenatal care reported that they got their antenatal care from a doctor, while 50% reported that they got their antenatal care from nurses/midwives. A majority of the women (75%) reported that they had sought for the services of traditional birth attendants. These findings show that despite consulting nurses and doctors for antenatal care, many women still seek out for the services of TBAs. This could be due to the amount of trust these women have in services of TBAs and are at home with cultural means of antenatal healthcare.

#### **4.4.5 History of pregnancy complications before labor**

To find out if the respondents who had ever been pregnant had had any complications before labor in their past pregnancies, the respondents were asked if in their last pregnancy, they had any problem or complication during pregnancy. Findings were presented in table 4.6

**Table 4.6: History of complications before labor**

|                   | No. of respondents | Percentage % |
|-------------------|--------------------|--------------|
| Had complications | 23                 | 27.7         |
| No complications  | 54                 | 65.1         |
| No response       | 6                  | 7.2          |
| <b>Totals</b>     | <b>83</b>          | <b>100</b>   |

65.1% of the respondents who had ever been pregnant in their lifetime reported that they had never had any complications. 27.7% of the respondents reported that they had had complications while 7.2% of the respondents did not respond to this question.

For the women who had complications, when asked where they sought their help as presented in table 4.7, 39.1% of the women reported that they had sought help from the TBAs. The same percentage (39.1) reported to have sought help from the health center. Only 8.7% sought help from the hospital while 13.1% did not respond to this question.

**Table 4.7: Place where help was sought**

| Place         | No. of respondents | Percentage |
|---------------|--------------------|------------|
| TBA           | 9                  | 39.1       |
| Health center | 9                  | 39.1       |
| Hospital      | 2                  | 8.7        |
| No response   | 3                  | 13.1       |
| <b>Totals</b> | <b>23</b>          | <b>100</b> |

One of the primary delays in deciding to seek care is a commonly held misconception that there is no need to go to the hospital for delivery if a woman has had a normal pregnancy and there is no indication that she will experience complications during delivery. Lack of sensitization and commonly held fallacies play a significant role in this perception of the potential for delivery complications. Many women and their families simply do not understand that complications during delivery can be unexpected and sudden and that skilled attendance at birth is vital to avoid and deal with life-threatening problems should they arise.

#### 4.4.6 Place of delivery for the most recent pregnancy

To get responses where respondents deliver their children from, they were asked the place where they delivered their most recent pregnancy. The findings were presented in table 4.8.

**Table 4.8: Pace of delivery for the most recent pregnancy**

| Place of delivery       | No. of respondents | Percentage % |
|-------------------------|--------------------|--------------|
| At home                 | 43                 | 51.8         |
| Health clinic/ hospital | 33                 | 39.8         |
| No response             | 7                  | 8.4          |
| <b>Totals</b>           | <b>83</b>          | <b>100</b>   |

51.8% of the respondents who had ever been pregnant reported to have delivered at home. 39.8% reported to have delivered in hospital while 8.4% did not respond to this question.

Home delivery shows that the deliveries took place without any skilled attendance. Home deliveries increase the chance of infection, and if complications arise there are few options available to handle them. Home deliveries play a role in high maternal mortality because they are bound to be unhygienic, unsupervised and when intervention is required it is usually not at hand.

Skilled attendance at birth can help decrease the chance of complications that result in death, but these findings indicate that skilled attendance at birth among Somali refugee women is very low.

A significant proportion of women decide to deliver from the village thinking that they will not

experience complications. They will delay seeking professional care when complications do arise because many make no prior emergency preparations, assuming the delivery will be normal.

#### 4.4.7 Help in delivery

In accessing the dependence of women on the services of TBAs, the respondents were asked who helped them in delivery in their last pregnancy. Findings were presented in table 4.9.

**Table 4.9: Help in delivery**

| <b>Helper</b>        | <b>No. of respondents</b> | <b>Percentage</b> |
|----------------------|---------------------------|-------------------|
| Relative/friend      | 7                         | 8.4               |
| TBA                  | 34                        | 41.0              |
| Midwife/nurse/doctor | 31                        | 37.3              |
| No response          | 11                        | 13.3              |
| <b>Totals</b>        | <b>83</b>                 | <b>100</b>        |

41% of the respondents reported that they were assisted by TBAs in delivery while 8.4% got help from relatives and friends. 37.3% reported that they got skilled assistance from midwives, nurses or doctors.

A significant portion of the sample gives birth by themselves or with the help of a TBA or relative because historically women delivered at home with the help of a close relative so there was no need to go to a special person and place for delivery. Home deliveries can lead to complications or even death because many make no prior preparations to travel to the hospital in case of emergency. By the time resources have been gathered to travel to a health center after complications arise, the woman might already be to a critical stage and an increased chance of death. Many women are also proud to have delivered by themselves and view a woman who delivers in a hospital as a coward who is afraid of delivery. It is believed that women who fear to deliver on their own are the ones that need to go to the hospital to deliver.



Another cultural attitude is “that everything is pre-determined by God” and delivery is a natural phenomenon that has always happened even before the advent of modern medicine. Therefore, women view home deliveries with the help of TBAs as natural and culturally appropriate, and await the outcome God has determined. Thaddeus and Maine (1994) found a similar attitude about the normalcy of delivery and recognized this attitude as an important delay in that a normal, natural phenomenon is not something that necessitates planning ahead or spending money for hospital expenses. These cultural beliefs influence women’s decision of whether to travel to a health facility. Bantebya Kyomuhendo (2003) describes these behaviors and beliefs as being rooted in a “fatalistic culture” towards birth in that childbirth is normalized and a natural process that women are supposed to endure and does not require special attention. This belief delays women going to health facilities because they are expected to bravely withstand the delivery process and the complications it could bring.

#### **4.4.8 Complications during labor and delivery**

To assess the prevalence of complications during labor and delivery among Somali women, respondents were asked to say whether they had experienced complications in their last labor and delivery. The results were presented in table 4.10

**Table 4:10: Prevalence of Complications during labor and delivery**

|                  | <b>No. of respondents</b> | <b>Percentage %</b> |
|------------------|---------------------------|---------------------|
| Complications    | 26                        | 31.3                |
| No complications | 37                        | 44.6                |
| No response      | 20                        | 24.1                |
| Totals           | 83                        | 100                 |

31.3% reported to have had complications during labor and delivery in their last pregnancy. A majority, 44.6% reported no complications while 24.1% gave no response to this

question. The high percentage of occurrence of complications during labor and delivery point out to the importance of skilled attendance during delivery. Some of these complications as illustrated in table 4.11 are life threatening and if immediate action is not taken the lives of both the mother and the baby are in danger. Some of the complications may severely affect the reproductive health these women.

The respondents who had experienced complications were asked to specify the complications they experienced. The findings were recorded in table 4.11.

**Table 4.11: Complications experienced during labor and delivery**

| <b>Complication</b>                              | <b>No. of women</b> | <b>Percentage %</b> |
|--|---------------------|---------------------|
| Heavy bleeding                                   | 19                  | 73.1                |
| Labor pains lasting longer than 12 Hours         | 9                   | 34.6                |
| Vaginal tearing                                  | 13                  | 50                  |
| Convulsions                                      | 6                   | 26.1                |
| Fever  | 11                  | 42.3                |
| Green or brown water coming from the vagina      | 3                   | 11.5                |
| Placenta not expelled within 1 hour of the birth | 7                   | 26.9                |
| No Response                                      | 1                   | 3.8                 |

Of the 26 women who had experienced complications, 73.1% had experienced heavy bleeding; 34.6% labor pains lasting longer than 12 hours; 50% vaginal tearing; 26.1 convulsions; 42.3% fever; 11.5% green or brown water coming from the vagina; and 26.9% placenta not expelled within 1 hour of the birth.

Clinically, women are dying from excess bleeding before and after delivery, complications resulting from high blood pressure, infections contracted during delivery, obstructed labor, and unsafe abortions (Sengendo, 2010). These causes of death are preventable

and treatable, and yet many women are still suffering from complications and/or death during pregnancy and delivery.

A significant portion of the population gives birth by themselves or with the help of a relative because historically women delivered at home with the help of a close relative so there was no need to go to a special person and place for delivery. Home deliveries can lead to complications or even death because many make no prior preparations to travel to the hospital in case of emergency. By the time resources have been gathered to travel to a health center after complications arise, the woman might already be to a critical stage and an increased chance of death.

TBAs are not able to handle complications if they arise, which could lead to disability or death. Sometimes, TBAs deliver but the procedures they follow are not effective. Some don't know how to examine and they even deliver complicated patients and they refer patients when they are in critical conditions. Deliveries with TBAs have the potential of being unhygienic and some lack basic equipment such as new sterile gloves. In case of over bleeding, a TBA cannot deal with it and in case one needs a C-section, she cannot carry it out. The TBAs live in similar conditions as the other community members and many are poor. Lack of money makes it difficult for TBAs to buy proper equipment for delivery such as gloves, disinfectant, thread, and razor blades, causing some of them to re-use supplies or go without them.

The risk associated with delivering with a TBA can be compounded by an inability to quickly mobilize the resources necessary to travel to the health center in case of emergency, delaying women from accessing life-saving interventions and increasing the chance of death (Chalo, Salihu, Nabukera, Zirabamuzaal, 2005). Because of the challenges faced by TBAs and the unpredictability of complications during delivery, maternal deaths still occur in the hands of TBAs.

#### 4.4.10 Complications during 6 weeks after birth

To assess the impact of TBAs on neonatal health of Somali refugee women, respondents were asked if they had any problems or complications during six weeks after birth. The findings were recorded in table 4.12.

**Table 4.12: Complications during six weeks after birth**

|                  | No. of respondents | Percentage |
|------------------|--------------------|------------|
| Had complication | 27                 | 32.5       |
| No complications | 44                 | 53.0       |
| No Response      | 12                 | 14.5       |
| <b>Totals</b>    | <b>83</b>          | <b>100</b> |

53% of the respondents reported that they did not have any complications within six weeks after birth while 32.5% reported to have had complications in six weeks after birth. Those who reported that they had complications were further asked to specify the type of complications they experienced. As presented in table 4.13, the women reported to have had either one or more of the following complications; heavy bleeding, bad smelling vaginal discharge, high fever, painful urination and swollen and painful breasts.

**Table 4.13: Type of complication within 6 weeks after birth**

| Complication                   | No. of women | Percentage % |
|--------------------------------|--------------|--------------|
| Heavy bleeding                 | 25           | 96.2         |
| Bad smelling vaginal discharge | 17           | 63.0         |
| High fever                     | 9            | 33.3         |
| Painful urination              | 18           | 66.7         |
| Hot, swollen painful breasts   | 2            | 7.4          |
| No Response                    | 1            | 3.7          |

Of the respondents who had complications within 6 weeks after birth, 96.2% experienced heavy bleeding. 66.7% experienced painful urination while 63% had bad smelling vaginal discharge. 33.3% reported high fever; 7.4% hot, swollen painful breasts; and 3.7% gave no response to this question.

Deliveries done by TBAs usually result in neonatal complications because most of them do not observe relevant procedures. These complications can be prevented early at the time of delivery if a woman delivers in hospital with skilled attendance. The TBAs, however, do not have capability to tell the early signs of these complications and they cannot prescribe relevant curative measures. This leaves the women who depend on their services at risk of multiple infections, and even death.

#### **4.4.11 Outcome of the most recent pregnancy**

Given that a majority of respondents had reported reliance on TBAs during delivery, the researcher sought to find out the outcomes of these deliveries. In order to determine whether TBAs had any impact on outcome of pregnancies among Somali women, respondents were asked to give the outcome of their most recent pregnancy. The findings were presented in table 4.14.

54.2% of the women reported that they had live births while 3.6% reported multiple live births. 10.8% of the respondents reported stillbirths while 1.2% reported multiple stillbirths. Spontaneous abortion was reported by 8.4% of the respondents while 2.4% and 1.2% reported induced abortion and ectopic pregnancy respectively.

Outcomes like stillbirth, spontaneous abortion and ectopic pregnancy are life threatening and when they happen, specialised care is required if the life of the mother is to be saved. The TBAs do not have the skills to detect a pregnancy that will arise into such outcomes and in most

cases they delay with the patient and take them to hospital at a time when the conditions of the patients are beyond the help of doctors.

**Table 4.14: Outcomes of the most recent pregnancies**

| <b>Outcome</b>       | <b>No. of women</b> | <b>Percentage %</b> |
|----------------------|---------------------|---------------------|
| Live birth           | 45                  | 54.2                |
| Multiple: live birth | 3                   | 3.6                 |
| Stillbirth           | 9                   | 10.8                |
| Multiple stillbirth  | 1                   | 1.2                 |
| Spontaneous abortion | 7                   | 8.4                 |
| Induced abortion     | 2                   | 2.4                 |
| Ectopic pregnancy    | 1                   | 1.2                 |
| No response          | 15                  | 18.1                |
| <b>Totals</b>        | <b>89</b>           | <b>100</b>          |

#### **4.5 Family planning**

The study sought to investigate the extent to which attitudes towards family planning and contraception among Somali refugee women in Nairobi has an effect on their reproductive health

##### **4.5.1 Expected Birth**

To find out attitudes towards pregnancy and childbirth in future, the respondents were first asked if they wanted to have a baby in the future. Their responses were presented in table 4.15.

**Table 4.15: Expected birth**

|                       | <b>No. of respondents</b> | <b>Percentage %</b> |
|-----------------------|---------------------------|---------------------|
| Want babies in future | 57                        | 64.0                |
| Don't want babies     | 25                        | 28.1                |
| No Response           | 7                         | 7.9                 |
| <b>Totals</b>         | <b>89</b>                 | <b>100</b>          |

64% of the women said that they would wish to have children in future. These results show that a majority of the respondents are still within the child bearing age and therefore suitable for this study. 28.1% reported that they would not wish to have babies in future while 7.9% gave no response. Respondents who wished to have babies were further asked when they wished to have the babies. Their responses were presented in table 4.16.

**Table 4.16: Time expected within which to have babies**

| <b>Time</b>               | <b>No. of women</b> | <b>Percentage %</b> |
|---------------------------|---------------------|---------------------|
| Within the next 12 months | 3                   | 5.3                 |
| Within 1-2 years          | 8                   | 14.0                |
| After 2 years             | 11                  | 19.3                |
| After I marry             | 2                   | 3.5                 |
| When God wants            | 27                  | 47.4                |
| No Response               | 6                   | 10.5                |

5.3% of the women who wished to have babies in future said that they would want babies within the next 12 months. 14% reported that they expect babies within 1-2 years, while 19.3% expected to have babies after two years. 47.4% of the women who expected to have children in future reported that they would do so when God wants. The somali are majorly Muslims and according to the teachings of islam, children come from God and He is the one who determines when and the number of children one can have.

#### **4.5.2 Use of contraceptives**

To find out the respondents' attitudes towards contraceptives, they were asked whether they used contraceptives. The findings were presented in table 4.17.

**Table 4.17: Use of contraceptives**

|                          | No. of respondents | Percentage % |
|--------------------------|--------------------|--------------|
| Using contraceptives     | 24                 | 27           |
| Not using contraceptives | 50                 | 56.1         |
| No response              | 15                 | 16.9         |
| <b>Totals</b>            | <b>89</b>          | <b>100</b>   |

Only 27% of the respondents reported the use contraceptives as compared to 56.1% of the respondents who reported not to be using contraceptives.

Respondents who did not use contraceptives were further asked to specify reasons for failure to use contraceptives. The reasons were put in five categories as follows: fertility related reasons, opposition to use, lack of knowledge, method related reasons and lack of access. The findings were presented in table 4.18.

Respondents pointed out more than one reasons for their failure to use contraceptives. 86% of the respondents were opposed to use of contraceptives due to religious prohibition while 78% due to husband opposition. Under fertility related reasons, 76% of the respondents who did not use contraceptives reported that they wanted more children then, 34% reported not having sex, while 22% were then pregnant. Under method related reasons for non use of contraceptives, 46% of the women reported fear of side effects. 24% reported that contraceptives were expensive while 5% reported lack of knowledge of the source of contraceptives.



**Table 4.18: Reasons for not using contraceptives**

| <b>Reason</b>                        | <b>No. of women</b> | <b>Percentage %</b> |
|--------------------------------------|---------------------|---------------------|
| <b>Fertility related reasons</b>     |                     |                     |
| Hysterectomy                         | 8                   | 16                  |
| Currently pregnant                   | 11                  | 22                  |
| Wants more children now              | 38                  | 76                  |
| Not having sex / infrequent sex      | 17                  | 34                  |
| Unable / difficulty getting pregnant | 7                   | 14                  |
| Postpartum (6 weeks after birth)     | 2                   | 4                   |
| Breastfeeding                        | 6                   | 12                  |
| <b>Opposition to use</b>             |                     |                     |
| Respondent opposed                   | 22                  | 44                  |
| Husband opposed                      | 39                  | 78                  |
| Others opposed                       | 3                   | 6                   |
| Religious prohibition                | 43                  | 86                  |
| <b>Lack of knowledge</b>             |                     |                     |
| Knows no method                      | 2                   | 4                   |
| Knows no source                      | 5                   | 10                  |
| <b>Method-related reasons</b>        |                     |                     |
| Fears side effects                   | 23                  | 46                  |
| Inconvenient to use                  | 12                  | 24                  |
| <b>Lack of access</b>                |                     |                     |
| Too far / method not available       | 6                   | 12                  |
| Expensive                            | 12                  | 24                  |
| No Response                          | 4                   | 8                   |

Among the Somali households the weight of decision-making lies with the male and thus the approval of the husband is a crucial for a woman to use family planning services. This is clearly shown by the finding that 78% of the respondents failed to use contraceptives because of husband opposition. However, the influence on a woman's ability to seek family planning

services extends beyond the husband to other household members, in particular, a mother-in-law. Women may need permission from their husband or household elders to seek health care. The doctrine of Islam has often been interpreted to forbid the use of family planning methods. Hence women's use of family planning services is often shaped by the prevailing religious attitudes of those in their community. Therefore, family planning services may be physically accessible in the local community, but cultural influences may mean that they may not be socially accessible

#### **4.5.3 Method of family planning**

In assessing the respondents' attitudes towards contraceptives, the respondents who reported the use of contraceptives were further asked to specify the method of family planning they used. The results were presented in table 4.19

**Table 4.19: Family planning methods**

| <b>Family planning method</b>        | <b>No. of women</b> | <b>Percentage %</b> |
|--------------------------------------|---------------------|---------------------|
| Pill                                 | 9                   | 37.5                |
| IUD                                  | 3                   | 12.5                |
| Male condom                          | 1                   | 4.2                 |
| Female condom                        | 0                   | 0                   |
| Implants                             | 0                   | 0                   |
| Injectables                          | 7                   | 29.2                |
| Female sterilization                 | 0                   | 0                   |
| Male sterilization / vasectomy       | 0                   | 0                   |
| Lactational amenorrhea               | 15                  | 62.5                |
| Rhythm / calendar / counting<br>days | 21                  | 87.5                |
| Withdrawal                           | 2                   | 8.3                 |
| Periodic abstinence                  | 19                  | 79.2                |
| No Response                          | 2                   | 8.3                 |

The respondents reported the use of at least more than one of the family planning methods given in the questionnaire as follows: pills- 37.5%; IUD- 12.5%; male condom- 4.2%; injectables- 9.2%; Lactational amenorrhea- 62.5%; Rhythm / calendar / counting days- 87.5%; withdrawal- 8.3%; and periodic abstinence- 79.2%. From these findings it is clear that Somali women prefer the use of cultural family planning methods to modern methods like pills, injectables, condoms and sterilization.

#### 4.5.4 Future use of family planning

To assess future and sustained use of family planning methods, the respondents who reported the use of contraceptives were asked if they would be using any method to prevent pregnancy in the next 12 months. The responses were presented in table 4.20.

**Table 4.20: Future use of contraceptives**

|               | No. of respondents | Percentages % |
|---------------|--------------------|---------------|
| Will use      | 7                  | 29.2          |
| Will not use  | 14                 | 58.3          |
| Don't know    | 2                  | 8.3           |
| No response   | 1                  | 4.2           |
| <b>Totals</b> | <b>24</b>          | <b>100</b>    |

29.2% of respondents who had reported the use of contraceptives reported that they will use while 58.3% reported that they will not use any method. The respondents who reported that they would not use any family planning in the 12 months that flowed were further asked to specify reasons for failure to use contraceptives in future. The findings were presented in table 4.21

**Table 4.21: Reasons why will not use contraceptives in future**

| <b>Reason</b>                        | <b>No. of women</b> | <b>Percentage %</b> |
|--------------------------------------|---------------------|---------------------|
| <b>Fertility related reasons</b>     |                     |                     |
| Wants more children                  | 10                  | 71.4                |
| Not having sex / infrequent sex      | 1                   | 7.1                 |
| Unable / difficulty getting pregnant | 0                   | 0                   |
| Breastfeeding                        | 2                   | 14.3                |
| <b>Opposition to use</b>             |                     |                     |
| Respondent opposed                   | 6                   | 42.9                |
| Husband opposed                      | 9                   | 64.3                |
| Others opposed                       | 2                   | 14.3                |
| Religious prohibition                | 11                  | 78.6                |
| <b>Lack of knowledge</b>             |                     |                     |
| Knows no method                      | 1                   | 7.1                 |
| Knows no source                      | 1                   | 7.1                 |
| <b>Method-related reasons</b>        |                     |                     |
| Fears side effects                   | 4                   | 28.6                |
| Inconvenient to use                  | 0                   | 0                   |
| <b>Lack of access</b>                |                     |                     |
| Too far / method not available       | 1                   | 7.2                 |
| Expensive                            | 3                   | 21.4                |
| No Response                          | 1                   | 7.2                 |

Reasons for future failure to use contraceptives were put in five categories. These are; fertility related reasons, opposition to use, lack of knowledge, method related reasons and lack of access.

Under fertility related reasons, 71.4% reported that they would not be using contraceptives in the following year because they wanted more children while 14.3% reported that they would be breastfeeding. Under opposition to use, 78.6% of the respondents who would not be using contraceptives in the following one year reported religious prohibition while 64.3 reported husband opposition. Under lack of knowledge, only 1.7% of the respondents reported that they will fail to use because they did not know of any method. Under method related reasons, 28.6% reported fear of side effects. Under lack of access, 21.4% reported that they would not be using any contraception in the following one year because of the cost.

Cultural barriers to use of contraceptives are evident in these findings. Desire to have more children is a cultural phenomenon in which many African societies ascribe a lot of importance to children especially male children. Somali being a purely patriarchal society, men had an ultimate say in all decisions of the family. The decision to use contraceptives is therefore determined by the husband who, because of the desire to have many children and is deeply rooted in muslim traditions, will oppose.

#### **4.6 Female Genital Mutilation**

The study sought to determine the influence of female circumcision on reproductive health among Somali women refugees in Nairobi. To do this, the study began by establishing the levels of prevalence of FGM among the respondents.

##### **4.6.1 Prevalence of FGM among Somali women.**

To determine the influence of FGM on Somali women's reproductive health the study sought to establish the prevalence of FGM among the respondents. Respondents were therefore asked if they had undergone FGM. Results were presented in table 4.22

**Table 4.22: Prevalence of FGM among the respondents**

|               | No. of respondents | Percentage % |
|---------------|--------------------|--------------|
| Circumcised   | 81                 | 91           |
| Uncircumcised | 3                  | 3.4          |
| No response   | 5                  | 5.6          |
| <b>Totals</b> | <b>89</b>          | <b>100</b>   |

A majority of the respondents (91%) reported to have been circumcised compared to only 3.4% who were not circumcised. These findings fall slightly below the findings made by the WHO (2008) that had found out that FGM among the Somali is 98%. This could be attributed to the fact that their long stay in Kenya has made some of the Somali to lose contact with some of their cultural traditions like FGM that is highly regarded in Somalia. However, the findings of this study are evidence of the high prevalence of FGM among the Somali.

The respondents who were circumcised were further asked if their genital areas were sawn in the process of FGM. The findings were presented in table 4.23.

**Table 4.23: Type of FGM undergone**

|                       | No. of respondents | Percentage % |
|-----------------------|--------------------|--------------|
| Genital area sawn     | 31                 | 38.3         |
| Genital area not sawn | 43                 | 53.1         |
| No response           | 7                  | 8.6          |
| <b>Totals</b>         | <b>81</b>          | <b>100</b>   |

Of the 91% of the respondents who reported to have gone through FGM, 38.3% had undergone infibulations- one of the most severe forms of FGM which involves the sewing of the vaginal opening. Most of the research on the health and sexuality consequences of FGM has been conducted on populations where the majority of women are subjected to the lesser

operations. However, among the infibulated women with extensive the operations, it would be reasonable to expect that the harmful effects on women’s reproductive health are more grievous.

#### 4.6.2 Age when circumcised

To find out the ages at which Somali women are circumcised, respondents were asked to give their ages when they were circumcised. The results were presented in table 4.24.

Most respondents (48.1%) were circumcised between the ages of 6-12 years. 13.6% were circumcised during infancy while 16% were circumcised between the ages of 13-18 years. 5% reported that they were circumcised at the ages of 19 years and over while 12.3% gave no response to this question.

**Table 4.24: Age when circumcised**

| Age in years                 | No. of respondents | Percentage % |
|------------------------------|--------------------|--------------|
| During infancy (5 and below) | 11                 | 13.6         |
| 6-12                         | 39                 | 48.1         |
| 13-18                        | 13                 | 16           |
| 19 and over                  | 4                  | 5            |
| Don’t know                   | 4                  | 5            |
| No response                  | 10                 | 12.3         |
| <b>Totals</b>                | <b>81</b>          | <b>100</b>   |

From these findings it is clear that FGM is done to all women including those that are already in their reproductive ages.

#### 4.6.3 Benefits of FGM

To find out the value ascribed to FGM by Somali women, respondents who had gone through the practice were asked to give the benefits of FGM. The respondents identified more than one benefit. The findings are presented in table 4.25

**Table 4.25: Benefits of FGM**

| <b>Benefit</b>                   | <b>No. of women</b> | <b>Percentage %</b> |
|----------------------------------|---------------------|---------------------|
| No benefits                      | 29                  | 32.6                |
| Cleanliness / hygiene            | 13                  | 14.6                |
| Social acceptance                | 51                  | 57.3                |
| Better marriage prospects        | 62                  | 69.7                |
| Preserve virginity               | 59                  | 66.3                |
| More sexual pleasure for the man | 21                  | 23.6                |
| Religious approval               | 43                  | 48.3                |
| Don't Know                       | 8                   | 9                   |
| No Response                      | 5                   | 5.6                 |

32.6% of respondents who had undergone circumcision reported that they did not see any benefit that comes with circumcision. 14.6% reported that FGM makes women clean; 57.3% for social acceptance; 69.7% for better marriage prospects; 66.3% for preservation of virginity; 23.6% for more sexual pleasure for the man; and 48.3% for religious acceptance. The perceived benefits of FGM show how deep this cultural practice is embedded among the Somali.

#### **4.6.4 History of birth complications**

To establish the relationship between birth complications and FGM, all the respondents were asked if in their reproductive history they had ever experienced complications. The findings were captured in table 4.26

62.9% of the respondents reported that they had experienced a complication in their reproductive history. 28.1% reported that they had not experienced any complications in their reproductive past. These high levels of complications are evident of the association between FGM and increased complications in reproductive health of women



**Figure 4.26: History of birth complications**

|               | No. of respondents | Percentage % |
|---------------|--------------------|--------------|
| Yes           | 56                 | 62.9         |
| No            | 25                 | 28.1         |
| No response   | 8                  | 9.0          |
| <b>Totals</b> | <b>89</b>          | <b>100</b>   |

The respondents who had history of reproductive complications were further asked to specify the complications they had experienced. The respondents reported more than one complications and the findings were presented in table 4.27

**Table 4.27: Reproductive complications experienced**

| Complication                    | No. of women | Percentage % |
|---------------------------------|--------------|--------------|
| Prolonged labor                 | 31           | 55.4         |
| Caesarean section               | 16           | 28.6         |
| Postpartum hemorrhage           | 28           | 50           |
| Extended maternal hospital stay | 23           | 41.1         |
| Infant resuscitation            | 6            | 10.7         |
| Stillbirth                      | 8            | 14.3         |
| Early neonatal death            | 2            | 3.6          |
| Low birth weight                | 5            | 8.9          |
| Episiotomy incision             | 2            | 3.6          |
| Uterine retroversion            | 1            | 1.8          |
| Pain during sexual intercourse  | 37           | 66.1         |
| No response                     | 8            | 14.3         |

55.4% of the respondents who reported to have experienced complications in their reproductive history reported that they had experienced prolonged labor while 28.6% had had

caesarean sections. 50% had had post-partum hemorrhage; 41.1% had prolonged stay in hospital; 10.7% had experienced infant resuscitation; 15.3% stillbirth; 3.6% early neonatal death; 8.8% low birth weight; 3.6 episiotomy incisions; and a majority (66.1%) had had pain during sexual intercourse. These results reflect the well documented impact of FGM on women’s reproductive health.

#### **4.7 Food Taboos**

This study sought to establish the influence of food taboos on reproductive outcomes among Somali women refugees in Nairobi. To begin, the researcher began by finding out the prevalence of food taboos among the respondents.

##### **4.7.1 Prevalence food taboos during pregnancy**

To ascertain their knowledge of food taboos, respondents were asked if they were aware of a practice where pregnant women are not allowed to eat some foods. Findings were presented in table 4.28.

**Table 4.28: Knowledge of food taboos**

|             | <b>No. of respondents</b> | <b>Percentage %</b> |
|-------------|---------------------------|---------------------|
| Yes         | 79                        | 88.8                |
| No          | 7                         | 7.8                 |
| No Response | 3                         | 3.4                 |
| Totals      | 89                        |                     |

88.8% of the respondents knew about food taboos while 7.8% did not know about this practice. 3.4% of the respondents failed to respond to this question. The respondents who had knowledge of food taboos were further asked if they had ever avoided any food during pregnancy. The findings were recorded in table 4.29.

**Table 4.29: Avoidance of food during pregnancy**

|             | No. of respondents | Percentage % |
|-------------|--------------------|--------------|
| Avoided     | 63                 | 70.8         |
| Not avoided | 20                 | 22.5         |
| No Response | 6                  | 6.7          |
| Totals      | 89                 | 100          |

70.8% of the respondents reported that in their pregnancies they had avoided some foods while 22.5% had not. 6.7% of the respondents did not respond to this question. These findings show that food taboos during pregnancy are prevalent among the Somali.

#### **4.7.2 Reasons for avoidance of certain foods during pregnancy**

To establish reasons why food taboos are practiced, those respondents who had avoided various foods in their pregnancies were further asked why they avoided the foods. Findings were captured in table 4.30.

**Table 4.30: Reasons for avoidance of certain foods**

| Reason                | No. of women | Percentage % |
|-----------------------|--------------|--------------|
| Respondent avoided    | 19           | 30.2         |
| Husband opposed       | 7            | 11.1         |
| Others opposed        | 4            | 6.3          |
| Religious prohibition | 48           | 76.2         |
| Cultural prohibition  | 54           | 85.7         |

The respondents reported more than one reason why they had avoided certain foods. A majority of respondents (85.7%) reported that they avoided certain foods due to cultural prohibition. 76.2% was due to religious prohibition while 11.1% reported that their husbands had opposed. 30.2% of the respondents reported that they had avoided certain foods at their own will.

### 4.7.3 Problems associated with non avoidance

To understand the importance ascribed to food taboos among pregnant Somali women, respondents were asked to specify the problems that are associated with non-avoidance of certain foods by pregnant women. The findings were presented in table 4.31

**Table 4.31: Problems associated with non-avoidance of certain foods during pregnancy**

| <b>Problem</b>             | <b>No. of women</b> | <b>Percentage %</b> |
|----------------------------|---------------------|---------------------|
| Overweight                 | 51                  | 81.0                |
| Seizures                   | 21                  | 33.3                |
| Difficult labor            | 59                  | 93.7                |
| Abortion                   | 30                  | 47.6                |
| Discoloration of the fetus | 29                  | 46.0                |
| No Response                | 1                   | 1.6                 |

93.7% of the respondents who had avoided certain foods during pregnancy reported that non avoidance would lead to overweight; 33.3% reported seizures, 81.0% reported difficult labor; 47.6% reported abortion while 46% reported discoloration of the fetus.

The most common reason for the food taboos was fear of difficult delivery as the result of increased size of the fetus due to consumption of nutritious foods. This was also reported in other studies. (Ojofeitimi, Ehigie, & Babafemi, 1982)

### 4.7.4 Foods avoided during pregnancy

To find out the types of foods Somali women avoided during pregnancy, respondents were asked to specify the foods they had avoided in their previous pregnancies. The findings were presented in table 4.32. From the table, 96.8% of the respondents reported that they avoided eggs; 85.7% avoided milk; 71.4% avoided red meat; 58.7% avoided white meat; 33.3% avoided

beans; and 20.6% avoided other foods like groundnuts, cheese, fish, bread, cakes, banana, and potatoes.

**Table 4.32: Foods avoided during pregnancy.**

| <b>Food</b> | <b>No. of women</b> | <b>Percentage %</b> |
|-------------|---------------------|---------------------|
| Milk        | 54                  | 85.7                |
| Eggs        | 61                  | 96.8                |
| Red meat    | 45                  | 71.4                |
| White meat  | 37                  | 58.7                |
| Beans       | 21                  | 33.3                |
| Other       | 13                  | 20.6                |
| No response | 2                   | 3.2                 |

The observations about livestock foods being the major taboo foods concur with the findings by other investigators. In Nigeria for example, it was observed that practically all women avoided livestock products such as meat, milk and cheese (Ojofeitimi, Ehigie, & Babafemi, 1982). This is one of the serious disadvantages of observing food taboos; since the major sources of proteins which are essential nutrients needed for the rapidly growing fetus are avoided. Restricting the food of pregnant and lactating women and children may cause under-nutrition of the pregnant mother leading to increased risks in pregnancy and labor, such as anemia and other micro-nutrient deficiency illnesses and low resistance to infection

## CHAPTER 5

### SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 Introduction

In this chapter, a summary of the findings of the study are presented and conclusions made from the said findings. Recommendations based on the study findings and conclusions are also made. Also, suggestions for further research are made.

#### 5.2 A summary of findings

Majority of the respondents were within the active ages of reproduction (18-39 years). 95.51% of the respondents were Muslims while a majority, 53.9%, had not attended any school.

##### 5.2.1 Traditional Birth Attendants

75% of the respondents reported reliance on the services of TBAs, most of whom are untrained, for antenatal care. There was a strong correlation between attendance of antenatal care and complications before labor. 65.1% of the respondents reported complications before labor. This can be attributed to the fact that the respondents relied on the services of TBAs who do not have training and capacity to provide relevant antenatal care. Even with these complications, a considerable number of respondents, 39.1%, sought the help of TBAs instead of specialized care from hospital. This can be a risk especially in cases where the complications are life threatening and need urgent specialized attention.

With regard to assistance during delivery, Somali women were found to rely on the services of TBAs. 51.8% of the respondents reported to have delivered at home while 41% of those who delivered at home reported to have been assisted by TBAs. There is also a strong correlation between complications during labor and delivery and assistance place of delivery. 31.3% reported to have had complications during labor and delivery in their last pregnancy. This

rate of prevalence of complications is high and can be a threat to Somali women's reproductive health and lives because a majority depends on the unspecialized care of TBAs. TBAs are not able to handle complications if they arise, which could lead to disability or death.

Impact of TBAs on Somali women's reproductive health is also reflected in neonatal health of the respondents. 32.5% of the respondents reported to have had complications in six weeks after birth. These complications include heavy bleeding, bad smelling vaginal discharge, high fever, painful urination and swollen and painful breasts. Again this can be attributed to the kind of care received during labor and delivery. Reliance on TBAs can be blamed for these complications because of lack of necessary skills to perform appropriate procedures during delivery. Their inability to prescribe relevant medical care can also lead to these complications.

With regard to the outcome of the most recent pregnancies, 54.2% of the women reported that they had live births; 3.6% reported multiple live births; 10.8% had stillbirths; and 1.2% reported multiple stillbirths. Spontaneous abortion was reported by 8.4% of the respondents while 2.4% and 1.2% reported induced abortion and ectopic pregnancy respectively. While live births account for the majority of the outcomes in this sample, the prevalence of stillbirths, abortions and ectopic pregnancies are worrying. These outcomes can be prevented or reduced further if women got the right care during pregnancy and delivery.

#### **4.2.2 Family planning**

The use of contraceptives was found to be very low. 64% of the women said that they would wish to have children in future. Only 27% of the respondents reported the use of contraceptives as compared to 56.1% of the respondents who reported not to be using contraceptives. The reasons for failure to use contraceptives are fertility related reasons, opposition to use, lack of knowledge, method related reasons and lack of access. The main

reasons for failure to use contraceptives were religious and husband opposition, 86% and 78% respectively. Desire for more children accounted for 76% of non-use of contraceptives.

High fertility levels have been found to be one of the causes of high maternal mortality and morbidity. The higher the levels of fertility, the more the women are exposed to risky pregnancies which coupled with resource constraints, availability of healthcare facilities and capacity contributes to poor state of women's reproductive health.

#### **4.2.3 Female genital mutilation**

91% of the respondents were found to be circumcised. 38.3% of the circumcised women had undergone infibulations. 57.3% of the respondents reported that FGM helped for social acceptance; 69.7% for better marriage prospects; and 66.3% for preservation of virginity. There was a strong correlation between birth complications and FGM. 62.9% of the respondents reported that they had experienced a complication in their reproductive history. These were: prolonged labor, 55.4%; caesarean sections, 28.6%; post-partum hemorrhage, 50%; prolonged stay in hospital, 41.1%; had experienced infant resuscitation, 10.7%; stillbirth, 15.3%; early neonatal death, 3.6%; low birth weight, 8.8%; episiotomy incisions, 3.6; and a majority (66.1%) had had pain during sexual intercourse.

#### **4.2.4 Food taboos**

70.8% of the respondents reported that in their pregnancies they had avoided some foods. Reasons for avoidance included cultural prohibition, 85.7%; religious prohibition, 76.2%; husband opposition, 11.1%; and avoidance at own will, 30.2%. Foods avoided include eggs, 96.8%; milk, 85.7%; red meat, 71.4%; white meat, 58.7%; beans, 33.3%; and other foods like groundnuts, cheese, fish, bread, cakes, banana, and potatoes, 20.6%.

There is a positive correlation between food taboos and state of maternal health of Somali women refugees. From these findings, many women avoided livestock products such as meat,



milk and cheese and other foods rich in proteins and iron. This is one of the serious disadvantages of observing food taboos; since the major sources of proteins which are essential nutrients needed for the rapidly growing fetus are avoided.

Restricting the food of pregnant and lactating women and children may cause under-nutrition of the pregnant mother leading to increased risks in pregnancy and labor, such as anemia and other micro-nutrient deficiency illnesses and low resistance to infection.

### **5.3 Conclusions**

From the study findings discussed above, the following conclusions were made; TBAs, attitudes towards family planning, FGM and food taboos were found to influence the reproductive health of Somali refugee women. These factors are therefore important intervention points for the government as well as the Non Governmental Organizations in the effort to minimize maternal mortality and morbidity among Somali refugee women.

Cultural beliefs and misconceptions play a key role in continued use of TBAs in provision of reproductive healthcare, observance of food taboos, FGM and low use of contraceptive to prevent unwanted pregnancies thus exposing women to risk pregnancies. Many Somali women hold misconceptions about only needing to go to the hospital in case of complications hindering them from improving their health behavior. Health education about the delivery process, dangers of FGM and more knowledge about family planning could greatly benefit Somali refugee women and start the process of changing health and health-seeking behavior.

Harmful traditional beliefs and practices that have been entrenched for many generations and have strong proponents within the Somali community will not be dislodged or replaced easily, unless concerted multi sectoral efforts are made to educate the people and traditional practitioners against traditional practices that are known to have harmful consequences.

## **5.4 Recommendations**

The following recommendations were put forward based on the study findings discussed in this study. First, TBAs among the Somali refugee community should be trained to be able to recognize complications, and learn more reproductive health information to be able to better inform pregnant mothers about good practices during pregnancy, refer those with high-risks for complications, and conduct deliveries in cases where women cannot access health centers. It is vital that someone with training be available in the community for emergency delivery purposes. Secondly, community sensitization programs should be increased and to be implemented through the local administration, folk theatre, cultural groups, youth and women's organizations, schools and extension services. Trained TBAs and health workers can be mobilized to transmit health messages to women and can serve as agents of change in their own communities. Religious leaders should also be involved in disseminating messages especially against harmful traditional practices such as FGM.

Thirdly, there should be concerted and strengthened actions towards eliminating food taboos among Somali refugee women. Health care providers must play a leading role in coordinating these efforts. The clinics should also put in place mechanisms that can routinely identify women observing food taboos, assess the reasons and provide appropriate nutrition education services at least for women who come to their clinics. Other governmental and non-governmental organizations and various public associations, such as Women's Associations should also be actively involved in endeavors aimed at eliminating these harmful beliefs.

Lastly, religious leaders should encourage their followers on the needs for family planning choices and community leaders should discourage the habit of not having family planning choice in their cultural norms. Limiting family size and reducing fertility rates would greatly improve the maternal mortality and morbidity rate as well as quality of life for women. Increasing the

time between births is proven to reduce maternal mortality. To increase the use of family planning, women need more sensitization about the benefits and possible side effects that they can get to reduce misconceptions surrounding its use. Family planning methods also need to be made more available and affordable at health centers.

### **5.5 Suggestions for further research**

This study had a relatively small sample size of 89 participants given the short period of time that was available to complete the research. It would be beneficial to attempt to replicate the study with a much larger sample size.

The study also depended on the responses of Somali women. Further studies should be conducted to incorporate the views and responses of health care providers.

It would also be beneficial to carry out the study using a qualitative study design.

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## **APPENDICES**

### **Appendix 1: Letter of transmittal**

**Dear respondent,**

I am Akivaga Joseph Isuzi, a Student at the University of Nairobi, College of Education and External Studies, School of Continuing and Distance Education, Department of Extra – Mural Studies pursuing a Masters Degree course in Project Planning and Management.

This is a Research Questionnaire on the Influence of Cultural Traditions on the Reproductive Health of Somali Women Refugees in Nairobi County, Kenya.

All information given will be treated with confidentiality and shall not be traced to the person of the respondent. Do not write your name on the questionnaire. Please answer all questions to the best of your knowledge.

Thank you for your cooperation in the study.

## Appendix 2: Questionnaire

QUESTIONNAIRE IDENTIFICATION NUMBER ..... **START TIME:** \_\_\_\_\_

NAME OF INTERVIEWER: .....

DATE OF INTERVIEW: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Day/ Month/ Year)

### a. Background characteristics

I am doing a study on influence of cultural traditions on the reproductive health of Somali women refugees and immigrants in Nairobi. I appreciate your taking the time to help us complete the following questions. Your responses are voluntary and will be confidential, which means that we will speak in private and that I will not write your name on the questionnaire. Therefore whatever information you share with me today will not have your name on it, and you can choose to not respond to certain questions or discontinue participation at any time; I'd like to start by asking you some general questions about your background and daily life. Are you ready to begin?

| No   | Questions and filters                               | Coding categories  | Skip to      |
|------|---|--|--------------|
| Q101 | How old are you now?                                | Age in completed years [__ __]<br>Don't Know 88<br>No Response 99  |              |
| Q102 | What religion do you practice?<br><b>CIRCLE ONE</b> | No religion 0<br>Muslim 4<br>Christian 2<br>Traditional 6<br>Other (specify)_____ 4<br>No Response 99                            |              |
| Q103 | Have you <b>EVER</b> attended school?               | Yes 1<br>No 2<br>No Response 9   | Q201<br>Q201 |
| Q104 | Are you attending school now?                       | Yes 1<br>No 2<br>No Response 9   |              |
| Q105 | What is the highest grade you completed?            | Grade [__ __]<br>If less than grade 1, enter 00<br>Primary 44<br>Secondary 55<br>Technical 66<br>University 77<br>No response 99 |              |

### b. Traditional birth attendants

Now I would like to ask you some questions about your current and previous pregnancies and traditional birth attendants (TBAs). These are sensitive topics. Some people may feel uncomfortable with these questions. Please remember that we will continue to make sure that your answers are absolutely confidential..

| No. | Questions and filters | Coding categories | Skip to |
|-----|-----------------------|-------------------|---------|
|-----|-----------------------|-------------------|---------|



|      |   |   |                      |
|------|---|---|----------------------|
| Q201 | Have you ever been pregnant?  | Yes 1<br>No 2<br>No Response 9  | Q301<br>Q301         |
| Q202 | Are you currently pregnant?   | Yes 1<br>No 2<br>Don't Know 8<br>No Response 9  | Q206<br>Q206<br>Q206 |
| Q203 | How many months are you in your pregnancy?  | Months [__ __]<br>Don't Know 88<br>No Response 99   |                      |
| Q204 | Have you seen anyone for antenatal care for this pregnancy?   | Yes 1<br>No 2<br>No Response 9  | Q206<br>Q206         |
| Q205 | Whom did you see?<br><b>CIRCLE ALL MENTIONED</b><br><b>1=MENTIONED</b><br><b>2=NOT MENTIONED</b>  | Doctor 1 2<br>Nurse / midwife 1 2<br>Traditional birth attendant 1 2<br>Other (specify) _____ 1 2<br>No Response 1 2            |                      |
| Q206 | Thinking back about your last pregnancy, <b>before</b> you started or went into labor, did you have a problem or complication during pregnancy (not labor or delivery)? | Yes 1<br>No 2<br>No Response 9  | Q209<br>Q209         |
| Q207 | Did you seek help for the problem(s) or complication(s)?  | Yes 1<br>No 2<br>No Response 9  | Q209<br>Q209         |
| Q208 | Where did you seek help?  | Had help at home 1<br>Health center 2<br>Hospital 3<br>Other (specify) _____ 4<br>No Response 9                                 |                      |
| Q209 | Where did you deliver your most recent pregnancy?   | At home 1<br>Health clinic / hospital 2<br>On the way to the hospital / clinic 3<br>Other(specify) _____ 4<br>No Response 9     |                      |
| Q210 | Did someone help you with the delivery?   | Yes 1<br>No 2<br>Don't Know / No Response 9   | Q212<br>Q212         |
| Q211 | Who helped with the delivery?   | Relative / friend 1<br>Traditional birth attendant 2<br>Midwife, nurse, or doctor 3<br>Other (specify) _____ 4<br>No Response 9 |                      |

|      |   |  |              |
|------|---|--|--------------|
| Q212 | Were there any complications during labor and delivery?   | Yes 1<br>No 2<br>No Response 9   | Q214<br>Q214 |
| Q213 | What complications did you have?<br><b>CIRCLE ALL MENTIONED</b><br><b>1=MENTIONED 2=NOT MENTIONED</b>                 | Heavy bleeding 1 2<br>Labor pains lasting longer than 12 hours 1 2<br>Vaginal tearing 1 2<br>Convulsions 1 2<br>Fever 1 2<br>Green or brown water coming from the vagina 1 2<br>Water breaks and labor is not induced within 6 hours 1 2<br>Placenta not expelled within 1 hour of the birth 1 2<br>Other (specify) _____ 1 2<br>No Response 1 2 |              |
| Q214 | During the 6 weeks after birth, did you have any problems or complications?   | Yes 1<br>No 2<br>No Response 9   | Q301<br>Q301 |
| Q215 | What problem(s) or complication(s) did you have?<br><b>CIRCLE ALL MENTIONED</b><br><b>1=MENTIONED 2=NOT MENTIONED</b> | Heavy bleeding 1 2<br>Bad smelling vaginal discharge 1 2<br>High fever 1 2<br>Painful urination 1 2<br>Hot, swollen painful breasts 1 2<br>Other (specify) _____ 1 2<br>No Response 1 2  |              |
| Q216 | In your most recent pregnancy, how did that pregnancy end?  | Live birth 1<br>Multiple: live birth 2<br>Stillbirth 3<br>Multiple stillbirth 4<br>Spontaneous abortion 5<br>Induced abortion 6<br>Ectopic pregnancy 7<br>No Response 9  |              |

**c. Family planning**

These next questions are about your current use of family planning methods.

| No.  | Questions and filters                     | Coding categories              | Skip to      |
|------|---|--------------------------------|--------------|
| Q301 | Do you want to have a baby in the future? | Yes 1<br>No 2<br>No response 9 | Q303<br>Q303 |

|      |  |   |   |
|------|--|---|---|
| Q302 | When do you want to have your next baby?   | Within the next 12 months 1<br>Within 1-2 years 2<br>After 2 years 3<br>After I marry 4<br>When God wants 5<br>Other (specify) _____ 6<br>No Response 9   |   |
| Q303 | Are you currently using any method to delay or avoid pregnancy?  | Yes 1<br>No 2<br>No Response 9  | Q305<br>Q306                                      |
| Q304 | What are the reasons you are not using a method to delay or avoid getting pregnant?<br><b>CIRCLE ALL MENTIONED</b><br><b>1=MENTIONED</b><br><b>2=NOT MENTIONED</b> | <b>FERTILITY-RELATED REASONS</b><br>Hysterectomy 1 2<br>Currently pregnant 1 2<br>Wants more children now 1 2<br>Not having sex / infrequent sex 1 2<br>Unable / difficulty getting pregnant 1 2<br>Postpartum (6 weeks after birth) 1 2<br>Breastfeeding 1 2<br><b>OPPOSITION TO USE</b><br>Respondent opposed 1 2<br>Husband opposed 1 2<br>Others opposed 1 2<br>Religious prohibition 1 2<br><b>LACK OF KNOWLEDGE</b><br>Knows no method 1 2<br>Knows no source 1 2<br><b>METHOD-RELATED REASONS</b><br>Fears side effects 1 2<br>Inconvenient to use 1 2<br><b>LACK OF ACCESS</b><br>Too far / method not available 1 2<br>Expensive 1 2<br>Other (specify) _____ 1 2<br>No Response 1 2 | Q401<br><br><b>Circle responses and go to 308</b> |
| Q305 | Which method have you been using?<br><b>CIRCLE ALL MENTIONED</b><br><b>1=MENTIONED</b><br><b>2=NOT MENTIONED</b>   | Pill 1 2<br>IUD 1 2<br>Male condom 1 2<br>Female condom 1 2<br>Implants 1 2<br>Injectables 1 2<br>Female sterilization / tubal ligation 1 2<br>Male sterilization / vasectomy 1 2<br>Lactational amenorrhea 1 2<br>Rhythm / calendar / counting days 1 2<br>Withdrawal 1 2<br>Periodic abstinence 1 2<br>Other (specify) _____ 1 2<br>No Response 1 2   |   |

|      |   |   |  |
|------|---|---|--|
| Q306 | Do you think you will use a method to delay or avoid pregnancy in the next 12 months?   | Yes 1<br>No 2<br>Don't Know 8<br>No Response 9  | <b>Q 401</b><br><b>Q401</b><br><b>Q401</b> |
| Q307 | What are the reasons that you think you will not use a method?<br><b>CIRCLE ALL MENTIONED</b><br><b>1=MENTIONED</b><br><b>2=NOT MENTIONED</b> | <b>FERTILITY-RELATED REASONS</b><br>Wants more children 1 2<br>Not having sex / infrequent sex 1 2<br>Unable / difficulty getting pregnant 1 2<br>Breastfeeding 1 2<br><b>OPPOSITION TO USE</b><br>Respondent opposed 1 2<br>Husband opposed 1 2<br>Others opposed 1 2<br>Religious prohibition 1 2<br><b>LACK OF KNOWLEDGE</b><br>Knows no method 1 2<br>Knows no source 1 2<br><b>METHOD-RELATED REASONS</b><br>Fears side effects 1 2<br>Inconvenient to use 1 2<br><b>LACK OF ACCESS</b><br>Too far / method not available 1 2<br>Expensive 1 2<br>Other (specify) _____ 1 2<br>No Response 1 2 |  |

**d. Female genital mutilation**

The following questions are about the practice of female genital mutilation or female circumcision

| No.  | Questions and filters   | Coding categories  | Skip to      |
|------|---|--|--------------|
| Q401 | In a number of countries, there is a practice in which a girl may have part or all of her genitals cut.<br>Have you ever heard about this practice? | Yes 1<br>No 2<br>No Response 9                                       | Q501<br>Q501 |
| Q402 | Have you yourself ever had your genitals cut?   | Yes 1<br>No 2<br>No Response 9                                       | Q405<br>Q405 |
| Q403 | Was your genital area sown closed?  | Yes 1<br>No 2<br>No Response 9                                       |              |
| Q404 | How old were you when this occurred?<br><b>IF THE RESPONDENT DOES NOT KNOW THE EXACT AGE, PROBE TO GET AN</b>                                       | Age in completed years [__ __]<br>During infancy 95<br>Don't Know 88 |              |

|      |   |   |  |
|------|---|---|--|
|      | <b>ESTIMATE.</b>  | No Response 99  |  |
| Q405 | <p>What benefits do girls themselves get if they undergo this genital cutting?<br/>         PROBE: Any other benefits?<br/> <b>CIRCLE ALL MENTIONED</b><br/> <b>1=MENTIONED</b><br/> <b>2=NOT MENTIONED</b></p>   | <p>No benefits 1 2<br/>         Cleanliness / hygiene 1 2<br/>         Social acceptance 1 2<br/>         Better marriage prospects 1 2<br/>         Preserve virginity 1 2<br/>         More sexual pleasure for the man 1 2<br/>         Religious approval 1 2<br/>         Other (specify) _____ 1 2<br/>         Don't Know 1 2<br/>         No Response 1 2</p>   |  |
| Q406 | <p>What benefits do girls themselves get if they DO NOT undergo this genital cutting?<br/>         PROBE: Anything else?<br/> <b>CIRCLE ALL MENTIONED</b><br/> <b>1=MENTIONED</b>      <b>2=NOT MENTIONED</b></p> | <p>No benefits 1 2<br/>         Fewer medical problems 1 2<br/>         Avoiding pain 1 2<br/>         More sexual pleasure for her 1 2<br/>         More sexual pleasure for the man 1 2<br/>         Follows religion 1 2<br/>         Other (specify) _____ 1 2<br/>         Don't Know 1 2<br/>         No Response 1 2</p>   |  |
| Q407 | Do you know of any health problems associated with female circumcision?   | <p>Yes 1<br/>         No 2<br/>         No response 9</p>   |  |
| Q408 | In your reproductive history, have you ever had any complications?  | <p>Yes 1<br/>         No 2<br/>         No response 9</p>   |  |
| Q409 | <p>Which complications have you ever had<br/> <b>CIRCLE ALL MENTIONED</b><br/> <b>1=MENTIONED</b>      <b>2=NOT MENTIONED</b></p>   | <p>Prolonged labour 1 2<br/>         Caesarean section 1 2<br/>         Postpartum haemorrhage 1 2<br/>         Extended maternal hospital stay 1 2<br/>         Infant resuscitation 1 2<br/>         Stillbirth 1 2<br/>         Early neonatal death 1 2<br/>         Low birth weight 1 2<br/>         Episiotomy incision 1 2<br/>         Uterine retroversion 1 2<br/>         Stillbirths 1 2<br/>         Pain during sexual intercourse 1 2<br/>         Other (specify) _____ 1 2<br/>         No response 1 2</p> |  |

**e. Food taboos**

Now I would like to ask you some questions about food taboos

|      |   |   |              |
|------|---|---|--------------|
| Q501 | In many societies, pregnant women are not allowed to eat some foods. Have you ever heard about this practice?                         | Yes 1<br>No 2<br>No Response 9  |              |
| Q502 | Have you ever avoided any fruit or food during pregnancy?   | Yes 1<br>No 2<br>No Response 9  | Q506<br>Q506 |
| Q503 | Why did you avoid the fruit/food?<br><b>CIRCLE ALL MENTIONED</b><br><b>1=MENTIONED</b><br><b>2=NOT MENTIONED</b>                      | Respondent avoided 1 2<br>Husband opposed 1 2<br>Others opposed 1 2<br>Religious prohibition 1 2<br>Cultural prohibition 1 2                                  |              |
| Q504 | What would happen if you did not avoid the food/fruit?<br><b>CIRCLE ALL MENTIONED</b><br><b>1=MENTIONED</b><br><b>2=NOT MENTIONED</b> | Overweight 1 2<br>Seizures 1 2<br>Difficult labor 1 2<br>Abortion 1 2<br>Discoloration of the fetus<br>1 2<br>Other (specify) _____<br>1 2<br>No Response 1 2 |              |
| Q505 | Which foods/ fruits did you avoid?  | Milk 1 2<br>Eggs 1 2<br>Red meat 1 2<br>White meat 1 2<br>Beans 1 2<br>Other (specify)<br>_____ 1 2<br>_____ 1 2<br>_____ 1 2<br>_____ 1 2<br>No response 1 2 |              |
| Q508 | How many times is a pregnant woman supposed to feed in a day?   | Once 1<br>Twice 2<br>Three times 3<br>More than three times 4<br>Don't know 8<br>No response 9  |              |
| Q509 | During your pregnancy, how many times did you feed in a day?  | Once 1<br>Twice 2<br>Three times 3<br>More than three times 4<br>Don't know 8<br>No response 9  |              |