

**MATERNAL HEALTH CARE CHOICES FROM THE AVAILABLE  
ALTERNATIVES IN NYANG'OMA SUB-LOCATION, BONDO  
DISTRICT, SIAYA COUNTY**

**BY**

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## DECLARATION

This thesis is my original work. It has not been presented for a degree in any other university.

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Signature.....

Date.....

Supervisor:

Dr. Charles Owuor-Olungah

This work has been submitted for examination with my approval as the University supervisor.

Signature.....

Date.....

## **DEDICATION**

This thesis is especially dedicated to my beloved mother, Nora Atieno, who passed away at a time when I seriously needed her social and psychological support during my course work, and to my daughter, Collette Suda, who was born at the same time.

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## LIST OF ABBREVIATIONS

ACK	-	Anglican Church of Kenya
ANC	-	Antenatal Care
ATC	-	African Traditional Churches
CBS	-	Central Bureau of Statistics
CHW	-	Community Health Workers
DEM	-	Disease Explanatory Model
EM	-	Explanatory Model
FGDs	-	Focus Group Discussions
GOK	-	Government of Kenya
GLAC	-	God's Last Appeal Church
HGTC	-	Holy Ghost Trinity Church
HIV	-	Human Immunodeficiency Virus
IAGAS	-	Institute of Anthropology, Gender and African Studies
ISMM	-	International Safe Motherhood Movement
KEDAHR	-	Kenya Danish Health Research Project
KDHS	-	Kenya Demographic and Health Survey
MCH	-	Maternal Child Healthcare
MMR	-	Maternal Mortality Ratio
MOH	-	Ministry of Health
NCPD	-	National Council of Population and Development
ROK	-	Republic of Kenya
PNC	-	Post-natal Care
SDA	-	Seventh Day Adventist Church
SPSS	-	Statistical Package for Social Sciences
TBAs	-	Traditional Birth Attendants
TT	-	Tetanus Toxoid
UNFPA	-	United Nation Population Funds
UNICEF	-	United Nation Children Funds
WHO	-	World Health Organization

## **ABSTRACT**

This study explored maternal healthcare choices of expectant mothers in Nyang'oma Sub-Location, Bondo District. The objectives of the study were: the identification and description of maternal healthcare providers in the area; the examination of the determinants for maternal healthcare choices; and the exploration of the perceptions and attitudes of the local community towards both formal and informal maternal healthcare providers.

The study employed community survey for which 100 mothers with children below eight months were selected by simple random sampling. Key informant interviews involving twelve maternal healthcare providers, from popular, professional and folk sectors were also purposively sampled to shed light on services they provided to expectant mothers. The study also used focus group discussion of discussants, who were sampled by region in the area. Information on maternal healthcare providers in the area, the kind of maternal healthcare services they provide, social support system and the perception of the community towards maternal healthcare providers were collected guided by the Disease Explanatory Model (DEM) proposed by Kleinman (1980).

The findings indicate that various maternal healthcare providers such as biomedical, neighbours, friends, retired nurse, grandmothers, faith healers, traditional healers and traditional birth attendants exist in the study area. Expectant mothers use the services of these maternal healthcare providers but their use is influenced by distance to the facility and occupation, social support network, and belief in pregnancy. The study confirms that the perceptions and attitudes towards both informal and formal maternal healthcare providers affect the use of their services.

The study illustrates the important role played by all maternal healthcare providers in Nyang'oma Sub-location in addressing maternal healthcare problems. However, the low status accorded to the maternal healthcare in the popular and folk sector by the conventional medical practitioners may hinder efforts to improve maternal health. Any attempt to improve maternal health should consider the complementary roles of all maternal healthcare providers to realize safe motherhood. The harmony of the maternal health care providers may be realized by creating a sense of co-existence and realization that both are complimentary to each other. This can be achieved through training.

This study recommends that maternal health issues should be approached holistically, bearing in mind that traditional healers, traditional birth attendants, faith healers, mothers-in-law, friends, neighbours and biomedical health practitioners also play a role that may significantly reduce the high rate of maternal and infant mortalities. It should also be borne in mind that the factors

influencing the use of these maternal health care providers should be appropriately addressed to facilitate improved maternal healthcare provision in the district and other parts of the country.

# **CHAPTER ONE: BACKGROUND TO THE STUDY**

## **1.1 The Concept of Maternal Healthcare Providers**

Maternal healthcare providers are groups of people or individuals who treat or assist expectant mothers solve pregnancy related problems and facilitate safe delivery. There are three categories of maternal healthcare providers used by expectant mothers. The first category consists of a biomedical/allopathic team, defined as the legally sanctioned healing professions such as modern western scientific medicine, which constitutes physicians, specialists, paramedical professions such as nurses, midwives and physiotherapists (Helman, 2001). Biomedical maternal healthcare providers trace their origins to seventeenth century image developed by Descartes, Bacons and Hobbes, where predictable laws could be discovered by science and controlled by technology (Davis-Floyd, 1981:99). Men are specialists in this category as obstetricians and gynecologists.

The conceptual separation of mother and infant is basic to this technology as the baby is removed from the mother and handed to a nurse, who inspects, tests, bathes, diapers and wraps the new born, administers the vitamin 'K' injection then hands it back to its mother (Helman, 2001). Davis-Floyd (1981) observes that the mother's womb is replaced by the plastic womb of the culture. Pregnancy and birth is medicalized as an expectant mother begins to be subjected to a medical process at the time of conception to the time when she gives birth. In the hospital environs, the mother lies surrounded by medical technology: external and internal foetal monitors, intra-venous drips, charts and instruments (Davis-Floyd, 1981). The gap between lay and obstetrical birth cultures has been created as women express considerable dissatisfaction with certain aspects of the medical management of birth (Helman, 2001). Graham and Oakley (1982) reported that the medical view of pregnancy abstracts it from the rest of the woman's life experience, and it is treated as an isolated medical event, as the expectant mother begins treatment at the onset of pregnancy, and leaves

medical care after giving birth. The hospital represents male and this is removing the female active participation on pregnancy and birth process from the women (Martin, 1992).

Missionaries and the colonial government introduced this birth culture in Kenya in the early nineteenth century. According to Raikes (1990), modern maternal healthcare services in Kenya were introduced at the turn of the century by the missionaries. As an extension of their curative dispensaries, some expectant mothers were examined and given food supplements. It has been suggested (Doyal, 1987 reported in Raikes, 1990) that the main aim of the missionaries in running the antenatal services was an extension of their missionary work where they saw antenatal services and childcare as part of the work of producing as many candidates as possible for baptism. As a result of this, there are Mission Hospitals providing maternal healthcare to expectant mothers in Kenya. Besides, there are also private and government dispensaries. The use of these categories of maternal healthcare providers is dependent on factors such as their accessibility, cost, maternal education and exposure, recipients' beliefs among others (Nangendo, 2006).

The second category is made up of traditional birth attendants (TBAs) and specialists in pregnancy related traditional medicine. Traditional birth attendants are community-based providers of healthcare during pregnancy, delivery and postnatal period and operate independently of the conventional healthcare (UNFPA, 2005). Though lacking formal education, these practitioners obtain the knowledge of handling pregnancy and childbirth from long experience with pregnancy cases. Some of them obtain this knowledge through apprenticeship with their experienced relatives. For generations, TBAs have provided maternal healthcare services in the rural areas of developing countries (UNFPA, 2005).

Traditional maternal healthcare providers abound in most rural areas while there are only a few in

urban areas of Kenya (Ikamari, 2004). Traditional birth attendants indeed contribute to positive outcomes in pregnancy healthcare because programmes that they are involved in have the greatest input (Ray and Salihu, 2004). Olungah (2007) also observes that pregnant mothers consult traditional birth attendants for various reasons and also offer solid social support in which women are accorded different levels of assistances. Traditional birth attendants combine the work of both the gynecologist and obstetrician and sometimes that of the herbalist. They examine and advise the expectant mothers on diet, exercise and appropriate traditional medicines (Nyamwaya, 1992; Olungah, 2007).

Nyamwaya (1992) further observes that indigenous health practitioners such as herbalists and traditional birth attendants play an important role in the improvement of the individual and community health. Some studies show that some traditional birth attendants do not consider hygiene when assisting expectant mothers (Nangendo, 2006; Ray and Salihu, 2004). This is quite dangerous as the mother and child may contract incurable diseases. They also lack drips and cannot also transfuse a delivering mother in case of excessive bleeding during delivery. However, mothers still have confidence in their services. This is because the community members have trust in them, and their medical practices is very much relevant within the context of their culture. There is need to improve their working environment through training and any support they may require to ensure safe delivery. There are also faith healers who pray and dispel off evil spirits believed to be causing trouble to expectant mothers. They are guided by philosophy of having faith in God for a desirable end result.

The last category comprises family members, neighbours, church members and friends. Here individuals usually begin the process by self-treatment whenever they feel any fever during the

formative stages of pregnancy, individuals buy drugs from chemist or shop in the local market place, preparation of pot medicine if they are aware of any for bathing and oral taking as protective devices changing their eating patterns and habits and consulting widely for advices from those around them (Olungah, 2007). Most pregnancies are dealt with within this category that is culture-laden. This category functions as the chief source and most immediate determinant of care. Kleinman (1980) observes that treatment by the individual and the family is the first therapeutic intervention resorted to by most people across a wide range of cultures. When expectant mothers are faced with maternal complications, they tend to choose amongst the three categories, based on, among other things, their proximity to them, financial capability and faith in their effectiveness judged by cultural considerations (Kleinman, 1980).

Maternal health care providers assist mothers with pregnancy problems world over. The pregnancy period is a time of potential anxiety, since it is fraught with possible negative outcomes such as miscarriages, physical defects in the baby, or death in childbirth for either the infant or the mother. Such negative outcomes that cause anxieties make people to turn to symbolic pregnancy rituals to protect the child and expectant mother as well as ensure a successful birth (Crapo, 1987). The rituals are found in the developing as well as the developed countries. Helman (2001) observes that in the developed countries, an expectant mother is surrounded by a routine checkup of prenatal care, care at birth aided by modern technology and by extension antenatal care (ANC) to ensure the survival of the mother and the baby. These rituals have been incorporated in most of the urban centres of the developing countries due to the influence of western culture (Raikes, 1990). While the rituals are also found in some parts of the rural areas of developing countries, their use is influenced by factors such as: formal education, social support systems, and belief systems surrounding pregnancy, cost of maternal health services and distance from the health facility.

In most societies, when a woman enters labour, she is attended to by one or more women who have already experienced childbirth themselves and who help her through the process. These people may be female relatives or friends, a traditional birth attendant or, in a hospital setting, by a medically qualified obstetrician (Crapo, 1987; Helman, 1994). In traditional African villages, there are always women who are called upon to act as midwives when the time for delivery approaches. Some of these are midwives experienced and may have assisted in the delivery of up to fifty or more babies in their areas (Mbiti, 1991: 90).

Maternal healthcare providers began to assist expectant mothers long before the transition to agriculture, in the Upper Paleolithic period, some 50,000 to 20,000 years ago (Trevatham, 1987; 1997). Because birth was difficult due to the increase in human brain size and change in the human pelvis, having assistance in delivery would have reduced problems arising from pregnancy (Trevatham, 1987; 1997). From the Neolithic transition to settled agricultural villages, birth became a social affair. Most births were attended to by relatives of the expectant mother (McElroy and Townsend, 2004). Traditionally, pregnancy and birth were not only family centred but also occurred within the realm of women's knowledge. Kitzinger (1997:211) observes that birth was a woman's work. Even though a man was present, he was marginal to the community of women who used skills passed on by elderly women, who would be their mothers or apprentices.

In Kenya, maternal health services began as integrated Maternal Child Health (MCH) programmes in 1972 (NCPD and CBS, 1999). In 1987 the safe motherhood initiative was launched in Nairobi, where specific programs to reduce maternal mortality rates and improve maternal health care were established. Reproductive health strategy was started in order to improve maternal health in Kenya (CBS, 2004). A study done by the CBS (2004) suggests that there are 414 maternal deaths per

100,000 live births, representing a 1 in 25 lifetime risk of dying from a maternal – related cause.

## **1.2 Problem Statement**

Safe motherhood can be achieved when the concept of comprehensive maternity care is actualized (Khatib *et al.*, 2009). Kenyan's maternal mortality and morbidity remains a pervasive concern in the village and national level (G.O.K., 2008). The first authentic estimation of maternal mortality ratio (MMR) was by the Kenya Demographic and Health Survey (KDHS) (CBS, 2001). The KDHS estimated the MMR for 1989-1998 at 590 per 100,000 live births while KDHS of 2003 (CBS, 2004) reported MMR at 414 per 100,000 live births. The KDHS estimated MMR for 2008-2009 at 488 per 100,000 live births (CBS, 2010). Currently, maternal deaths account for 15 percent of all deaths among women aged 15-49 (GOK, 2011). This is a worrisome trend requiring some concerted intervention.

Studies in Kenya indicate that the majority of maternal deaths are due to direct obstetric causes such as hemorrhage, unsafe induced abortion, hypertensive disorders of pregnancy and obstructed labour (Maine *et al.*, 1997; Ikamari, 2004). The large numbers of maternal deaths resulting from direct obstetric causes have been attributed to the limited health facilities serving a large number of clients and to long distances travelled to health facilities. The majority of women have to travel long distances to reach the nearest modern health facility (NCPD and CBS, 1999). The risk of maternal death is influenced both by the risk associated with pregnancy and especially the frequency of pregnancy (that is, the number of times a woman becomes pregnant). Women who suffer from obstetric complications recover, but suffer long-term disabilities including sterility and vesicovaginal fistula (Maine *et al.*, 1997). Sterility and vesicovaginal fistula are conditions in which mother's birth canal has been ruptured as a result of prolonged labour.

According to Neema (1994), the proper development of a mother's pregnancy and delivery are culturally conditioned and involve not just the individual mother, but her family, neighbours and community. At the same time they often involve interaction with biomedical health workers, whose cultural construction of pregnancy and birth differs from that of local women.

Besides the many problems related to pregnancy, expectant mothers usually have the challenge of selecting appropriate maternal healthcare providers in their localities. Women have options of birth locations ranging from government hospitals, mission hospitals, private clinics, maternity units, to home (Neema, 1994; Foster and Anderson, 1978). Their proximity, financial capability and faith in their effectiveness judged by cultural considerations are among the factors that affect the choice of maternal healthcare providers. Consequently, an expectant mother may land on a maternal healthcare provider who may not assist her much but may complicate her problems further. UNFPA (2011) recommends pregnancy to be attended by trained midwives, who, unfortunately, are few in the rural areas. The interaction between clients and healers, in this case, mothers and midwives, is important when examining health care decisions as it can inhibit or facilitate later use of a health facility.

Particular studies in Kenya (Olungah, 2007; Nangendo, 2006) have unequivocally looked into why the expectant mothers make choices for maternal health provider to approach when faced with pregnancy problems. The previous studies have only looked at cultural hindrances to utilization of modern health facility by expectant mothers, but have not looked at general maternal healthcare choices. This study therefore set to explore the choices expectant mothers make to use maternal healthcare provider, the determinants for their uses and perceptions and attitudes of the local community towards both formal and informal health providers. To realize this objective, the study adopted the following questions to guide the process of investigation:

- Who are the maternal healthcare providers in Nyang’oma sub-location?
- What critical factors influence the choices of maternal healthcare providers?
- What perceptions and attitudes does the local community have towards both formal and informal maternal healthcare providers?

### **1.3 Objectives of the Study**

#### **1.3.1 General Objective**

The general objective of this study was to explore the choices the community makes from the available alternatives maternal healthcare providers in Nyan’goma Sub location, Bondo district, Siaya County.

#### **1.3.2 Specific Objectives**

1. To identify and describe the maternal healthcare providers available in Nyang’oma Sub - Location.
2. To examine the determinants of the options expectant mothers have in terms of healthcare providers to go for.
3. To explore the perceptions and attitudes of the local community towards both formal and informal maternal healthcare providers.

### **1.4 Rationale**

An understanding of maternal healthcare providers’ choices in the study area and their implications provide useful information which could assist policy makers to design appropriate plans to effectively address the expectant mothers’ challenging needs. Though much effort and emphasis

have been laid on ensuring the use of modern healthcare facilities for safe maternal healthcare (WHO, 2006 2012), it has been met by serious drawbacks, since a majority of rural women have other options. It has been stated that 30%-80% of deliveries in the developing world take place at home (McCathy and Kowal, 1995). Most of these deliveries are attended to by untrained persons such as traditional birth attendants, relatives such as mothers, mothers-in-law and aunts as well as neighbours with inadequate facilities to address complications. Some of these deliveries end up in preventable foetal deaths and deformities.

An analysis of the determinants of maternal healthcare provision is crucial in order to know the suitable approaches to safe motherhood that would ensure smooth, accident-free pregnancy and delivery processes. The life of an expectant mother and the unborn child are crucial to a nation's demographic growth and development to the extent that impediments to their existence require serious attention. The death of a mother when delivering, adversely affect the family members as well as the community at large. This is worse when she leaves behind the new born. The members of the family would be left with a hard job of taking care of the new born. In every community mothers are known to take full charge of the family. Losing a mother and especially when delivering would be a hard blow not only to the family and community alone, but also to the entire country. Mothers are signs of fertility and losing them means fertility is retarded. Mothers are the best caregivers, the producers of most family foods and the ones from whom children learn their language and befitting behaviours. Their health and security are necessary for the sustained development of societies.

## **1.5 Scope and Limitation**

This study was carried out in Nyang'oma Sub-location of Bondo District, Siaya County. Its main focus was on the choices expectant mothers make for maternal healthcare providers from the

available alternatives to use. Safe motherhood can be achieved when information regarding the use of maternal health can be captured in their immediate setting. For this reason, the study concentrated on the maternal healthcare providers available for use, the determinants for their use and the perception and attitudes of the community towards both formal and informal maternal healthcare providers in the area.

The study focused on maternal issue, however, it is dominated by female and for this reason; much information would have been generated by a female researcher and a female research assistant. On the contrary, the researcher and research assistant were all males and it was expected that this would hinder the openness of the respondents on some sensitive information, most of whom were females. The male link to this study could only be understood if the researcher was a medical doctor playing a role of a biomedical expert, which was not the case.

My introductory remarks, that I came from South Nyanza, made some mature old mothers to view me as a person who could definitely marry their daughters and for that reason they became awesome when I mentioned to them some reproductive terms. The issues of avoidance of a prospective son-in-law interfered with free communication with such respondents.

While I landed in Nyangoma sub-location as a mere field researcher who was interested in knowing the available option of dealing with pregnancy issues and delivery, I was received with a lot of respect by the community since I didn't belong to that locality. The respect was too much and almost translated to revere that any word that I uttered was not taken lightly. At times I could overhear some females in the health facility that I visited at Uyawi health centre whispering to one another when I was almost approaching them that they watched their sentiments. Some mothers even went as far as discussing with me issues that were not connected to maternal health, although there were general

health issues. The fact that I was from the University of Nairobi community also created too much expectation where members of the community were expecting assistance and the rural respondents expected that I would either find immediate solution to their problems or influence the way the healthcare was organized and being offered.

While infant mortality is compounded with maternal mortality, it was the interest of the study also to investigate whether the choice expectant mothers make have a bearing on the infants' deaths but this was beyond its scope.

The geographical scope of this study was confined to sub location level and also a small sample used due to limited financial resources, thus, the results cannot be generalized given the small sample size and unique experience, perceptions and attitudes of the community members with pregnancy and maternal healthcare providers across different sections of western Kenya. Being a snap shot study, it was not possible to make follow ups to expectant mothers to have a clear picture of maternal healthcare they approached.

## **1.6 Definition of Concepts**

**Maternal Healthcare Providers:** are persons or institutions that assist expectant mothers during pregnancy and parturition (delivery/giving birth) such as biomedical personnel, traditional birth attendants, specialists in traditional medicine and family members as well as friends and neighbours.

**Determinants:** these are factors, such as formal education, occupation and distance, social support network and belief systems, that influence the choices of maternal healthcare providers.

**Perception:** a way of seeing or understanding both informal and formal healthcare providers by expectant mothers.

## **CHAPTER TWO: LITERATURE REVIEW**

### **2.1 Introduction**

This chapter reviews literature on maternal healthcare providers and determinants for the use of maternal healthcare providers. Issues such as formal education, occupation and distance to the health facility, social support network in pregnancy, belief systems surrounding pregnancy and the perceptions and attitudes expectant mothers have towards both formal and informal maternal healthcare providers and the role they play in the choice of healthcare are examined. It also captures the theoretical framework that guided the study.

### **2.2 Maternal Healthcare Providers**

In the Luo community, traditional birth attendants give women who are giving birth herbal medicine to expel retained placenta, to reduce postpartum abdominal pain (*ojiwo*) and to aid breast milk production (Kawango, 1995; Prince, 2004). They also boil and administer various traditional herbs locally referred to as “pot medicine” (*yadh agulu*) to pregnant women to drink. They are required to drink this mixture in the mornings and evenings. Studies report that the herbal mixture is believed to make the growing foetus strong and healthy as well as to protect it from being infected by rashes and skin infections locally known as (*yamo*) (Nangendo, 2006; Mulemi and Nangendo, 2001). They also help in disentangling the umbilical cord (*wino*) from the neck of the baby so that blood flow is not interfered with during birth (Kawango, 1995: 93). During difficult delivery, some rituals were performed to help the delivering mother (Mboya, 1938). The traditional birth attendants are respected by rural communities for their maturity and their role as confidants (Temmar *et al.*, 2006: 89).

In western Kenya, traditional birth attendants assist expectant mothers during labour pains and when

delivering. They provide support to up to 34 per cent of deliveries (Maine, 2003). The continual preference for traditional birth attendants by pregnant mothers in this region can be attributed to factors such as their proximity to the women's homes, respectful attitude for expectant mothers regardless of their age and flexible modes of payment (Maine, 2003). Midwives often work in the hospitals, and therefore, live and practice in urban centres. In Kenya, for example, 56 per cent of health workers, including community health workers, are based in urban areas with 25 per cent located in Nairobi alone (Graham, 1997). Hardly can one find skilled birth attendants always in close proximity of expectant mothers in the rural areas.

Although traditional birth attendants assist many pregnant women in the rural areas, the nature and environment in which they operate raise a lot of health concerns. For instance, the traditional birth attendants lack speedy measures in handling emergency cases. In rural areas of the Asian continent where traditional birth attendants handle about 90 per cent of deliveries, Reedzu (2005: 13) observes that some of the methods put pregnant mothers at health risk. These attendants cut the umbilical cord with unsterilized knives or pieces of broken earthen pots, and forcibly pull the umbilical cord to remove the placenta. The problem observed by Reedzu affects the Kenyan localities as well. Among the Luo community, Nangendo (2006) reports that some TBAs sometimes use blunt knives or stalks of sorghum to cut the umbilical cord and this may cause tetanus to both the child and the mother.

Moreover there are also some myths and misconceptions that forbid pregnant women from eating nutritious and healthy food (Reedzu, 2005; Olungah, 2007). Since pregnant women really need balanced diet and energy giving food, cultural taboos that deny them access to such foods put their life in jeopardy. Poverty also contribute to mothers not taking a balanced diet food as they may lack money to buy them.

Traditional maternal healthcare providers also lack tools to deal with complicated pregnancy cases such as obstructed labour, ante partum hemorrhage, and eclampsia, hence their practice has been deemed less valuable. This has led to a pressure group called the International Safe Motherhood Movement (ISMM). ISMM started in 1997 to concentrate on skilled attendance during labour and emergency obstetric care just in case of complications (Krucke and Barclay, 2004). However, members in this sector are not always present during the moments when women develop pregnancy related complications.

Hodnett *et al.*, (2004) observe that a traditional maternal healthcare provider gives continuous emotional support to women in labour, to improve the outcome of labour. It has even been suggested that traditional birth attendants provide emotional support to labouring women in the hospital ward for successful birth outcomes. However, in most areas of sub Saharan Africa, they are not allowed into the labour wards (Roosmalen *et al.*, 2005). d'Oliveira *et al.*(2002) observe that in the University Hospital of Dar es salaam with a caseload of 30 – 60 births a day, women in labour were left in bed without continuous support givers. Medical student interns, doctors and midwives attend to them rarely because of their overwhelming numbers. This lack of emotional support for women in labour has been described as violence against women in health-care institutions (d'Oliveira *et al.*, 2002). Hodnett *et al.*, (2004) have observed that the need for continuous emotional support for women during childbirth reduces the need for intra partum analgesia and women report less dissatisfaction with their childbirth experiences.

### **2.2.1 Pattern of Health Care Seeking Behaviour in Pregnancy**

Human reproduction is both a biological and a cultural process. Conception, placental and foetal development, gestational stages, and labour contractions are essentially the same in all human

societies (McElroy and Townsend, 2004). The two scholars further observe that the experience and interpretation of reproduction are culturally diverse, with great variation in ideas of how and when conception occurs, that is, how the foetus develops, how to protect the pregnant woman and where birth should occur.

Different communities have different ways of managing pregnancy and childbirth. Among the !Kung of the Kalahari Desert, for example, a woman is taught not to be afraid and not to cry during labour, as fear might cause her to die (Shostak, 1981). Shostak further observes that relatives sometimes come to help with the cutting of the umbilical cord only when they hear the newborn baby cry. At other times, the young mother may handle the after-birth and cut the umbilical cord by herself. While birth in !Kung of the Kalahari Desert is an individual affair, in other communities, pregnancy and birth is a family affair. Jordan (1993: 33), reports that pregnancy and childbirth is a family affair among the Maya in Mexico and the woman's husband is expected to be with her during the labour so that he can see how the woman suffers. In addition, sisters, grandmothers, mothers-in-law and neighbours could be called upon to assist with delivery if the labour takes long. The family functions as a support system and as a cost saving mechanism when its function has been disrupted by the illness or dysfunction of one or more members (Lousataunau and Sobo, 1997:24).

According to Hankings (2000:70), some hunting and gathering groups encourage a solitary birth as an ideal, but most foraging people provide assistance at birth. Arctic people traditionally built a separate dwelling for birthing, where a few women attended to the labouring woman. Solitary birth is also rare among farming people, but there are exceptions such as among the Bariba of Benin, who regard a woman giving birth alone as having courage and endurance. Browner and Sargent (1996) observes that Bariba midwives attend births only if complications arise, although neighbours or

relatives may help in the cutting of the cord and delivering the placenta.

Expectant mothers who develop pregnancy problems tend to make choices about who to consult in the popular, folk, or professional sectors. They make these choices according to the context in which they find themselves such as the type of helper who is around them, whether payment is needed for the services required and if the mother can afford to pay, and the explanatory model they use to explain the origin of the pregnancy and birth problems. Advice and treatment pass along the links in this network – beginning with advice from family, friends, neighbours and friends of friends, and then moving to sacred or secular folk healers, or physicians (Helman, 2001).

Expectant mothers may visit both complimentary and biomedical practitioners at the same time as well as using one or the other for pregnancy problems (Foster and Andreson, 1978). The concept of the bio-medically oriented “lay-referral” system originated with Freidson (1960), who suggested that when people become ill, they first turn to family and friends, then to suggested lay “experts,” and finally, if nothing works, to a physician and the biomedical system, although lay norms may influence this option. Today, the term means that people try the most familiar or the simplest and cheapest treatment first and then seek more expensive, complex, or unfamiliar treatments if necessary.

While treatment choice can follow a hierarchical sequence, often patterns of resort are cumulative and quite pluralistic, involving many treatment modalities at once (Lautaunau and Sobo, 1997:90). Moreover, people hardly comply with all the rules surrounding each type of treatment. People often creatively combine recommendations, coming up with the regimen they feel is right for them. Chrisman (1977) points out that the health-seeking process is dynamic, and people are constantly re-evaluating their symptoms and revising their plans. In any case, people who seek biomedical

assistance already have used some type of home treatment. Shamans or diviners might treat illnesses by prescribing a confession and an atonement session in which family members confess or declare wrongdoings to others and try to set their relationships right.

It has been observed (Logan, 1978) that an expectant mother in the Ajijic community in Mexico, regardless of her cognitive orientation with respect to conception and pregnancy, may select from several options for delivery. She may choose to have her child in a hospital, and if so, she may choose from a large number of hospitals, which are available. If a woman decides to have her baby at home, she may select one of the three currently active traditional birth attendants (TBAs) or she may request the services of a locally based physician, several of whom consult to attend to home deliveries. A few women have had babies at home without any form of traditional or modern professional assistance. Studies indicate that expectant mothers in rural areas of Kenya use both biomedical and traditional maternal healthcare providers (Githagui, 1985; Nangendo, 2006; Olungah, 2007).

## **2.3 Determinants of Maternal Healthcare Choices**

Expectant mothers make decisions periodically on the maternal healthcare facilities to use. Their decisions are determined by several factors, namely: formal education, occupation and distance to the healthcare provider, social support network and belief systems. These factors are discussed below.

### **2.3.1 Formal education in maternal healthcare choices**

Formal education is a condition for social and economic development and a vehicle for development (GOK, 1994a). Formal education is an institution in which governments and educators have placed

ultimate faith in. It is expected to bring benefits such as promoting equality, raising consciousness, consolidating the goals of a revolution and developing human potential to satisfy both individual and social needs. According to Khasiani (1995), formal education, especially high educational attainment, enhances the status of women through improving their knowledge on health and that of their families, increasing their economic opportunities, and reducing chances of poverty.

Osero (1990) observes that formal education turns villagers from traditional healing. Education exerts its influence indirectly by raising the social status and self-image of women, by increasing their choices in life, making decisions for themselves and empowering them on their rights to health. Uneducated women have little understanding of the physiology of reproduction or how it can be altered, and accept pregnancy as divinely ordained (WHO, 1989). This has a bearing on the choices women make for maternal healthcare providers. An uneducated woman is less ready to seek professional healthcare than her educated sister, either because she is not fully aware of what is to offer or because she is frightened and out of touch with available health services.

An educated girl has an open mind to new ideas and the possibility of change (WHO, 1989). Newland (1977) observes that for many women and girls, the classroom is the first and the only setting in which they perform as individuals rather than as members of a particular family. This is the only context in which they can achieve a sense of worth and identity that does not come from their roles as wives, mothers or daughters. In this, the school serves not only as a source of new knowledge about the world outside their immediate communities, but also about themselves as well (Newland, 1977). Depending on the conservatism of her community, an educated girl need not be the same as her mother and grandmother before her, and she may be able to make a rational decision to seek professional advice and care for pregnancy problems.

Areas with the lowest female literacy rates correspond with where trained personnel attend to few births (WHO, 1989). This statistic is explained in terms of the propensity of the mother to seek professional care in the health centres. An analysis of maternal deaths in a Nigerian study indicated that 219 of the 7,654 women in the sample who had not received prenatal care died in childbirth compared to 19 of the 15,020 who had done so (Harrison, 1985). Harrison further observed that the most important influence on seeking prenatal care was education. Casual observation suggests that the poor and uneducated often receive little consideration from government officials, including those in medical service. In Ibadan, literate patients received better treatment at government hospitals and health centres than the illiterates, particularly by way of more specific diagnoses (Maclean, 1974).

Suda, (1997) agrees that education is important for women's reproductive health and behaviour. In her study conducted in Kericho, Suda observed that many uneducated rural women did not receive antenatal care while some of them said that they visited antenatal health facilities much later in their pregnancy. In the study conducted in Kwale, and Kirinyaga areas of Kenya, lack of knowledge for antenatal care was the main reason for not attending clinics (Mwabu *et al.*, 1991). In the study conducted in Eastern Uganda, Katahoire (1998) has argued that understanding why and how mothers' education brings about improved chances of child survival is necessitated by starting from an analysis of the way women themselves understand and live out their experience of schooling. She further observed that women's subjective experiences with schooling were expressed in terms of their social roles and responsibilities as wives, mothers, and responsible members of their society in Samia Bugwe. Katahoire (1998) reported that there were statistically significant associations between mothers' schooling and the use of preventive health services for immunisation of children, and antenatal care. Formal education, she noted, is crucial in changing and modifying people's

attitudes and beliefs.

Simkhada *et al.* (2007) carried out a systematic review of 28 publications to identify and analyze the main factors affecting the utilization of antenatal care in developing countries. Their study revealed that sixteen studies found that women's education was the best predictor of antenatal care visits. A study conducted by Nielsen *et al.* (2001) in rural India found out that women who had attended school for more than 5 years were more likely to have had the recommended number of visits of antenatal care compared with women who were less educated. According to Nielsen *et al.* (2001), despite obvious advantages of antenatal care, many women in both developing and developed countries neither get adequate care nor seek care at all. In Kenya, majority of women are not well educated, hence they may underutilize the antenatal care.

### **2.3.2 Occupation and Distance**

Occupation influences the choice of maternal healthcare providers as it determines the economic status of a woman. It is believed that people of low economic status tend to underutilize modern health services because of the financial cost and or a sub-culture of poverty that fails to emphasize the importance of good health (Osero, 1990). For Gesler, (1979) higher economic status has a relationship to a higher level of effort to seek modern health care in Nigeria. In rural India, social class and education were positively correlated with the use of allopathic practitioners (Djurfeld and Lindberg, 1975).

The study conducted by Islam *et al.* (2006) in rural Bangladesh showed that there was a significant association between economic status and place of delivery ( $p < 0.01$ ). The respondents with higher economic status prefer both their mother's home and a hospital/clinic at substantially higher

proportions than those of lower economic status, while the reverse is true in the case of their own home. According to Stekelenburg *et al.* (2004), a large proportion of these home deliveries take place without skilled attendants. Anderson and Foster (1978) underscore the fact that costs of healthcare services undermine the use of modern health facilities.

Distance has been widely identified as a major barrier to the utilization of ANC in rural parts of most developing countries. A study conducted by Effendi (2008) in Indonesia found out that there was a statistically significant association between distance to ANC service and regular utilization of ANC service. The study by Mubyazi *et al.* (2010) in rural Tanzania found out that from more than half of the women interviewed at clinic level, concerns were raised about long travel distances to ANC clinics. This was considered a discouraging factor for regular ANC service utilization.

According to Maine *et al.*, (1997), the distance to health facility, availability and efficiency of transportation and cost of health care are likely to influence pregnant women's readiness to seek care from allopathic practitioners. Distance exerts a dual influence, as long distance can be an obstacle to reaching a health facility (Maine *et al.*, 1997). The effect of distance becomes stronger when combined with lack of transportation and poor roads (Thaddeus and Maine, 1990). Distance to the nearest health facility has been found to be one of the determinants of institutionalised delivery in Asia (Niraula, 1994; Kakhar *et al.*, 1995). Niraula (1994) found out that in Nepal, people who were close to the roads where a modern health facility was located were more likely to use health services than those who were far away.

Nielsen *et al.*'s (2001) study revealed that location of a Health Sub-Centre in the village influenced the number of antenatal care visits. Women who lived in villages with a Health Sub-Centre located in the village itself were more likely to have at least five antenatal care visits than women who lived

in villages without a Health Sub-Centre. A study by Islam *et al.* (2006) found out that place of delivery was an important factor in determining safe motherhood in Bangladesh. About 94% of the deliveries take place either in their own homes (70.3%) or in their mother's homes (23.4%). Only 2.2% of the rural women delivered their baby in hospitals/clinics. The study established a significant association between place of delivery and the number of pregnancies. Further, in a study by Couillet *et al.* (2007), a univariate analysis of the use of ANC services and its determinants showed a significantly positive relationship between distance to a health centre (<5 km). Mubyazi *et al.* (2010) argued that women living far away from public health facilities may be forced to access private health facilities including the private-for profit facilities where services are commercialized and often charged at full price.

In order to address the impact of distance, Edgerley *et al.* (2007) examined whether the use of a community mobile health van (the Lucile Packard Childrens Hospital Women's Health Van) in an underserved population allows for earlier access to prenatal care and increased rate of adequate prenatal care, as compared to prenatal care initiated in community clinics. One of the goals of the van is to improve access to prenatal care. Women with positive urine pregnancy tests receive a dating ultrasound on the van, initial prenatal care, counseling regarding healthy pregnancy, and are given a packet of information and prenatal vitamins. The van acts as a bridging device as the women are then referred to local community clinics for further prenatal visits. The study found out that underserved women utilizing the van services for prenatal care initiated care three weeks earlier than women using other services. The study concluded that women who initiated prenatal care on the Women's Health Van achieved earlier access to prenatal care when compared to women initiating care at other community health clinics. The use of such a van would therefore promote utility of ANC in the location. In Meru North district, Magadi *et al.* (2000) investigated the relationship

between healthcare and reproductive health behaviour and found out that proximity to antenatal clinic is important for frequent use of ANC services.

Many studies identify cost as a barrier for poor people in developing countries. Cost of accessing care (travel cost, service fees, equipment cost) is an important determinant of whether to seek care or not, especially where distances to healthcare facilities are large (Simkhada *et al.* 2007). Mubyazi *et al.*' (2010), for in instance study in Tanzania found out that women living in rural areas faced greater difficulty with transport than women living in urban areas. In the rural areas of both districts, especially in rural Mkuranga, great concerns were expressed with the shortage of public transport and this was reported to be contributed to poor road conditions that discourage private car owners to operate there. The situation gets more serious during the rainy season. In Nyang'oma sub location, public vehicles were seen occasionally in the morning and evening as they transported people who were going to and from the market. Few individuals also owned private vehicles.

However, Effendi's (2008) study in Indonesia found out that there was no statistically significant association between travel cost to ANC service and regular utilization of ANC service. Further, the same study revealed no statistically significant association between convenience of transportation to ANC service and regular utilization of the ANC service. In addition Ekele and Tunau's (2007) study in a Nigerian hospital also established that the cost of hospital delivery as a deterrent to hospital birth was not a major factor. This implies that factors that influence the utilization of ANC services are context-specific.

Cost as a variable receives considerable attention which includes transportation costs, physician and facility fees and the cost of medications and other supplies. Cost and distance go hand in hand as consideration in the decision making process, as longer distances entail higher costs (Thaddeus and

Maine, 1990). The additional costs include the need for efficient help to run homes and make daily trips to the healthcare facility to provide necessities for the new mother (Kakhar *et al.*, 1995). In this regard therefore, expectant mothers will use the maternal providers who are at close proximity to them.

According to Mubyazi, *et al.* (2010), costs of health services may be direct or indirect. Direct costs relate specifically to services such as diagnostics and treatment and the indirect costs may relate to transport, food and time in connection with health seeking actions. This is reinforced by Adamu and Silihu (2002) who observed that the prohibitive costs involved include transportation, registration fees, drugs, gloves, laboratory fees for a battery of antenatal care tests, syringes, cotton wool and, often soap and disinfectants. Occupation and distance are very important in the process of making decisions for maternal healthcare provision because they determine the affordability for healthcare services rendered and transportation costs incurred. Olungah (2007) has also underscored the importance of those accompanying the women to be accommodated, food expenses and other hidden costs that are distance determined.

### **2.3.3 Social support network in pregnancy**

An episode of illness in the Luo community is not traditionally an individual affair as Nyamwaya (1992) observed in the Pokot community. According to Nyamwaya, when an individual falls sick, a number of consultations at the lay level take place to determine what course of action is to be followed in dealing with the illness. The consultations take place amongst the relatives who make crucial choices for the kind of treatment or healers to approach. This group of people matter when it comes to decision making on the kind of maternal healthcare provider to approach when an expectant mother falls sick from pregnancy or any other related problems.

Olungah (2007) observes that in the Luo community, pregnant women are often not the decision makers regarding care seeking during pregnancy, birth or the post-partum period. On the contrary, the decision is made by a group of people who offer assistance and are the determinants of the care seeking patterns and well being of the pregnant woman. Janzen (1978) refers to this group as the ‘therapy managing group’ or important others and as ‘birth partners’ by the focused ANC approach advocated for by the WHO. These groups form a support network during pregnancy (Olungah, 2007). The network comprises the in-laws (mother-in-law, father-in-law, brother-in-law, sister-in-law), husbands/spouse/partner, co-wives, older children, servants, peers, neighbours, grandparents, parents, aunties and fellow siblings (common among the teenage pregnancies) and other relatives among others. According to Olungah (2007), the mentioned network not only provides the day-to-day comfort for the mother but also determines where and when she attends maternal healthcare, what she consumes and controls even the available information to her.

#### **2.3.4 Belief Systems Surrounding Pregnancy**

According to Simkhada, *et al.* (2007), the use of reproductive health services is mediated by cultural influences that shape the way individuals perceive their bodies, their health and available healthcare services. Barriers to accessing reproductive health services arising from restrictive cultural norms are among the factors commonly experienced by women, particularly in developing countries (Smith *et al.*, 2004). For instance, Mathole *et al.* (2004) reported the fear of accessing health services due to the fact that blood could be used for bewitching women if it came into the wrong hands, or that it would be tested for HIV and the result recorded on their ANC card in Zimbabwe.

Belief systems surrounding pregnancy often influence where an expectant mother chooses to have checks during pregnancy. Hahn and Muecke (1987) have called these belief systems “birth cultures”.

The birth culture of a particular society informs members about the nature of conception, the proper condition of procreation and childbearing, the workings of pregnancy and labour and the rules and rationale of pre and postnatal behaviour. In Chinese groups, women and their bodily fluids are regarded as dangerous and polluting for men, who therefore avoid the scene of birth and any contact with the woman for a month following the birth. Under this circumstance, female traditional birth attendants are preferred to the modern clinics. Nyamwaya (1992) agrees that belief systems influence the choice of therapeutic alternatives. Nyamwaya further observes that, in some societies, women do not like the idea of males attending to them during childbirth. Women prefer delivering babies under the supervision of traditional birth attendants because they are females.

In many cultures in the non-industrialized world, giving birth in the lithotomy or supine position favoured by western obstetrics is not common (Helman, 2001:121). Women stand, squat or sit reclining against something or someone in the latter stages of labour. In the second stage of labour, the midwife is often seated on the floor in front of the labouring woman (Mac Cormack, 1982 cited in Helman 2001:121). Most expectant mothers have trust in the services delivered by the traditional birth attendants who allow them to take the birthing position they want if it is not harmful to the expectant mother and the unborn. Such instance has also been noticed in Mexico where medical facilities for birthing were readily available but women preferred traditional birth attendants for assistance with their deliveries (Glantz and Halperim, 2000). For Glantz and Halperim the Mexican women favour traditional birth attendants because they allow them to choose birthing locations and birthing positions and also to have relatives present during the birth. This is in contrast to modern health clinic environs where midwives and obstetricians are harsh on their patients (UNICEF, 1995; Jewkes, 1998; London, 2005; Allen, 2002).

The lived experiences of women profoundly influence their responses to health, illness and life

challenges (Callister, 2005). In most communities, women have no power to make decisions on which maternal healthcare providers to approach in the event of any pregnancy related problems. Men in most cases decide for their women. For example, in Islamic societies, women in labour pain will hardly be taken to hospitals without an official permission from their husbands (Maine *et al.*, 1997:11) such, that when the husband is on a long journey, the woman is likely to suffer a great deal. Adamu and Salihu (2002) revealed that other important reasons cited for non-utilisation of antenatal services were God's will and the husband's permission. The expression, 'God's will' within the context of the Hausa culture, was of interest. They reported that the prevalent belief is that anything that is beyond one's reach, ability or power is explained in terms of one's helplessness and weakness before God. Thus, God's will, could also be interpreted as one's acceptance of one's destiny (Fienman and Jansen, 1992). This is in the same line with the Luo who majority are Christians and few are Muslims.

The fact that stoicism is valued and women gain respect when they suffer in silence in some communities is likely to complicate matters of maternal related problems as the members of the family may not be able to identify prolonged labour (Maine *et al.*, 1997). Health care seeking behaviour is strongly influenced by the characteristics of the illness as perceived by individuals. Despite being acknowledged as potentially risky, pregnancy, labour and delivery are commonly considered natural work for women. According to Olungah (2007), pregnancy in the Luo context is perceived as a normal condition that requires minimal intervention particularly from the point of view of medical care. In the same context, Khayundi (2000), stated that the Luo do not regard pregnancy as a pathological condition that requires close observation and assistance with the domestic work load. It is regarded as a normal condition. Such fatalistic views can lead to the perception that the condition is not amenable to treatment, and can thus act as effective barriers to a

timely decision to seek care (Thaddeus and Maine, 1990).

The Luo community believes that modern health providers cannot treat some pregnancy problems. Sindiga (1995:79) observes that the problem of abdominal pain during pregnancy (*tuo ich*), postpartum abdominal pain (*ojiwo*) and women infertility (*dhako maok nyuol*) cannot be treated in the modern hospitals. Women turn to the traditional birth attendants for medicinal remedies when faced by such related health problems rather than go to modern healthcare facilities (Okumu and Gachuki, 1996).

Foster (1976) observed that non-western medical systems possess two categories of disease causation, that is personalistic and naturalistic. Correlated with the personalistic category is the belief that disease is due to the active purposeful intervention of an agent who may be human or non-human. Diseases under this category include the uncommon conditions, which members of a community cannot comprehend. The diviners or traditional healers deal with such conditions. Under the natural category, diseases are believed to stem from natural forces and can be dealt with by the allopathic healthcare providers. This has a bearing on the choice expectant mothers make for maternal healthcare provision. When it is suspected that the problem of pregnancy is unusual and may stem from the hands of human or non-human sources, the expectant mother may seek an intervention of traditional healers or diviners. The natural pregnancy problem may be taken to the hospital.

According to Nangendo (2006), the Luo community strongly believes that it is a cultural impropriety for any Luo child to be born outside the father's homestead. He further observes that the blood of childbirth must be spilled within the homestead, the placenta must be buried at the homestead, and the mother and infant must be secluded. Cohen and Atieno-Odhiambo (1985) also observe that the placenta had to be handled with much care. The Luo feel, according to Nangendo, that if any of

these injunctions is violated, magical harm and misfortune from a supernatural source may result. This will force a mother to have her child delivered at home rather than in the hospital. Beliefs and practices in handling pregnancy are very vital on the choice for pregnancy healthcare provision. Nangendo (2006) sought to determine the influence of beliefs surrounding pregnancy on the choice of maternal healthcare providers and his insights will be used in the current study.

## **2.4 Perceptions towards Informal and Formal Maternal Healthcare**

Perceptions and attitudes towards maternal healthcare providers is a phenomenon that should be looked into in order to have a clear understanding of maternal healthcare seeking behaviour. Generally, people's perceptions and attitudes towards healthcare give policy makers an appropriate approach to be made in the process of safe motherhood initiative. Studies indicate that perceptions and attitudes expectant mothers have towards formal maternal healthcare services is more negative than positive (Nang'endo, 2006; Tsui *et al.*, 1997; Mulemi, 1998; Ouko, 1998). This explains why, formal maternal healthcare services lag far behind in most developing countries. According to Tsui *et al.* (1997), home births either alone or with someone from the community, remains a strong preference. This could be due to the positive attitude and perception expectant mothers have towards the informal maternal healthcare providers.

Tsui, *et al.* (1997) state that the decision to seek professional assistance for women suffering with complications is made even more complex by what is considered "appropriate care". Appropriateness depends on the perception of the interpreter as to the nature of the complication (physical versus spiritual) and of the seriousness of the condition. Perception should also be looked at in terms of the way complication presents itself. Excessive bleeding in a delivering mother is perceived to be out of the hands of the informal maternal healthcare providers. In this instance, the

bleeding mother has to be taken to a formal healthcare provider. In other communities in middle-East, it is believed that a complication like obstructed labour is caused by adultery during pregnancy (Tsui *et al.*, 1997), and that formal healthcare cannot deal with this problem. In such a case, an informal maternal healthcare is preferred, especially a diviner. The patient would be required to confess her sins to be relieved than to seek care from the formal healthcare system. In the same breadth, Omare (1999) observes that among the Abagusii, beliefs associated with infidelity are linked to miscarriage. Visiting a formal maternal healthcare provider may not solve this problem. It is perceived that an informal maternal healthcare provider can deal with the problem. The expectant mother should drink warm cattle blood and *amarongo/amanyasi* to prevent the occurrence of a miscarriage (Omare, 1999).

Informal maternal healthcare is better in Indonesia because it has been perceived when a mother is delivering, she is kept by forces during labour on the side of life that is linked to the home and the inner calm found there in (Ambaretnami *et al.*, 1993). This calm is perceived not to be found in the formal maternal healthcare facilities. The Indonesian women do not want to think about negative events or plan ahead for such which will disrupt their sense of inner calm. They instead plan for the best chance scenario, hoping that a complication will not arise. Should a complication arise during delivery with the traditional birth attendant, she may or may not be referred, depending on whether the attendant believes the woman will accept referral (Ambaretnami *et al.*, 1993). According to Tsui *et al.*, (1997:36), Bolivian women perceive the home to provide privacy, no strangers to look, laugh, and touch the woman. A Bolivian woman said:

“At home it is private you don’t pay anything.....They don’t understand us well in the hospital; besides, my friends tell me that they touch everything-our-genitals and also there’s a lot of men health staff.” (Tsui *et al.*, 1997:36)

Although the complications of delivery that can kill may be recognized by Bolivian women, they are

not considered amenable to medical intervention. Locally, recognized causes of maternal death include *arrebato*, a disease caused by failing to bind the woman's head, and the rising up of the *magre*, an organ formed behind the naval during pregnancy that should be 'lowered' during childbirth with the womb, baby placenta and blood. There is no organ equivalent in biomedical anatomy, but the fear of the *magre* rising is so great that women bind their abdomen to keep it down. To prevent this complication, Bolivian women not only bind their bellies but also wrap their heads, drink tea and other home preparations, and massage bellies both to apply heat and to assure the proper position of the baby. Few women believed that these problems could be prevented by going to the prenatal care and to the hospital for delivery.

The "secret of pregnancy", feeling of shame, and the uncertainty about the outcome of the pregnancy are so strong among the Fulani and Hausa in Nigeria that no preparations are made concerning labour and delivery by women and their husbands. The home is the natural place for delivery, more familiar and less threatening than a medical facility, and does not expose one to shame. Little or no assistance is sought by these women during delivery even in formal maternal healthcare (Ambaretnami *et al.*, 1993).

The postpartum period, described most often by women as non-life-threatening, is generally filled with traditions and taboos. Many are harmless or beneficial, but some can interfere with the use of valuable postpartum services. Women in Indonesia are prohibited from leaving their homes for 40 days, so they do not seek postpartum care from a formal healthcare provider unless the situation becomes very grave (Ambaretnami *et al.*, 1993). Ambaretnami *et al.* (1993) state that Nigerian women normally go through a period of hot baths or massage with hot napkin after delivery to rid the body of blood that has coagulated inside the woman during delivery. The Yoruba believe that failure to observe the hot bath period (7-40 days) has dire consequences of swelling and smelly

vaginal discharge, which formal maternal healthcare providers can hardly make any beneficial help. Similarly, the Luo see informal maternal healthcare as capable of dealing with complications attributed to the spirits (Luke, 2000), that formal maternal healthcare providers cannot solve.

## **2.5 Theoretical Framework**

The Disease Explanatory Model (D.E.M.) proposed by Kleinman (1980) guided this study. The model recognizes three sectors of healthcare; popular, folk and professional (Fig 1). In the popular sector, treatment is based on shared cultural understandings and is provided by non-specialists, like oneself, one's mother/grandmother, one's friends, or other kin and relations. Folk sector healers are specialists whose practice is based on traditional methods and philosophies. Legally sanctioned modern healthcare makes up the professional sector with physicians trained in western medicine.

According to Kleinman (1980), each sector has its own ways of explaining and treating ill health, defining who the healer is and who is the patient, and specifies how healer and patient should interact in their therapeutic encounter. The maternal healthcare providers exist in three categories. The first category consists of the family members, friends and neighbours. The second category comprises traditional birth attendants, specialists in traditional medicine that can treat pregnancy complications and the last category consists of government hospitals, mission hospitals and private clinics. The provision of pregnancy healthcare in most cases begins within the sphere of family members, friends or neighbours or even church members, where the maternal pregnancy related problem is recognized. This forms part of the popular sector, which includes a set of beliefs about pregnancy health maintenance such as series of guidelines, which are specific to each cultural group, about the correct behaviour for preventing the occurrence of maternal problems (Omare, 1999).

Chrisman (1977) observes that most healthcare services in the popular sector take place between people already linked to one another by ties of kinship, friendship, neighbourhood or membership of work or religious organizations. Both patient and healer share similar assumptions about health and illness, misunderstandings between the two are rare. When the provision of maternal healthcare to expectant mothers turns out to be unbearable to the members of the family, friends, neighbours, they call for assistance from traditional experts. These are traditional birth attendants and persons specialized in traditional medicines and spiritual healers. Expectant mothers can as well seek care from the biomedical sphere depending on the availability, cost and accessibility of the healthcare facilities and the condition of the problem. This forms part of the professional sector that comprises the legally sanctioned healing professions such as modern western scientific medicine also known as allopathic (Helman, 2001). Most healthcares take place within the popular sector.

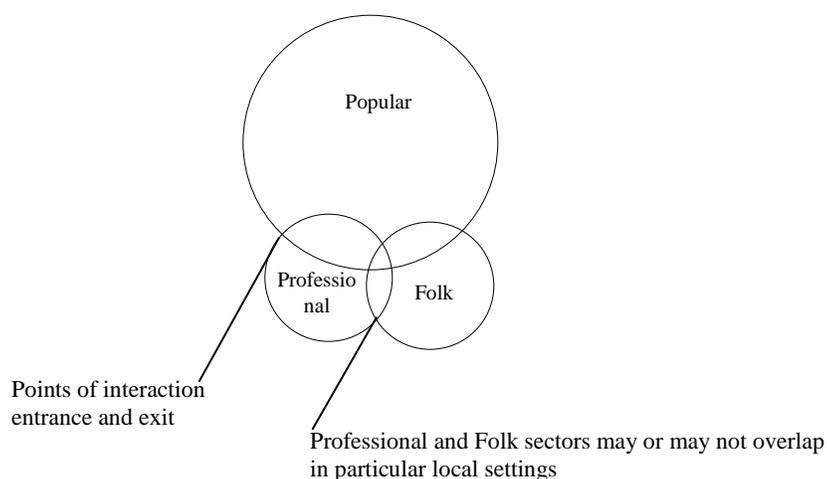


Figure 1: Three sectors of healthcare. Source: (Kleinman, 1980)

### **2.4.1 Relevance of the theory to this study**

This model is relevant to this study in that the process of dealing with pregnancy problems in most societies revolve around the three sectors of health care. It starts from the popular sector, where the family members and friends offer solution to pregnancy related problems in the form of pieces of advice relating to pregnancy, then to traditional therapies and finally to biomedical options. Sometimes, it could start with traditional to biomedical or from biomedical to the traditional. All these three categories have roles they play in dealing with pregnancy related problems, depending on their proximity (immediate availability), costs, cultural, convenience among others.

This theory was used by Ndobi (1997) to explain health care seeking behaviour in the utilization of modern medical facilities in the Saboti Division of Transzoia District in Kenya. Just like any other theory the Disease Explanatory Model (D.E.M) has its strengths and weaknesses. The strength being that it has proved useful in explaining the maternal healthcare seeking patterns. The results of the study reveal that maternal healthcare providers exist in the folk, professional and popular sectors. The desirability of each is dependent on the interpretation and perception of the problem in question, the availability and accessibility of the healthcare provider as well as the attitude of the patient and her team towards the said providers. Other determinants include affordability and cultural factors.

In terms of the utilization pattern, it was noticed that expectant mothers used the existing maternal healthcare providers interchangeably. If she failed to succeed in one, she moved on to the other or even used all of them simultaneously. The flexibility of choices is a desirable quality of the model.

The weakness of this model is that the terms chosen are problematic (Laustaunau and Sobo, 1997). According to Laustaunau and Sobo (1997), the notions of a distinct health system and of professionalization are somewhat culture-bound. It is relevant to the current organization of the

health systems in the developed nations; however, its relevance is hindered by the fact that the scheme has only three parts. These two scholars argue that there are many different types of healers in our folk and professional sectors and a more elaborate scheme may be necessary if the internal workings of these systems are fully understood. Singer (1995) has criticized Kleinman's use of the (E.M) approach for ignoring power relations between social groups and between classes. This critique is taken into consideration in analyzing the data reported here.

## **2.5 Assumptions**

1. Various maternal healthcare providers are available for expectant mothers.
2. The use of maternal healthcare providers depends upon various determinants.
3. Expectant mothers in the local community have positive perceptions towards both the informal and formal maternal healthcare providers.

## **CHAPTER THREE: METHODOLOGY**

### **3.1 Introduction**

This chapter describes the research site, population composition and study design. It also describes the sampling strategy and sample size, as well as methods and instruments of data collection and how the data was processed and finally analysed. It also reflects on the problems encountered.

### **3.2 Research Site**

#### **3.2.1 Location**

Nyang'oma sub location is located in Bondo District, Nyanza province. The district was carved out of the original Siaya District in May 1998. The total area of Bondo District is 1, 972 km<sup>2</sup> of which 972 km<sup>2</sup> is land surface, while 1000km<sup>2</sup> is covered with the waters of Lake Victoria, the second largest fresh water lake in the world. The district lies between latitude 0<sup>0</sup> and 30<sup>0</sup> south of equator and longitude 30<sup>0</sup> and 34<sup>0</sup> east. It borders Siaya and Busia Districts to the northwest, Kisumu District to the east and Rachuonyo, Homabay and Suba Districts across the lake on the southeast and south respectively. To the west lies the republic of Uganda (GOK, 2008).

#### **3.2.2 Physiographic and Natural Conditions**

The major physical feature in the district is Lake Victoria, which runs from the part of Kisumu in the east to the border of Busia in the northwest. Along its border with Siaya District, runs the River Yala, entering Lake Victoria through the Yala swamp. At the border with the lake lies the Uyoma Peninsula. The district has few scattered hills namely Usenge, Ramogi in Usigu Division, Rambugu in Rarieda Division, Abiero and Sirafuongo Hills in Nyang'oma division and Naya in Madiany Division (GOK, 2008).

The altitude of the district rises from 1,140 metres to 1,350 metres above sea level on the shores of Lake Victoria in the south and southwest and to the north and east. The physical features have a bearing on the district development potential. Areas with higher altitude have higher rainfall and are therefore suitable for agriculture and livestock production. Lake Victoria and Yala swamp have great potential for irrigation, water development and fishing activities. The soils are mainly laterite with a low water retention capacity (GOK, 2008).

### **3.1.3 Infrastructure**

The road network in Bondo District is still poor. The district has only 45.8 km of tarmac roads out of a total of 544.4 km. The other 498.6-km of roads are either gravel or earth and in some areas impassable during rainy seasons (GOK, 2002). Nyang'oma sub location has very poor infrastructure with roads that is making transportation difficult. There are impassable narrow roads barring the movement of vehicles to interior places. Also making the roads impassable are thick thickets growing all over the area. The rough terrain in the area may be too hostile to comfortably transport an expectant mother to a health facility. Since there are no enough vehicles, the community heavily relies on motorcycles and bicycles as means of transportation. It becomes a big challenge to transport a mother in labour by these means of transport given the fact that the roads are also hilly. Olungah (2007) observes that a woman would be called upon to do much of the walking after paying dearly for the transportation cost. The area also lacks electricity.

### **3.1.2 Socio-economic activities**

Residents grow crops such as maize, beans, cassava and sorghum for subsistence and for sale to small-scale business people in the area. They also engage in small-scale gold mining and fishing to supplement their diet and for commercial purposes. Other commercial activities within the study

area include trading in mining and fishing products as well as bicycle transportation(boda boda) (Nyambedha, 2000).

The farmers here rear livestock such as cattle, sheep, goats, and donkeys. Donkeys are used to carry luggage and water while goats, sheep and cattle are used as food for they provide meat and milk used by the people. Cattle dung is used to smear houses and also in their farms as manure. The people can sell their livestock to get money for use when need arises. The people also rear chicken (Nyambedha, 2000). Fishing is a major activity from the various water masses mainly, Lake Victoria. The district has twenty-eight gazetted fish landing beaches, which have great potential for production of popular fish species such as the Nile perch, Tilapia, and “*Omena*” (daga). Beaches are also a hub of business activities and a meeting place for all sorts of transactions (Olungah, 2007). Formal employment opportunities in the study area are found in the neighbouring boarding schools and the local catholic mission (Nyambedha, 2000; Olungah, 2007).

### **3.1.5 Health Infrastructure**

The area has a very poor coverage of biomedical health facilities. Among the health facilities within the Nyang’oma Division are the Nyan’goma Mission Dispensary, Nango, Ouya, Anyuongi and Nyagudi government dispensaries. There are also minor maternal and child health clinics operated by private providers in the semi-urban settlements within the fish landing beaches such as Wagusu, Uyawu, Nyamnwa and Sirongo among others (Olungah, 2007). There is a Catholic Missionary hospital that is quite good, but is considered too expensive for pregnant women to afford using it. The only good government hospital is the Bondo District hospital, which is situated 12 kilometers away from the Nyang’oma Sub Location residence. Muga (2004) observes that traditional birth attendants (TBAs) are preferred in this area because they always live with them and their mode of

payment is flexible.

### **3.1.6 Population size and composition**

The majority of the inhabitants of Nyan'goma are Luo. According to the 1999 population and housing census, Bondo District in which Nyang'oma falls had a total population of 238,780 (CBS, 2001). The NCPD/CBS survey indicates that 81% of the population lives in the rural areas (NCPD/CBS, 1999:10). The women in the fertility age group (15-49) were 54, 828 in 1999 (GOK, 2008).

## **3.2 Study Design**

This study was a small scale descriptive research concerned with maternal healthcare provision. Fieldwork was conducted between August 2007 and November 2007 using a survey questionnaire, key informant interviews and focus group discussions (see appendices 1, 2.1, 2.2, 2.3 and 3). A notebook and a tape recorder were used to record the discussions that were later transcribed.

The research explored the maternal healthcare providers in the study area and determinants for their use. Perceptions and attitudes towards both informal and formal maternal healthcare providers were also examined. The exploration aimed at having a clear understanding of the existing maternal healthcare providers in the popular, folk and professional sectors and to know the determinants for their use. The researcher enlisted the assistance of an experienced research assistant in the Kenya Danish Health Research Project (KEDHR) to collect data.

Maternal healthcare providers in the professional sector were contacted to assist in locating mothers with children below eight months as they went to attend Post-natal care (PNC). The researcher first recruited a few respondents from the Uyawi health centre and later enlisted their assistance to locate

others. Finally, the researcher got 100 mothers who took part in the community survey. The known traditional birth attendants were also enlisted to identify both trained and untrained traditional birth attendants.

### **3.3 Population**

The population of the study comprises all mothers of child bearing age and maternal healthcare providers in Nyangoma sub location of Bondo district.

#### **3.3.1 Unit of analysis**

A single mother of child bearing age constituted the unit of analysis.

### **3.4 Sampling**

The study employed the simple random, purposive and snowball sampling techniques. At the beginning, there was exit recruitment of 12 mothers who brought their children for PNC at Uyawi Health centre and 8 mothers who brought their children for PNC at Nyangoma Catholic mission hospital. Through them, another group of 80 mothers were selected using the snowball sampling technique to arrive at the 100 respondents who took part in the survey. Purposive sampling technique was used to arrive at the healthcare providers in the professional, folk and the popular sectors who were involved in key informant interviews. Four nurses, two from Uyawi dispensary and two from Nyan'goma Catholic mission hospital were interviewed. Maternal healthcare providers in the popular sector including one retired nurse and two other mothers who admitted having assisted expectant mothers were also interviewed. Three faith healers and two traditional birth attendants falling in the folk sector were sampled.

### **3.5 Methods of Data Collection**

The research adopted both qualitative and quantitative techniques of data collection. Emphasis was laid on the qualitative method of data collection.

#### **3.5.1 Secondary data sources**

The study utilized secondary data sources. Documentary materials such as journals, books, articles and the internet were explored for information with regard to maternal health issues in Kenya, their challenges and determinants for maternal health provider choices.

#### **3.5.2 Survey questionnaire**

Structured questionnaires which were filled by the respondents were issued during the study period. To allow for quantification and qualification of the data collected, the questions in the questionnaires were both open and closed ended (Bernard, 1995). A total of 100 structured interviews were conducted to women with children below eight months using this tool (Appendix 1). The questionnaires yielded information on the demographic characteristics of the respondents, their knowledge and awareness of the maternal healthcare care providers in their area and determinants such as the occupation, distance to healthcare provider, the belief surrounding pregnancy and social support system in maternal healthcare seeking behavior in the study area. The questionnaire was also used to get information on where the expectant mothers seek help when faced with pregnancy problem and the perception and attitude they have towards both formal and informal maternal healthcare providers.

#### **3.5.4 Key informant interviews**

Key informants are people believed to be knowledgeable on the topic under investigation (Bernard,

1995). In depth interview were carried out with key informants who included: two nurses from Nyang'oma Catholic Mission Hospital and Uyawi health center (Appendix 2.2), two traditional birth attendants from Ugue 'A' and Kachola village (Appendix 2.1), one retired midwife from Muamu village and one mature old mother from Ugue 'B' (Appendix 2.3). These key informants were purposively selected on the basis of their positions and knowledge in maternal health issues. They were important in giving insights into the role played by the maternal healthcare providers in dealing with the problems of pregnancy, healthcare seeking behavior in pregnancy and healthcare delivery. Issues of cultural practices in the community in relation to pregnancy, the accepted healthcare provider to deal with specific problems of pregnancy, the determinants for the use of maternal healthcare provider and the perception the community members have towards both formal and informal maternal healthcare providers.

### **3.5.3 Focus Group Discussions**

Focus group discussion is a special type of group interview in which a small group discusses ideas, information freely and spontaneously among themselves guided by a moderator (Bernard, 1995). Three separate Focus Group Discussions were held with participants as follows: 8 participants consisting of young mothers between ages 15 – 30 from Ugue 'A' village, 11 participants consisting of mothers between ages 31 – 45 from Muamu village, 9 participants consisting of old mature mothers who had long experience with births from Ugue 'B' village. One research assistant facilitated each focus group and the proceedings were tape recorded and later transcribed. The researcher took notes during all the focus group discussion. The discussions provided rich qualitative information on perceptions and attitudes of the community members towards both formal and informal maternal healthcare providers and determinants for the use of maternal healthcare providers in the area. An interview guide for Focus Group Discussion (Appendix 3) with set of

instructions was used. This exercise assisted in the verification of information obtained from the structured survey questionnaires.

### **3.6 Data Analysis**

Data was analyzed using both qualitative and quantitative methods. The results of community survey were coded and simple frequency tables generated to summarize the information using Microsoft Excel. Qualitative data was analyzed thematically along the lines of set objectives. This involved reading and reviewing field notes after the process of transcription. Key quotations from the data using informants' own words were incorporated to illustrate the main ideas and to give a detailed picture of the existing maternal healthcare providers in the area, determinants for their use and consequences of the perceptions and attitudes towards both informal and formal maternal healthcare providers.

### **3.7 Problems Encountered and Their Solutions**

The study area was highly malaria endemic. The researcher got ill with malaria and stomach-ache. This was solved by contacting health personnel in the Nyan'goma Catholic Mission Hospital. One of the respondents also fell sick in the process of data gathering. A bicycle that the researcher used to reach them was used to take her to Uyawi dispensary for treatment. There was also a problem of traveling to far places as some villages like Muamu and Ugue 'A' were very far from the KEDAHR (Kenya Danish Health Research Project) office. The use of bicycles in the research site solved this problem.

### **3.8 Ethical Issues**

The research was conducted with the approval of the Institute of Anthropology, Gender and African

Studies, University of Nairobi. The research permit had earlier been granted under the auspices of KEDAHR and the office is located at the Nyan'goma Catholic Mission. This research was conducted after the subjects were informed of its purpose and nature. They were also informed of their importance in taking part in the study. The reason for selecting the few to take part in the study was also explained to them.

The researcher clarified to the subjects that their involvement in the study was out of their willingness and that anybody was free to withdraw at any time. They were also assured of confidentiality and that pseudonyms would be used to protect their identity. The participants were asked for permission to take notes and to record their conversation using a tape recorder. Information gathered about a particular respondent was also preserved only for the purpose of research. The subjects who took part in the study were acknowledged for the time they dedicated for the study. They were also assured that the findings would be published and feedback shared amongst them for their own interpretation and consumption.

## CHAPTER FOUR: RESULTS PRESENTATION

### 4.1 Introduction

This chapter reports on the findings of the study. It describes demographic information, the maternal healthcare providers in Nyang'oma Sub-Location, determinants for their uses and perceptions and attitudes towards both informal and formal maternal healthcare providers.

### 4.2 Demographic Information

Table 4.1 below shows the level of education of respondents in the community survey.

**Table 4.1: Level of Formal Education of respondents against maternal healthcare providers choices**  
N=100

Level of education	Maternal healthcare choices				Frequency	
	Professional	Popular	Folk	All providers	Total	%
College/University	-	-	-	-	-	-
Secondary	5	2	5	5	17	17
Upper primary	15	20	26	17	78	78
Lower primary	-	1	1	1	3	3
No formal education	-	1	1	-	2	2
<b>Total</b>	20	24	33	23	<b>100</b>	<b>100</b>

Source: Primary data, community survey

Amongst the respondents who took part in the study, only 17% had attained secondary level of education. The majority (78%) had acquired upper primary level while 3% had acquired lower primary level of education. Some 2% of the respondents had no formal education. The table above shows that no respondent had attained college or university level of education.

It is expected that education should change the individual's mind from using traditional healers. However, the study established that some mothers (5%) who had attained secondary school

education used the services of traditional maternal healthcare providers. For instance, one 35 year old respondent from Muamu village, who had attained secondary school education gave the following information concerning education and her healthcare choices:

“I have gone to school to the level that I am now teaching pre-primary school pupils. I use the services of traditional healers whenever I develop any maternal health problem because they are usually living with us. However, when the condition of a pregnancy requires a modern healthcare provider like caesarian section, I must just use that to survive.” **(Key informant interview)**.

The foregoing revelation suggests that as much as education is expected to draw people’s attention from traditions, it should be seen as an avenue of freedom enabling an effective choice of the available therapeutic options. It opens the mind of people to freely try other kinds of healthcare when one fails. The respondents conceded that, unlike in the past when one was bound to follow the demands of culture strictly, formal education has enlightened them on innumerable alternatives so that they are able to select things that work from those that don’t. They had a view that a strong decision making process is developed on the basis of an informed insight, an intellect acquired from formal schooling. Formal education also empowers the local people to demand that traditional birth attendants use new razor blades to cut the umbilical cords, unlike in the past when blunt and unsterilized objects were invariably employed.

An interview with a 34 year old informant from Ugue A who has attained secondary school level, on the influence of formal education in maternal healthcare providers’ choices, had the following to say:

“Formal education has enabled me have an independent mind on the kind of maternal healthcare to approach. Though we are advised to use the conventional maternal healthcare, sometimes, the facility is far and one can decide to use any other maternal health provider. When I am attended by a traditional birth attendant I insist she wears a glove and use a new razor blade to cut the umbilical cord.” **(Key informant)**

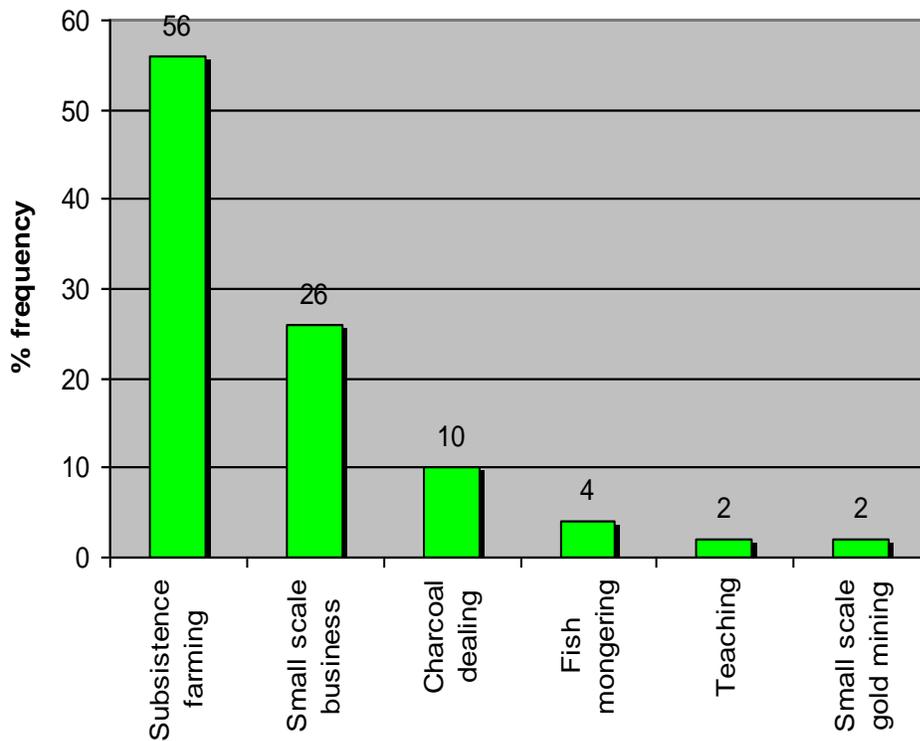


Fig. 2: Respondents' Occupation, Source: Primary data (Community survey)

Figure 2 above shows that the majority (56%) of respondents were subsistence farmers, accounting for more than half of the sample size. Small-scale business accounted for 26% of the respondents, followed by charcoal dealing (10%) fish-mongering (4%) and lastly, teaching and small scale gold mining accounted for (2%) each. The subsistence farmers majorly depend on produce they obtain from their small gardens such as maize, millet, cassava, beans, vegetables and produce from cattle that they keep such as milk and meat. They live a bit far from the lake and in most cases they sell their produce to Lake People who spend most of their time fishing in the lake. They also keep goats and sheep. Besides, they rear chicken that they may sell for money. The subsistence farmers reported that they get an average of Ksh.1, 500 per month.

The small scale business persons own small shops in which they sell items such as sugar, salt, soaps, paraffin and other essential commodities. Some sell second hand clothes, and a few (three) own chemists. Others own food kioks where they sell porridge and tea amongst others. There are others who sell a variety of fish locally known as *omena* (Dagaa), *tede* (small Nile perch), *fulu* (Aplocromis) and others that they have purchased from the fish mongers at both Nango Market and Nyang'oma Trading Centre.

Towards Sirafuong'o, the inhabitants take advantage of the bushes that grow in the field and burn charcoal to compliment their means of livelihood beside other economic activities. Most of the inhabitants of Nyang'oma live below the poverty line. Consequently, they would prefer the services at their close proximity usually given by traditional birth attendants, traditional healers and retired nurses/midwives who assist them at home at lower charges or no fees. Concerning the cost of healthcare at the health facility, Auma (aged 34 with three children) said:

“You need roughly Ksh. 1,500 or more to cater for transport and hospital bills when you deliver and sleep in a health centre for one day. This is for government healthcare facility (Uyawi health center). For Nyang'oma Catholic Mission one may spend up to about Ksh. 2,500 for overnight admission. In that case, I can only go to maternal healthcare providers who I can only pay a chicken or some tins of maize or promise to pay her later after helping me successfully.” **(Focus Group Discussion)**

### **4.3 Maternal Healthcare Provision in Nyangoma Sub-Location**

The maternal health care providers in the study area have been identified and described under the three health care sectors, namely: popular, professional and folk.

#### **4.3.1 Professional Maternal Healthcare Providers**

The major maternal healthcare facilities in Nyang'oma sub-location where expectant mothers seek

healthcare services include Uyawi Health Centre and Nyang'oma Catholic Mission Hospital. Whereas the Uyawi Health Centre is owned by the government, Nyang'oma Catholic Mission Hospital is privately owned by the missionaries. Uyawi Health Centre is situated at Nango Trading Centre and Nyang'oma is situated at the Nyang'oma Mission Centre.

Other maternal healthcare facilities are Oyamo Dispensary situated at Oyamo Island, Nyagudi Dispensary situated at Nyagudi trading centre and Anyuongi Dispensary situated at Anyuongi trading centre. The three mentioned dispensaries usually have one nurse each who provides maternal healthcare services to mothers. The respondents reported that they lack equipment for maternal health. Besides, they rarely have drugs that can be given to the sick. The respondents said that they rarely use these dispensaries. Instead, they may use either Uyawi Health Centre or Nysang'oma Catholic Mission Hospital. There are two nurses at Uyawi Health Centre. One of the nurses is in charge of maternal healthcare. The other nurse is in charge of general treatment. There are inadequate maternal health facilities and qualified personnel in maternal issues. Serious maternal health problems are referred to Bondo District Hospital, which is about 17 kilometers from the health centre. There is no hospital van or vehicle that can transport expectant mothers with serious maternal complications to the district hospital. In most cases, relatives of expectant mothers rely on public vehicles, which pass by Nango market centre. In some situations, mothers are transported by bicycles to the District Hospital in Bondo.

The study established that the modern health facilities which are available in the community are being underutilized by the expectant mothers in the study area. Under a normal delivery, expectant mothers just deliver at home alone or assisted by either a grandmother or a traditional birth attendant. An in-depth interview with the nurse in charge of maternal healthcare at Uyawi Health

Centre concerning the use of the facility yielded the following:

“Few expectant mothers in the area use the facility. They come for the first antenatal visit when they are 24 weeks pregnant. When the time for delivery comes, they disappear. However, when they develop complications such as obstructed labour during delivery, they have no choice rather than coming to ask for our assistance. However, there are cases we cannot handle as we lack equipment required for them” (**Key informant**).

There are also Community Health Workers (CHWs) who deliver basic healthcare and act as intermediaries between the lay people in the community and the nurses at the Uyawi Health Centre. They advise the patients who have gone to the health centre on the requirements for treatment, such as need to carry an exercise book where the clinical officer prescribes the medicine and registration fees among others. The CHWs also give drugs and inject patients where necessary. Usually, they obtain drugs, syringes and needles from chemists that are located in the trading centers. They treat common ailments such as malaria, stomach-ache, among others. Besides the CHWs, there are also Traditional Birth Attendants (TBAs) who were trained in basic skills of managing minor maternal health problems. They assist mothers in normal deliveries especially when the nurse in charge is absent.

#### **4.3.2 Maternal Healthcare Providers in the Folk Sector**

The study found out that there were informally trained traditional birth attendants who assist expectant mothers with delivery or in cases of abdominal pain at home in Nyang’oma Sub-Location. The expectant mothers reported that they prefer their services because they are caring and loving. The TBAs reported that they attained the knowledge of handling pregnancy from their grandmothers. They also said that they had stayed in their field as maternal healthcare providers for quite a long time; even before the era of modern maternal healthcare, they successfully assisted mothers with delivery and are referred to as “*Jocholo*” in the local language. An in-depth interview

with one TBA concerning services rendered to expectant mothers yielded the following information:

"Since there is a hospital here, poor pregnant woman who goes to the hospital will be asked for money, but she does not have. Such people come to me for assistance. I usually help them, by massaging their abdomen. When a pregnant woman is in labour, I give her labour medicine (*yadh muoch*) to reduce the pain. After delivering her baby, I cut the umbilical cord and give her a calabash of warm porridge to replenish the energy used during delivery" (**Key informant**).

Besides the traditional birth attendants, there are local healers who are specialists in herbal medicine that is believed to cure certain diseases such as '*sigete*' '*rariu*' '*yamo*' and '*kisoni*' among others. The community believes that a young or middle aged woman with '*sigete*' feels terrible pain, especially when she is experiencing her monthly periods. It is also believed that this condition also prevents women from conceiving. There is no exact cause for this disease. Another disease is '*rariu*', a condition that results in abdominal pain without preventing conception. *Rariu* is believed to cause disturbing pain to an expectant mother. The community believes that such conditions can be addressed by herbalists.

The local people further believe that two diseases '*rariu*' and '*sigete*' can be transferred from one mother to another when she unknowingly passes the place where the sick mother has poured water that she has used for bathing. For this reason, young mothers or mature girls are not supposed to walk aimlessly especially at dawn and at dusk. They are warned against going to draw water from the river or boreholes at odd hours, lest they unknowingly pass a 'bad thing' on the way. This is given as a precautionary preventive measure against certain maternal diseases. During an FGD at Ugue 'B' village, one of the discussants aged 24 with one child of 10 months narrated how she developed '*sigete*':

"My grandmother warned me against going to draw water during dusk from the well but I used to differ with her. She used to tell me about some mothers with bad intentions bathing in water and pouring on the way for people to pass as a way of transferring '*sigete*' to others. I used never to believe that. I had not also experienced the wrath of the disease.

When I got married, I bore one child. I just used to go to fetch water during dusk. One day, I passed water that was poured on the way when I was from the well. I got shocked since I never passed it on my way to the well. Since then, I developed a problem of '*sigete*' that treating is difficult. Although at the moment, my mother-in-law has been giving me traditional herbs that I usually take. Soon, I believe I will get out of this problem".

**(Focus Group Discussion)**

It was reported by the mothers in the focus group discussion, conducted in Muamu village, that '*yamo* and '*mbunda* are far more troublesome, affecting both the mother and her unborn child in the womb. These diseases result in poor health on the side of the mother and the baby. The discussants believed that these diseases cannot be treated by the biomedical health practitioners, but are better handled by traditional healers. As a result, the expectant mother with this kind of problem will seek the assistance of a traditional healer. Mary, a 26 years old mother of four children had the following to say about her experience with the conditions:

"Whenever I am pregnant, I usually develop problems, whose cause I don't understand. I think these problems are caused by '*yamo* and '*mbunda*". When I give birth to a child, the child falls sick most of its lifetime and eventually dies before reaching its third birthday. I used to go to the hospital to be given drugs before I knew that '*mbunda*' was the source of my health problem when I am pregnant. As the drugs were not having any impact on my health, I decided to sit at home. Then my mother-in-law brought a traditional healer who gave me some herbs. I drunk some and bathed in them. Since then, I have not experienced the problem again" **(Focus Group Discussion).**

The discussants noted that '*yembe*'/'*mbuda*' are treated using traditional herbs. Expectant mothers often use '*yadh agulu*' (pot drug) to clean their wombs as well as the foetus. Although, most people in the community know the drugs to use for maternal problems, administering them is done by only a few who have knowledge of their efficacy. There are diseases that must just be attended to by these specialists. Such diseases are like '*kisoni*' (a condition resulting to a mother often losing her child). The herbalists are referred to as '*joyath*' (medicine men/women).

In the view of informants (mothers-in-law), in the case of a disease that a local '*jayadh*' cannot

address, they can call one from outside the community. For example, a problem of a *'jakisoni'* (a woman who gives birth and her children die often) can be treated by such experts. It is believed that *jogunda'* (evil spirits) are behind the deaths of the children. These *'jogunda'*, spirits of the dead who never had children when they were alive, are not happy to see some mothers have children. For this reason, they claim them back. *'Jogunda'* can follow the new mother up to her new home and cause the death of her children. Such *jogunda* are referred to as *jogunda ma kadayo* (maternal evil spirits) and are considered to be notorious. Those that are found in the new home are referred to as *jogunda ma kakwaro* (paternal evil spirits). When both *'jogunda'* combine they can be a severe deterrent to the family's happiness and future.

In one instance, a mother-in-law explained that in situations where a woman loses a child quite often, something must be wrong and needs to be treated in a traditional way. A traditional healer must be invited to administer herbs to send away the evil spirits that cause deaths of these children. The mother-in-law reported that there is a special way of handling this woman when pregnant. She must not give birth to her child anywhere a part from in her house. The after birth of this mother must be handled with great care as they wait for a traditional healer to perform a special ritual to it; then it is buried as per the specialists' instructions. There is a special goat locally referred to as *'diend kisoni'* that is slaughtered for the healer on the very day when he/she comes to administer rituals to spell away the evils.

Faith healers or spiritual healers are also found in the sub-location and abound in different denominations. These faith healers are more pronounced in the African Traditional Churches (ATC). Such churches include the 'Legion Maria' church, which is at Nango trading centre, *'Luong Mogik'* (God's Last Appeal Church) which is in Ugue 'A' village and *'Roho'* (Holy Ghost Trinity Church)

which is in Muama and Kachola villages. There are special mothers who pray for and massage the expectant mothers. They use special oil known as ‘deepak’ (oil that is bought from a shop and is believed to have healing effects to expectant mothers) for massage.

In the Legion Maria Church, the ‘mother’ is locally referred to as ‘*Kathorina*’ (a ‘mother’ who prepares medicine for the patients) in the church. In *Luong Mogik* and *Roho*, the mothers are referred to as *lakteche*. It is believed that they can also pray for a barren woman to have a baby. Not only do barren women seek their assistance but also expectant mothers go to them for help when faced with problems such as abdominal pain and when experiencing labour pains.

According to the followers of these denominations, these ‘mothers’ have been called by God and filled with the power of the Holy Spirit to help expectant mothers with problems. Through the power of the Holy Spirit, they can foresee and foretell problems lying a head. They are not only able to tell whether the baby in the womb is a baby boy or a baby girl but can also dispel *nawi* (magic) that are believed to cause maternal diseases. For these reasons, expectant mothers have strong faith in them. One of the ‘mothers’ in the *Luong Mogik* (God’s Last appeal) Church was interviewed about the services they provide to expectant mothers and she had the following to say:

“I strongly believe that giving birth safely is God’s plan. He does not want anybody to suffer because he is a loving God. People just suffer out of their ignorance about God. I got God’s call when I had a problem with my second birth. There was nobody who could assist me at that time. Some mothers were just passing by my house and they heard me writhing in pain. They came and prayed for me and the birth turned out to be successful. Since then, I was instructed in a dream to assist expectant mothers. Many expectant mothers come to me for assistance. I pray, massage them with ‘deepak’ as per God’s instructions”  
**(Key informant).**

The ‘mother’ in the Legion Maria had the following to say regarding the services she renders to

expectant mothers who approach her for help:

“Somebody’s faith is vital for healing process. The expectant mothers who come for assistance from me must have strong faith that everything is possible through the able hands of God. I do not just help expectant mothers with maternal related problems but I also pray for the barren to have babies. I massage the expectant mother with ‘deepak’ as I pray for her. They have been helped through my prayers for those with strong faith. There was another expectant mother I delivered her baby. So I also assist with delivering babies under normal deliveries. I also give these mothers *kathorina’s* drug (water boiled in a special way) to drink to fight any disease that they can develop when pregnant”

**(Key informant).**

An interview with a mother in *Roho* (Holy Trinity Church) regarding the services she gives to expectant mothers yielded the following:

“I assist expectant mothers with abdominal pain and barren mothers. I also help mothers with delivering their babies. I usually pray for them and massage them using ‘deepak’. I also give them holy water (*pi hawi*) that I have prepared in a special way and have been blessed by God to drink. I do deliver mothers under normal circumstances” **(Key informant).**

### **4.3.3 Maternal Healthcare Providers in the Popular Sector**

The study found out that most maternal health problems are first identified within oneself and self medication done by the expectant mother. Expectant mothers, who may not be sure of the remedy to their health problems, usually consult with the closest person to them. These are notably grandmothers, mothers-in-law. Here, a transfer of pieces of advice about the experience one has had with the current problem takes place. The solution is then sought in accordance with their own understanding and interpretation regarding the causes of the particular health problem. This is always the case when the problem surpasses an individual. In fact, attempts are made to seek solutions from the immediate family members and extended family members who interpret the cause of pregnancy problem. Both close and extended relatives as well as friends and neighbours often come in to assist the expectant mother out of the health problem in question. Some mothers reported that when they had problems during pregnancy especially abdominal pain, they would ask

their grandmothers to massage them and eventually they got better.

In the popular sector, pot drugs locally known as '*yadh agulu*' is also prepared by grandmother, oneself or mothers-in-law and taken by expectant mothers to dispel '*yamo*', a condition that results in the birth of unhealthy babies who eventually die before the age of three years. This drug is also taken by expectant mothers to clean their wombs and also to feel light when pregnant. At home, there are also some herbs that are given to expectant mothers to reduce and induce '*muoch*' (labour pains). Some herbs are given to disentangle '*wino*' (the after birth that ties around the baby) and to stop '*ojiwo*' (abdominal pains that follow immediately after delivery).

Many (72%) respondents reported that before they went to TBAs or hospital or any other place, they discuss their problems with their closest relatives. They administer drugs according to their relatives' own understanding regarding the causes and nature of the pregnancy problem. It was observed that most births (52%) occurred in homes with the assistance of mothers-in-law or co-wives (in good relation) or by oneself. The cutting of the umbilical cord was also done by oneself or co-wives or mothers-in-law. In a focus group discussion at Muamu village, Achieng' who is 26 years old and with two children had the following to say:

“When I am pregnant, the person I usually see first before any other person is my grandmother who massages my abdomen. She also assesses the extent of my problem and advises me appropriately” **(Focus Group Discussion)**.

When the problem surpasses the family members, they tend to consult other people in the community who are believed to have some experience regarding the problem at hand. Here is where retired nurses, who are out of official duty, may be consulted for help. One retired nurse (Nyakindu) reported that she assists expectant mothers in her home-stead. She had a well prepared room for delivering expectant mothers. In one of the Focus group discussions at Kachola village, one of the

discussants, Auma, 36 years old with six children, said the following concerning, Nyakindu:

“No one has ever been like Nyakindu, when it comes to assisting expectant mothers with delivery issues. She understands women very well and knows how to handle them. She talks to them well and help them during delivery. She does not quarrel with anyone as she says that she also went through the same. All my children from the first born to the sixth born were born at ‘Nyakindu’s home-stead. Even when my female relatives come to visit me and they want to deliver, I refer them to her. I have confidence in her but we must not forget that giving birth successfully is God’s plan. Even Nyakindu tells us that” **(Focus Group Discussion).**

Further investigation regarding Nyakindu and the nature of maternal healthcare services she provides indicated that she assists expectant mothers with delivery services using modern drugs that she buys from the pharmacy. Nyakindu proudly said that a maternal problem that she cannot manage, cannot be managed by any other mid-wife in Nyang’oma Catholic Mission Hospital or Uyawi Health Centre. She claimed that such a problem can only be treated at the Bondo District Hospital or New Nyanza Provincial hospital in Kisumu. Nyakindu, however, conceded that there are some maternal diseases that she could not be able to treat, notably, ‘*rariu*’ and ‘*sigete*’. She said that such conditions can only be handled well by her father-in-law who is an expert in the use of traditional drugs. An in-depth interview with Nyakindu gave the following information:

“My father was a clinical officer and as a young girl, I used to stay with him. I really admired his work and I developed interest in knowing the drugs and the kind of diseases they treated. After having completed my O-Level, I decided to do nursing. I worked in Kisii District hospital for quite a long time. The work that I enjoyed doing most was assisting expectant mothers. It is believed that some pregnancy problems could only be treated using herbs. For such, I could ask mothers with the problems to consult any herbalist who could manage the condition. When I retired from the official healthcare system, I did not retire my knowledge and experience in handling pregnancy problems. I do that perfectly and many expectant mothers come to seek assistance from me. In fact, some come from very far” **(Key informant).**

#### **4.3.4 Patterns of Maternal Healthcare-Seeking Behaviour**

The study found out that it was common for respondents to use almost all maternal health care providers concurrently. 23% of the respondents reported that they tried one maternal health care

provider for a particular problem, but if they did not succeed, they usually sought available alternatives. This implies that expectant mothers in the community did not just rely on one particular maternal healthcare provider. In a focus group discussion held with some discussants in Muamu village, one of them recounted that there was a mother who had a problem with delivering. She approached her mother-in-law for assistance at home but was not successful. Since she was a Legion Maria faithful, she made a final decision to go to ‘mothers’ at legion Maria church at Nango market centre. They prayed for her and massaged her with ‘deepak’. After sometimes, she delivered a baby boy. In the focus group discussion at Kacholla village, Anyango of 36 years had the following to say:

“My co-wife was experiencing terrible pain when she was expecting. I, together with my mother-in-law, took her to a traditional birth attendant but things never worked out well for her. We changed our minds and since we are Legion Maria followers, we opted to take her to our church situated behind Nango market center where we found ‘mother’ who prayed to her and massaged her with Deepak. Soon she gave birth to a bouncing baby boy”  
**(Focus Group Discussion).**

#### **4.4 Determinants of Maternal Healthcare Choices**

The variables examined in the study included: distance to healthcare facility and cost of maternal healthcare services, social support systems and belief systems surrounding pregnancy.

##### **4.4.1 Distance to Health Facility and Cost of Maternal Healthcare Services**

Table 2 below shows the distribution of healthcare facilities by distance from respondent’s homes. The table shows that a majority of the respondents (68%) lived more than eight kilometers away from the formal health facilities. The table shows that 28% of them lived furthest from these facilities (more than 15km away from their homes). Only 4% of the respondents lived about 2km

away from these health facilities. They reported that they used the facility only when they had serious complications like excessive bleeding that cannot be handled by the informal healthcare providers.

**Table 2: Distribution of Healthcare Facility by Distance**

N=100

Distance (Km)	Frequency	% frequency
0-2	4	4.0
3-5	6	6.0
6-8	22	22.0
9-11	17	17.0
12-14	23	23.0
15+	28	28.0
Total	100	100.0

Source: Primary data, community survey

In a focus group discussion held at Kachola village, discussants said that faith healers and TBAs are flexible and can respond to a call to assist an expectant mother at home. They argued that this may save the expecting mother from walking long distances, in contrast to a health facility where one has to walk or be transported there to access health services. In their views, nurses or midwives are never flexible as they can only operate within the perimeter wall of the health facility. One of the mothers said that some labour pains are unpredictable and can start anywhere. The respondents reported that they use either a bicycle or a wheelbarrow to transport the sick to the health facility. Furthermore, poor and impenetrable access roads hamper the available means to the health facility. In a focus group discussion with Aoko of 31 years old from Kachola village, had the following to say:

“We stay far from the healthcare facility. Labour pain can strike any time even at night. It is not easy to go up to the health centre to deliver. Sometimes you even lack the money to pay for bus fare to the health facility. In such circumstance, one end up delivering at home alone or by assistance of a TBA” **(Focus Group Discussion)**.

The study however found out that some mothers did not seek the services of the health facility despite close proximity. Such mothers said that they did not need to go to the health facility when they can be assisted when they want to deliver at home by their mothers-in-law or TBA at a flexible cost. Cost in this case was looked at in terms of the expenses incurred to hire a taxi or bicycle to the health facility, health facility items that must be used such as gloves, exercise books, new diapers and clothes for the new baby, trough, new slippers, the food that one has to eat when in the health centre or the hospital, its preparation amongst others. Other costs reported by the respondents are the admission expenses and the cost of dripping water, drugs amongst others. Table 3 below shows the distribution of respondents by place of delivery

**Table 3 Place of Delivery N=100**

<b>Place of delivery</b>	<b>Frequency</b>	<b>% frequency</b>
Private dispensary (Nyangoma)	2	2
Public dispensary (Uyawi)	20	20
Home	52	52
TBAs Home	18	18
Faith healers	8	8
<b>Total</b>	<b>100</b>	<b>100</b>

Source: Primary Data, Community Survey

Table 3 above shows that a majority of expectant mothers delivered at home (52%); followed by those who visit the Uyawi Health Centre at 20% and TBA's home at, 18%. The table shows that 78% of expectant mothers in Nyang'oma deliver babies outside the official healthcare (professional sector). Amongst those who deliver in the informal maternal healthcare providers, some reported that they deliver alone and cut the umbilical cord by themselves. They may only summon a close relative to help in case of complication. Only 22% of the respondents sought assistance from the

formal healthcare providers (at Nyang'oma and Uyawi).

#### **4.4.2 Social Support System**

This is a group of people who are always around expectant mothers. They are usually mothers-in-law, sisters, mothers, grandmothers, god mothers among others. They play a pivotal role in the decision making process regarding the maternal healthcare choices, depending on how the problem presents itself. When a problem is serious, they tend to make a faster decision on the right maternal health care provider to consult, depending on their experience. Bad reception and treatment by the healthcare providers may make them avoid using that service. Young expectant mothers listen to them and take their pieces of advice seriously and they follow what they say strictly. In the study area, mothers-in-law in most cases were the decision makers in matters of maternal healthcare choices. One of the mothers-in-law, Akumu who took her daughter-in-law to Nango Dispensary had the following to say:

“Sometimes you can take your patient to Nango dispensary for treatment when she is seriously sick but nurses who are there are sluggish like a snail. They do not respond quickly to the problem of your patient. Sometimes a patient feels so bad and can fall down before seeing the clinical officer in charge” (**Key informant**).

Such experiences make these social groups to think otherwise and to decide for their patients the kind of maternal health care providers they should use. At times, when the expectant mother fails to get assistance locally, this group will come together and offer a solution to the problem. They look for means of transport to take her to the health facility. They can sell their goat or chicken to hire a bicycle or a taxi to have the sick treated. Besides, they also accompany the sick to the healthcare provider.

#### **4.4.3 Belief System Surrounding Pregnancy**

In the study area, it was established that a pregnant mother is handled with a lot of care as it is

believed that she is delicate, described by the saying, '*ngama yach ng'awo*' (a pregnant woman is delicate). She is prohibited from doing certain things. She should not fight with her co-wife. If this happens, she may miscarry. To prevent this from recurring, she and her co-wife with whom they fought take '*manyasi*' (a mixed concoction for treating '*chira*'). She must not have sexual intercourse with a man whose wife is dead who is still 'unclean', locally referred to as 'still in state of *chola*' as this will affect the baby inside her womb. For this reason, sexual intercourse during pregnancy is prohibited unless with your own husband who is not having extra-marital relations with any widow who is still in a state of '*chola*' (unclean).

It was reported by one of the mothers-in-law that sometimes a husband may demand for sexual intercourse when his wife is pregnant. When this happens and the wife develops problems such as miscarriage, they will have to use '*manyasi*' given to them by a traditional healer. Such problems are believed to lack hospital therapy. The old mother of 61 years gave the following information concerning the belief systems regarding sexual intercourse during pregnancy:

"According to our traditions, a pregnant woman should not have extra-marital sex. Her husband should not also have the same. Should a pregnant woman develop health problems associated with extra-marital sex, it is *chira*. This problem can only be prevented by administering mixed concoction to both the husband and wife. One does not need to take the patient to the hospital for this" (**Key informant**).

This implies that some sexual relations were forbidden by the Luo during pregnancy. Daughters-in-law are always informed by their mothers-in-law to take care lest they develop maternal diseases. When a young mother conceives and experiences subsequent miscarriages, she consults her mother-in-law who inquires about her sexual relationship with her husband during pregnancy. Her mother-in-law would advise her appropriately on proper channels to follow when dealing with the problem. One of the informants (an experienced mother in beliefs systems surrounding pregnancy) reported that the mother-in-law invites a traditional healer who gives her '*manyasi*' to save her. This is done

if it is confirmed that the problem is as a result of prohibited sexual intercourse. Both the husband and the wife take '*manyasi*' together from the same calabash for it to be effective. In the view of the respondents, '*manyasi*' is a concoction made from herbs that are meant to treat the illness in question. The philosophy of '*manyasi*' is losing ground in the modern world especially in the urban areas amongst affluent families as they have embraced the conventional philosophy of medicine. However, in the rural areas, '*manyasi*' is believed to have strong effect.

The study also found out that the after birth, locally referred to as '*biero*' should be handled with great care. Special attention is given when the traditional birth attendant who has assisted the mother at home is known. When the after birth is handled in an incorrect manner, it is believed that it can affect the mother. Bearing another child can be a problem. Initially, giving birth at home was to see to it that the after birth was not just thrown away but handled with care to safeguard the fertility of the mother. But with the introduction of the hospital birth, it has been given little attention especially to those giving birth in the hospital. But to those giving birth at home, they still hold a strong value for handling the after birth. In fact, in certain instances, some expectant mothers would choose to give birth at home just to ensure that the after birth is handled with care to safe guard their fertility. An interview with one of the mothers-in-law, Awino aged 62 concerning handling of the after birth yielded the following information:

“When you deliver in the hospital, the nurses place the after birth in a trough then they give you to throw it away. But when you deliver at home, the after birth must be buried in the middle of the hut. At home, delivery is done by someone you know. When you develop pregnancy problem resulting to infertility afterward, you blame it on her because she did not take care of herself when delivering your child. But delivery in the hospital is done by anybody and tracking down the person who delivered your child in case of problem of infertility is hard. In such instance, you seek assistance from anybody who knows and is willing to help you” (**Key informant**).

One of the mothers-in-law reported that the burying of after birth especially for the first baby implies that the new mother and the new baby have established a dwelling place in the new home.

The baby, especially a baby boy, can claim a sense of belonging in that homestead and has a right of materialistic ownership. He can own and inherit the father's property. He can be referred to by the community members as one of their own. When the afterbirth is buried somewhere else, the child is referred to as an 'outsider' *'jaoko'*. If squabbles/wrangles break out between his mother and father and they separate, it is believed that because she buried the afterbirth of her first child in that homestead, she must just belong to that homestead.

#### **4.4.4 Pregnancy and Breach of Customs**

The study found out that Luo customs are entrenched in people's lives. It is part of the people's world view. World view is the way people look, understand and interpret phenomenon around them. A breach of them can result to *'chira'* (emaciating disease) which can only be treated by the use of *'manyasi'*. Children and expectant mothers are closely monitored and protected not to fall victims to the breach of such central customs. A second wife *'nyachira'* in a homestead must not pass or plant *'golo kodhi'* during the first planting season before her first co-wife *'mikayi'*. The breach of this custom is more common with pregnant mothers. Should a second wife plant millet (*bel*) or cowpies (*ng'or*) seeds before her first co-wife, when pregnant, she may miscarry. Awino of 54 years, one of the key informants stated that:

"In cultivating the field or planting seeds in the first season of the year, we must follow the order of seniority. The first wife must do it first then followed by the second one to avoid misfortunes from occurring in the homestead as it interferes with their fertility. They will always experience blood flow as the womb cannot hold the baby as a result of breaching the customs" (**Key informant**).

According to the informants, another phenomenon that leads to breach of customs is usually experienced during menopause locally referred to as *'ae ria'* common with the mothers-in-law. This means that these mothers-in-law do not actually participate in *'golo kodhi'* whereby actual sexual

intercourse is involved. In this instance, when she has a daughter-in-law who is pregnant and she wants to plant millet/maize seeds on her field, she must wait for one or two weeks from the time of planting before she plants her seeds as per the instruction of her mother-in-law. This is also applied to harvesting or bringing home the cereals of the first harvest season in order to avoid misfortunes from occurring to her. Should this daughter-in-law happen to breach this custom, she must take ‘*manyasi*’ to correct her fertility. It is locally believed that failure to use ‘*manyasi*’ will result to simultaneous miscarriages, as Akumu, one of the key informants of 58 years old narrated:

“A daughter-in-law may live with a mother-in-law who is in menopause. Under this situation, the mother-in-law instructs her daughter-in-law not to go to the field before two weeks elapses after she had planted” (Key informant).

The informants reported that this problem is common in the polygamous families and it is usually brought about by rivalry amongst the co-wives who are not always at peace with one another. According to the informants, if a first co-wife ‘*mikayi*’ wants ‘*nyachira*’ (second wife) to suffer because she feels jealous of her progress, she would time her during planting or harvesting seasons and make her suffer especially when pregnant by not following the laid order of sexual relation and harvesting. When the second co-wife proceeds to harvest the millet unknowingly and subsequently consumes it, she may destroy her fertility. Her conception is believed to be followed by subsequent flow of miscarriages. They believe that she cannot hold a baby as her womb is open. These problems may be avoided by maintaining good relationships and obeying the family homestead rules.

#### **4.5 Perceptions towards Maternal Health Providers**

The findings from the discussion groups revealed that the mothers had unfavorable perceptions towards maternal healthcare providers in the formal health facilities. They said that at home, one delivers in a familiar environment and may be assisted by a person who she understands and who, in

turn, also understands her. Notably, these are mothers-in-law, mothers who have delivered more than three babies, traditional birth attendants or by oneself. In their view, ‘someone they know cannot treat them in a bad manner as opposed to someone they do not know’. The respondents reported that in the health facility, the environment is strange and filled with strangers who usually treat one the way they desire. The participants in a focus group discussion at Muamu village had a view that in the Luo community, privacy is of great value to opposite sexes for grown ups. A man should not see a woman who is not his wife when naked and even her husband should not see her when delivering. In their view, this is the opposite of what takes place at the health facility where men also take part in delivering expectant mothers. This they perceive as exposing their privacy to even a man who might marry their daughter so as to be their in-law locally referred to as ‘*or*’. The hospital not only predisposed them to tabooed relations but the study also found out that some nurses in the health facility were rude and harsh to pregnant mothers. In a focus group discussion at Muamu village a respondent reported thus:

“I am afraid whenever I think of the nurses who assist mothers with delivery at Uyawi health centre, One day I went to deliver my second born there; I met this harsh nurse who did not spare me, saying that at the time of conception she was not invited neither was she there. So I should stop making noise. At that time I was feeling pain” **(Focus Group Discussion)**.

The discussants expressed reservation with formal healthcare facilities, commenting that they hated dying in the hospital the way their relatives have died in the hands of unfamiliar people and environment, holding that instead, they would rather die at home.

## **CHAPTER FIVE: DISCUSSION**

### **5.1 Introduction**

This chapter discusses the findings of the study that include the maternal healthcare providers found in the area and the nature of services they provide to the expectant mothers, the determinants of their use and perception and attitudes of the formal and informal healthcare providers.

### **5.2 Discussion**

#### **5.2.1 Maternal Healthcare Providers**

It was observed that various maternal healthcare providers existed in the study area. They include government health centres, dispensaries, Nyang'oma Catholic Mission Hospital, traditional healers, traditional birth attendants, faith healers, mothers-in-law, grandmothers, friends and friends of friends. This is consistent with Foster and Anderson (1978) who observed that a wide variety of health care options exist in every contemporary society. The choice of maternal healthcare providers is remarkably influenced, for this reason by their existence and the cost for the services rendered. People are remarkably pragmatic in testing and evaluating health care alternatives available to them. The outcome of the individual decision making process of healthcare provision is to a large extent the result of a cost benefit analysis not only in economic but also in social terms.

Prince (2004) observed that local mothers use traditional medicine for curative value during pregnancy especially to ease labour pains. Several studies have also indicated that these mothers use traditional medicine for various purpose, for example, to expel retained placenta, to aid breast milk production, to make the growing foetus strong and healthy, to distangle the umbilical cord and also to be light while pregnant (Nangendo, 2006; Kawango, 1995; Nyamwaya, 1992; Olungah, 2007; Mulemi and Nangendo, 2001). In the past, during a difficult delivery, grass (*modhno*) was taken

from a denuded home (*gunda*) made of a bundle, and then untied to the body of the woman in labour. She was also rubbed with a grinding stone while a prayer to the ancestors believed to be obstructing the birth was recited over her (Mboya, 1938). This view was confirmed in this current study where it was established that sometimes a husband may demand for sexual intercourse when still in a state of *chola* (unclean because of death of a close relative), when his wife is pregnant. This may make her develop problems such as miscarriage, and will propel the two to use ‘*manyasi*’ given to them by a traditional healer.

Consistent with previous studies done by Foster and Anderson (1978), this study established that it was common for respondents to use almost all maternal health care providers simultaneously. Some respondents (23%) reported that they tried one maternal health care provider for a particular problem, but if they did not succeed, they usually sought available alternatives. This implies that expectant mothers in the community studied did not just rely on one particular maternal healthcare provider. Foster and Anderson observed that people are also flexible in reconciling indigenous beliefs with modern western treatment options such as pharmaceuticals. They further observed that western and traditional medicine is not seen as competitive, but complementary. An expectant mother who tries to get medical service from a traditional practitioner and does not succeed, will seek assistance from an allopathic practitioner for diagnosis of malaria and use anti-malaria medicines.

As Olungah (2007) underscores that care seeking decision-making is usually un-informed, slow and in many instances, sought from multiple unskilled sources before considering skilled care, the expectant mothers in the study area sought decision from their mothers-in-law or any other close relatives who tried out first if they could deal with the problem and if it failed they would try other

available options. Expectant mothers often revolve between the various existing options within the community. The utilization pattern of healthcare clearly responds to the multi-health systems locally available. Traditional, modern and religious therapies are combined during pregnancy and delivery.

Under the pattern of healthcare seeking behaviour, it is apparent that expectant mothers begin the process by treating themselves whenever they feel any pain during the first stages of the pregnancy. They do this by purchasing drugs over the counter from the shops in local market places, preparing pot medicine if they are aware of any for bathing and oral taking as protective devices, changing their eating patterns and habits and consulting widely for advice from those around them. Thereafter they resort to seeking for help from the traditional birth attendants and the community health workers. Others consult religious experts for prayers and the antenatal clinics (Olungah, 2007; Helman, 2001).

As Chrisman (1977) points out that the healthcare-seeking process is dynamic, the expectant mothers in the study area re-evaluated their symptoms and revised their plans for what could work for them. Logan (1978) also shared the same view in a study conducted amongst the Ajijic community in Mexico. The expectant mothers moved back and forth in their care seeking approach without any clearly defined pattern. Whereas one expectant mother may begin by going to ANC clinic after defining her condition, others may begin by consulting community or going for prayers by the spiritual experts or praying themselves for heavenly intervention.

### **5.2.2 Determinants of Maternal Healthcare Choices**

Education seemed to have an impact on the healthcare choices in the study area. The study found out that a majority of the respondents had not attained secondary school level. The study also revealed

that these respondents preferred non-formal health facilities. This reinforces a previous study done by Suda (1997) in which she concluded that formal education in women has affected the use of health care facilities. She observed that educated women have a changed mind from traditions to a modern way of interpreting and understanding problems arising from pregnancy. She suggested that a community where there is a low level of literacy is likely to avoid using modern health facilities that they do not understand. Since they do not understand the physiological processes and cannot interpret their problems from the perspective of formal education, they often turn to the sphere they know better.

The occupation of a mother determines her income that could be used to seek maternal healthcare provision. Mothers working in formal sectors have access to health security and for that reason; they may choose to use modern healthcare facilities to treat diseases when they are pregnant. This goes hand in hand with the cost of maternal healthcare services. The majority of mothers who took part in the study were involved in informal sector of occupations. Their monthly incomes were minimal and could not cater for their medical services. They could not afford the high medical services fees. This discouraged some mothers from accessing healthcare facilities. This confirmed Foster and Anderson's (1978) notion that, underutilization of existing medical services was often not the result of indigenous medicine or resistance to western medicine, but could be explained by the cost and availability of those services. Simkhada *et al.* (2007) also looked at the affordability of healthcare facility in terms of travel cost, service fees and equipment cost. These in their view are important determinant when it comes to choosing the maternal healthcare provider to approach. Given the informal occupation of most of the respondents, they can hardly afford to incur the cost of accessing care.

It was also found out that distance to a healthcare provider influences the choice an expectant mother makes. This is in line with a study done by Allen (2002) in Tanzania. She found out that physical distance from a woman's home to a health centre or hospital is an important determinant that influences whether or not she uses the facility. The expectant mothers in the study area reported that it is easier and practical to choose a mother-in-law or traditional birth attendant who is at their close proximity, rather than to rely on skilled maternal healthcare providers who usually operate within the perimeter wall of the health facility that is far. Nearly 90% of the respondents live more than six kilometers from the nearest hospital, and this makes it extremely difficult for expectant mothers to reach even relatively nearby facilities. The KDHS (2003) reports that the poor infrastructure in Kenya complicates the matter of maternal issues and is a great impediment to a great number of people in seeking health care facility. Several studies also share the same view (Olungah, 2007; Nangendo, 2006; Mubyazi *et al.*, 2010; Effendi, 2008; Couillet *et al.*, 2007)

The study further found out that the social support system is a crucial institution in the decision making process and access of maternal healthcare providers. In the study area, mothers-in-law in most cases were the decision makers in matters of maternal healthcare choices. As Olungah (2007) previously underscored, people in ones' social network may urge one to visit a doctor or antenatal care clinic to prevent problems from escalating or for just routine checkups. The social support group may also suggest for mothers to use the available options for health within their reach. For instance, they can decide that a mother either should use faith healers or traditional healers. And this is always dictated by their knowledge of the disease and how it presents itself. In making any plan of successful motherhood intervention, it is crucial to involve them.

The study shows that an expectant mother has to depend on other people for assistance in decision

making when it comes to dealing with the problem of pregnancy. This is supported by a study conducted by Nyamwaya (1992) amongst the Pokot community, who observes that a sick individual consults close relatives who decide for her the kind of treatment or healer to approach. As Nyamwaya noted that this group matter amongst the studied community, it also matters amongst the Luo community of Nyangoma Sub-location. A number of people in the immediate environment of an expectant mother participate in decision making process, for example the study shows that mothers-in-laws made decision on the maternal healthcare provider to approach. This indicates that she is not the sole decision maker regarding her care-seeking pattern during her pregnancy, a view shared by Olungah (2007). Usually, the social support system consists of a network of close relatives who ensure that the expectant mother observes the traditional rituals, attend to a proper maternal healthcare provider as per their knowledge, and is protected against the effects of jealous relatives or other people with evil minds.

As noted by the study, the social support system dictates the maternal healthcare provider to be used by the expectant mother. If a healthcare provider mistreats an expectant mother as it happened in the health facility in the full watch of a mother-in-law that forms a social support system, then she can advise her sister-in-law to use another available option for maternal health problem. The decision may not be right, since she might decide to take her sister-in-law to an unskilled care provider that is not recommended by the safe motherhood intervention. In this way, the support system action may curtail individual and limit the female agency.

Several reasons explain the over-reliance of expectant mother on the social support system to make decision for a maternal healthcare to approach: it is from this social support system where all the social ills that afflict expectant mother emanate and subsequently, the arena where it can also be

eliminated for the general good of future generation. The involvement of this system in social activities could offer psychological assistance against stress, anxiety and depression. The social support system can also protect an individual from developing an illness and cope better with the burden of pregnancy and other medical problems (Olungah, 2007). This view is supported by a mother who was infected by '*sigete*' (a condition in which a young or middle aged feels terrible pain, especially when she is experiencing her monthly periods), because she passed water that was poured on the way when she was going to fetch water from the well. Had she heeded the advice from her grandmother against drawing water at dusk from the well, she would not have suffered from the disease. This shows the vital roles played by the social system in a social setting. The role of safe motherhood can be achieved if the social support system is allowed to take part in all the happenings of the maternal health in all aspects of pregnancy.

The study found out that belief systems surrounding pregnancy influence the expectant mothers' choices of maternal healthcare provisions, for instance, maternal issues stemming from women who often lose their children. The local people do not take this as a normal thing. They attach this occurrence to an evil spirits of young mothers who died without bearing children or who died while giving birth. Others said it could be spirits of *nyasigogo* (a woman who was married and later on separated or divorced her husband). When this woman dies, she is never accorded a decent burial. She is buried outside the homestead. According to the Luo community, someone who is buried outside the homestead is considered an outsider. Spirits from such women are believed to cause unrest to young mothers who are successful in their marriage. It is believed, they are jealous of the progress, especially on fertility of these mothers. They manifest themselves by claiming the young ones of the mothers.

It is inappropriate for a woman to lose children in two consecutive births. The community may think that something is wrong. In the study area it was reported that it is wrong for a mother to lose children quite often. When they believed that something was wrong, they insisted on tradition as Mboya (1938) points out; if a woman usually ‘killed’ children, she was bound (to prevent further occurrences) with traditional medicine. Such a woman could be treated by an old woman who was experienced in this field, ‘*wuon yath kisoni*’. The medicine was administered when the woman became pregnant and when she delivered and if it was time to shave off the baby’s first hair, *obwanda*, it was the same medicine woman who was summoned to do the shaving. The baby was given names such as Owiti, and Ondiek if it was a boy and Awiti if it was a girl. At present, if a woman loses her children frequently, she is treated in the same manner it was done in the past. This reflects a continuation of the Luo maternal health care traditions.

The house, a material expression of the woman’s bodily and social being- also embodies her intercourse. Established when she gets married, it is left disintegrated after death. Important transitions in the woman’s life are entrenched into the materiality of the house as they are in the woman’s body. This also has an influence on maternal healthcare choices, as a woman would prefer to get treated when pregnant in her house and especially when giving birth. It has been stated that women in Uhero village prefer to give birth inside their houses on the floor or behind the house on the ground (Prince 2004). Past and present practices suggest that giving birth in the house establishes a material connection between the newborn child and the home to which it belongs, as well as the woman, her house, her future fertility, and her children.

Similarly to previous studies (Feiman and Janzen, 1992), this study found out that faith, illness and healing go hand in hand. This study established that the locals strongly believed that giving birth

safely is God's plan. The faith healers pray as they massage expectant mothers according to God's instruction. This is quite evident by the healing roles played by the 'mother' who was a legion Maria follower and 'mothers' in *Luong Mogik* (God's last appeal church) and *Roho* (Holy trinity church). The 'mothers' through the power of the holy spirit could dispel magic that could not be handled by the biomedical healthcare providers at the healthcare facility. This therefore means that if a problem of pregnancy is believed to be caused by magic or evil spirits, then the expectant mother will choose the service of a faith healer. As Fieiman and Janzen (1992) earlier stated, they believe that cures do not occur if not willed by God, and fatalism is the doctrine sometimes adopted by the believers.

Further findings revealed that mothers prefer giving birth at home where their afterbirth is buried to protect their sense of belonging to a particular clan, unlike in the hospital where the afterbirth is thrown in the pit by a stranger. Besides, the birth process and afterbirth is handled by a known care provider to the community and tracing her in case of problems such as infertility may be easy. Consistence with this view is a study conducted in Zimbabwe where Mathole *et al.*, (2004) observes that women fear accessing health facility because their blood can be used for bewitching them if it falls on strange hands. Nangendo (2006) also shared the same view as he observed that the Luo community prefers the blood of child birth to be spilled in the homestead to safeguard future fertility. This strongly influences the choice of maternal healthcare providers that such mothers make. According to Cohen and Atieno-Odhiambo (1989: 25), the placenta was buried by the side of the house to ensure continued fertility and to establish a material connection between the newborn and the home. Thus, the strong link between the mother, her newborn and their home remains a significant factor in maternal healthcare decisions in Nyang'oma, and by extension the entire Luo community.

### **5.2.3 Perception and attitudes towards formal and informal healthcare**

This study found out that a majority of the mothers resorted to traditional informal healthcare during pregnancy and childbirth. This is in agreement with studies which have also shown that expectant mothers in most of the rural areas in Kenya often resort to traditional medicine and traditional birth attendants when faced with pregnancy problems (Olungah, 2006; Nangendo, 2006; Muga, 2004; Okumu and Gachuki, 1996; Mulemi, 1998; Ouko, 1998). In the study area, the subjects perceive informal maternal health care providers, as a group of care givers who are always ready to assist expectant mothers any time and for that reason they often use the services of TBAs because of closeness and flexible payment in tandem with findings of Nagendo (2006), Olungah (2007) and Maine (2003).

Home is perceived as the best place for delivery by expectant mothers because it connects the new born with the community as most of the rituals conducted to welcome the baby are performed at delivery. The expectant mother is also attended to by a familiar person. Home is also friendly as most support required by the delivering mother would be given. The informal maternal health providers treat these mothers with a lot of respect and care and also only female helpers are allowed to be present at the place of delivery. This is in contrast to the hospital environs (formal maternal healthcare) where no such rituals are done; moreover, male healthcare givers are the frequent visitors to the female wards. This is a breach to the traditional gender taboos associated with maternity care. The hospital is preferred for difficult deliveries as the locals argued that mothers would be given intravenous drips to add them more energy and occasionally they would be transfused in case of excessive bleeding during delivery.

While the demographic and epidemiological records indicate high maternal mortality and morbidity rate in reproductive health, the anthropological view is rooted in agency, identity, suffering and assistance to disease that produces social relations and conditions that shapes the actions of individual during pregnancy (Olungah, 2007). The ethnographic records of anthropology portray traditional knowledge of pregnancy as being a normal condition (Nangendo, 2006; Olungah, 2007). In the study area, some respondents share the same view by reporting that they did not have to see a healthcare provider, since they could deliver and cut the umbilical cord by themselves. Only in a critical condition could they invite their mothers –in-law or traditional birth attendants or co-wives to assist with the cutting of the umbilical cord or any other assistance. In their view, pregnancy and giving birth is a normal occurrence and should not be medicalized as to warrant attention of a care giver, a view shared also with Tsui *et al.* (1997) and Shostak (1981).

This perspective does not go down well with the safe motherhood initiative which insists on a skilled care provider during delivery. The Ministry of Health also recommends for a skilled birth attendance at the health facility however, there are scattered health facility with under –staff personnel who barely get adequate equipments and drugs to work efficiently. When over worked, these personnel, especially nurses and midwives may end up mistreating the expectant mothers hence discouraging them from using the formal care givers. This is a critical issue that the Ministry of Health should consider while insisting on delivery of expectant mothers in a health care facility, by a skilled care giver.

Contrasting the stand point of the Ministry of Health and Safe Motherhood initiative are the anthropologists who are critical to the medicalization of pregnancy and childbirth. Their view is that the process has eliminated a definitive member of the birthing team; the female patient. The process

has made the woman an object upon which the conventional healthcare staff works and from which it delivers what is often perceived as the primary patient, the baby (Olungah, 2007). An expectant mother is seen as perceptible as the staff easily controls her physiological and reproductive process. The feminist anthropologists see this as validation of women's birthing experiences through the traditional, patriarchal realm of medicine. Martin (1992) observes that, science represents a male, biased model of human nature and social reality and therefore, infuses the scientific, hospital experience for labouring women with male oriented ways.

The western philosophy of pregnancy and birth process that defines the 'proper' way of handling an expectant mother may not be easily infused by the traditional people who have undergone through a totally different process of enculturation and socialisation from the west. The former defines an expectant mother as a sick individual who should regularly enlist the care of a professional health provider from the onset of pregnancy to delivery; a view that is contradicted by the latter. The community is inclined more to the informal maternal healthcare provider than the formal one because the former offers an environment and arena where social-cultural interaction is inevitable. Any program aimed at improving the maternal health should consider the perception the local community has towards both informal and formal healthcare provider.

## **CHAPTER SIX: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

### **6.1 Summary**

Maternal healthcare choices formed the basis of this study, whose objectives included the identification and description of maternal healthcare providers in the area, the examinations of determinants for maternal healthcare choices and the exploration of the perceptions and attitudes towards maternal healthcare providers. Maternal healthcare is crucial to the Luo community of Nyang'oma sub-location.

The findings indicate that there are four modern healthcare facilities which include: Uyawi Health Centre, Nyagudi Dispensary, Anyuongi Dispensary and the Nyang'oma Mission Catholic Hospital. These healthcare facilities are however, underutilized for a number of reasons, especially their proximity, costs and insensitivity. The other maternal health providers in the area included traditional birth attendants, traditional healers, and faith healers who are often used by expectant mothers because of their flexible mode of payment and also they are always with them. The last category comprises social network of mothers-in-law, grandmothers, neighbors and friends, who expectant mothers first consult for pieces of advice and who may administer certain drugs used as antidotes to their problem. These three categories form the healthcare sector described by Kleinman (1980), which this study used as theoretical guide.

Expectant mothers in the sub-location have opportunities to choose either one or all of the maternal healthcare providers or use them interchangeably, depending on their understanding of the causes and magnitude of their problems. The following determinants were found to influence maternal healthcare choices: social support systems, belief systems in pregnancy, costs of the services offered and long distances that an expectant mother has to travel to the healthcare facility.

A social support system, which is the network of relatives to the pregnant mother, is usually involved in making the choice for maternal healthcare services, being liable to incurring the costs of health services provided and weighing the right healthcare providers to approach, based on the last experience with a particular maternal healthcare provider. The belief systems surrounding pregnancy are also crucial in the choice expectant mothers make for it is believed that certain maternal issues should just be dealt with in a particular and specific way. A case in point is a mother who often loses her children or plagued with diseases like *rariu*, *sigete* and *mbunda*. Breach of the Luo customs when a mother is expecting is usually thought to lead to maternal complications that can only be addressed by a traditional healer. The traditional healers worked within the Luo world view and philosophy of existence.

Regarding costs and long distances to the health facilities, expectant mothers may prefer to choose a maternal healthcare provider at her close proximity and which is considered relatively affordable. As a result of this, expectant mothers quite often use the services of the traditional birth attendants, mothers-in-law and faith healers. These groups of people always live with them, share and understand the cultural contexts in which pregnancy problems may unfold and subsequent ways of dealing with them. They are more flexible in their mode of payment and are friendlier to the expectant mothers.

Finally, the study explored the perception of expectant mothers towards both formal and informal maternal healthcare providers. It was found out that the expectant mothers in the study area perceive the informal maternal healthcare providers as the group of healers who understand their problems better and are ready to provide them with needed assistance. They argued that, as opposed to the harsh healthcare providers alongside strange environment to which they are exposed, informal

maternal healthcare providers are friendlier and assist them in the environment in which they are very much familiar.

## **6.2 Conclusion**

Maternal healthcare as a global problem requires immediate attention to safeguard the life of the mother and the unborn child. Clear knowledge of the existing maternal healthcare providers and the determinants of their choices are crucial to the improvement of healthcare services in any locality. All the maternal healthcare providers in Nyang'oma play a pivotal role in addressing the ever rising maternal issues such as abdominal pain, miscarriages, prolonged labour, hemorrhages, unsafe induced abortion and correcting fertility. However, existing misconceptions are a serious hindrance to their relative contributions in this field.

Maternal health issues should be approached holistically, bearing in mind that inclusion of traditional healers, traditional birth attendants, faith healers, mothers-in-law, friends, neighbors and biomedical health practitioners may significantly reduce the high rate of maternal and infant mortalities. It should also be borne in mind that the factors influencing the use of these maternal healthcare providers should be appropriately addressed to facilitate improved maternal healthcare provision in the district and other rural localities in the country.

## **6.3 Recommendations**

The study makes a number of recommendations.

- Firstly, the government, in liaison with the local community and NGOs, should make available accessible, well-equipped health-care facilities and qualified personnel to manage pregnancy problems in the rural areas in the country.

- Nurses/midwives should be appropriately trained in community cultural aspects regarding maternal health. The community should be sensitized on the importance of seeking appropriate and immediate health intervention to safeguard the lives of its members.
- Expectant mothers should be discouraged from delivering alone at home in the absence of an expert maternal healthcare provider. Members of the social support group should be effectively informed to enable them to provide essential advice to expectant mothers on appropriate health-care seeking manners.
- There is need for periodic appraisals of the healthcare providers in the country to hasten their efficiency on healthcare provision.
- Future studies should be carried out on how best the informal birth attendants and the formal health providers can work in harmony in order to complement the services and encourage locals to patronize formal health facilities. This should help in reducing complications occasioned by lack of adequate maternal healthcare.
- The maternal healthcare providers in the three sectors should complement one another to realize positive outcomes in safe motherhood.

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# Appendix 1: Questionnaire for Women of Childbearing Age

## 1. Introduction

Good morning/ evening. My name is Andrew Aura I am a postgraduate student from the Institute of Anthropology, Gender and African Studies, University of Nairobi. I am carrying out a research for my thesis on the maternal healthcare choices in Nyang'oma Sub-Location. Your views and contribution to this research is highly valued and will be accorded utmost confidentiality. It will assist the government to come up with policy that will improve maternal healthcare services in the area and the entire country. Kindly allow me to ask some questions to enable me generate vital data that will meet my research objectives. If you agree, please sign here.....  
Date.....

## Section 1: Demographic of the respondents

Respondent number

1. Village-----

2. Sub location-----

3. Marital status? -----

- 1) Single
- 2) Divorced
- 3) Married
- 4) Separated
- 5) Others Specify

4. Age -----

5. What is the highest grade of school you completed?

- 1) Lower primary
- 2) Upper primary
- 3) Secondary
- 4) University/college
- 5) Others (specify)-----

6. What is your occupation? -----

7. How much do you earn per month?.....

**Section 2: Maternal healthcare providers in the study area**

8. List maternal healthcare services providers in the area?

- a).....
- b).....
- c).....
- d).....
- e).....
- f).....
- g).....
- h).....

9. Do you have a health clinic in your area?

- 1) Yes
- 2) No

10. If yes name them.....

11. Can you state some of the of health problems that make you go to the clinic-----

-----  
-----  
-----

12. Where else do you go to if you have health problem? -----

-----

13. What kind of particular pregnancy related problems makes you go to that place? -----

-----

14. Where do you give birth to your children?

- 1) Hospital
- 2) Home
- 3) Others (specify)  -----

15. How many living children do you have?-----

16. Where were they born?.....

**Section 3: Determinants of maternal healthcare choices**

17. How far is the health clinic/dispensary/hospital from your home? -----.

18. What is the condition of road to the nearest health clinic/dispensary/hospital? -----

- 
19. What is the usual mode of transport to the health clinic/dispensary/hospital? -----  
-----
20. What religion are you?
- 1) Christian
  - 2) Moslem
  - 3) Others (specify)
21. What do your religion teach you about the place of giving birth and treating maternal related problems? -----  
-----
22. What denomination are you?
- 1) Catholic
  - 2) SDA
  - 3) ACK
  - 4) Others (specify)
23. Does your denomination influence your choice of pregnancy healthcare provider?
- 1) Yes
  - 2) No
24. If yes, comment on their influence of your choice for maternal healthcare -----  
-----  
-----
25. Do you seek consent when going to seek maternal healthcare from either traditional birth attendants or modern maternal healthcare clinic?
- 1) Yes
  - 2) No
26. If yes, from whom do you take permission?
- 1) Husband
  - 2) Mother-in-law
  - 3) Father-in-law
  - 4) Others (specify)
27. Have you gone to seek maternal healthcare without permission?
- 1) Yes

2) No

28. If yes, how did your husband or mother-in-law/father-in-law handle the case? -----  
-----  
-----

29. In your opinion do you think your husband or mother-in-law/ father-in-law demand to be given permission-----  
-----

30. Have you had pregnancy related problems? (Tick only one)

1) Yes

2) No

31. If yes, which one? (Specify) -----  
-----

32. In your view, what caused your maternal related problem? -----

33. Where did you get treatment for that problem? -----

34. Were you advised to chose on a particular maternal healthcare provider-----

1) Yes

2) No

35. If yes, who advised you? -----

36. If you were not advised, why did you choose that particular maternal healthcare provider? -----  
-----

37. Give reason for your preferred place-----

#### **Section 4: perceptions and attitudes towards the maternal healthcare providers**

38. When you develop abdominal pain, which maternal healthcare provider do you approach?.....

39. Give reason for your choice.....  
.....  
.....

40. When you are experiencing labour pain which maternal healthcare provider do you approach?  
.....

41. Give reason for your choice.....

.....  
.....

42. Do you like the informal maternal healthcare giver?

1) Yes

2) No

43. If yes, give reason for why you like it-----

-----

44. If no, give reason for why you do not like it -----

-----

45. Do you like formal maternal healthcare?

1) Yes

2) No

46. If yes, give your reasons-----

-----

47. If no, give your reasons-----

## **Appendix 2: interview Guides**

### **Appendix 2.1: Interview Guide (Professional sector)**

- When do pregnant mothers attend maternal healthcare facilities?
- Can you comment on some of the ailments that make pregnant mothers come to the dispensary
- What does ANC entails?
- How do your clients respond to this kind of service?
- Do they complete this service?
- How many complete?
- Why in your opinion do you think they do not complete ANC?
- For those who start ANC and complete, do they give birth in the hospital/dispensaries?
- Why do you think they do not give birth in the hospital/dispensary?
- Have you heard any complain from them?
- When they come to clinics, are they forced or they come willingly, or in serious condition or just for pregnancy check up.

## **Appendix 2.2: Interview Guides for Popular sector; Mothers-in-law, retired mid-wife**

- Have you assisted pregnant mothers with pregnancy problem?
- What kind of assistance have you given to them?
- When do you give this assistance?
- How often do you assist them?
- Give example of some of the problems with you assisted expectant mothers
- What challenges have you met when handling expectant mother. Mention some of them
- How did you handle the challenges?
- Highlight any cultural beliefs surrounding pregnancy among the local residents of Nyang'oma
- The accepted and right way of handling pregnancy
- The right place for seeking maternal health care
- Comment on the birthing position assumed by the pregnant mother during delivery.
- Who must be there when a woman is giving birth?
- Drugs to be used by expectant mother.

## **Appendix 2.3: Interview Guides for Traditional birth attendants and faith healers**

- Are you a trained traditional birth attendant?
- How did you qualify to be a traditional birth attendant?
- Do you attend to pregnant mothers with problems of pregnancy currently?
- Do many pregnant mothers seek treatment from you?
- Why do pregnant mothers seek treatment from you?
- Which pregnancy related problem do you attend to most often?
- How do you traditionally handle pregnancy?
- How many do you attend to per day?
- Do you face any challenge when attending to pregnant mothers, mention some of these challenges?
- How do you handle these challenges?
- What is your view concerning the proper way and nature of handling pregnancy problem?

### **Appendix 3: Focus Group Discussion Guides (theme)**

1. How can the maternal healthcare providers be effectively classified and ranked?
2. What are the central qualities of a good health care provider?
3. How best are pregnancy problems handled in this locality?
4. What is the popular view of maternal healthcare systems in Nyang'oma?