FACTORS INFLUENCING ATTENDANCE TO ANTENATAL CARE SERVICES IN KENYA, THE CASE OF SOMALI WOMEN IN EASTLEIGH NAIROBI COUNTY, KENYA

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DECLARATION

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

Sign.....Date.....18/07/2015.....

Bernard Mwendwa King'oo

L50/75960//2014

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

Sign.....Date.....20/7/2015.....

Prof. Christopher M.Gakuû

Department of Extra-Mural Studies

University of Nairobi

DEDICATION

This Research Project is dedicated to all mothers who have ever been victims of Maternal Health Care inattendance.

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ACRONYMS AND ABBREVIATIONS

AIDS- Acquired Immune Deficiency Syndrome
CPR- Contraceptive Prevalence Rates
HIV- Human Immune Deficiency Syndrome
KNBS- Kenya National Bureau of Statistics
MDG- Millennium Development Goals
NFHS- National Family Health Survey
NGOs- Non Governmental Organizations
PATH- Program for Appropriate Technology in Health
RCK- Refugee Consortium of Kenya
SPSS - Statistical Program for Social Scientists
UNFPA- United Nations Population Fund
UNHCR- United Nations High Commission for Refugees
UNICEF- The United Nations Children's Fund
US- United States
USAID- United States Agency for International Development
WHO- World Health Organization

ABSTRACT

Approximately 1000 women die each day worldwide from pregnancy related causes, 99% of them in developing countries and more than 50% in sub-Saharan Africa with most deaths concentrated around the time of delivery. Most of these delivery time deaths would have reduced if antenatal services were readily available and fully utilized by all expectant mothers. The study set out to investigate the influencing factors to the attendance of antenatal care services among the Somali women in Nairobi, Kenya. The objectives of the study were ;To establish the influence of the presence of Traditional Birth Attendants (TBAs) in antenatal services seeking behavior among Somali women in Eastleigh, Nairobi, investigate the extent to which level of awareness influences attendance to antenatal care by the Somali women in Eastleigh, Nairobi County, investigate how cultural beliefs towards modern reproductive services affect antenatal seeking behavior among the Somali women in Eastleigh, Nairobi and find out how economic status contribute to the number of Somali women who seek antenatal care. The target population was all Somali women living in Nairobi. This study grew out of an observation made by the researcher during a Parliamentary Health Committee tour to the Pumwani Maternity and most recent Journals in the facility, which indicated most of the babies in the incubators, and still births, were of Somali origin. Sample size was determined by use of online formula for sample size determination at http://www.raosoft.com/samplesize.html and adopted snowball sampling in the study. Questionnaires were pre-tested at the School of Communication at Daystar University, Nairobi. Data collection was carried out by the researcher over a period of four weeks by use of self administered questionnaires from respondents who could read and write and also with the assistance of a research assistant for the illiterate respondents. All questionnaires were edited and responses coded before data was entered into the computer by the use of the Statistical Program for Social Scientists (SPSS), version 11.5. Cross tabulation was the main method used for data analysis. After analysis, data was summarized and presented in form of frequency tables, percentages and proportions. Majority respondents were within the active ages of reproduction with a majority 72% practicing Islam while 50.8% had no formal education. There was great reliance of TBAs with a strong correlation between attendance of antenatal care and the final delivery aid where 81.4% of the respondents reported to have relied on the same service providers during their delivery period. The study established great need of awareness programmes geared towards enlightening the Somali women with 63.6% of the respondents unaware since most of them were illiterate. The study recommended that women be encouraged to undertake entrepreneurial activities since there was high relationship of economic status and attendance to antenatal clinics.

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Maternal mortality and morbidity are some of the most important global health issues facing the world today. Worldwide, approximately 1000 women die each day from pregnancy and childbirth related causes (WHO, 2010). In addition, 99% of these maternal deaths occur in the developing world, with sub-Saharan Africa accounting for over half of these deaths (Ibid). The international community has committed to improving maternal health by 2015 with Millennium Development Goal (MDG) number five, which aims to reduce maternal mortality by three quarters and reach universal access to reproductive health care (www.worldbank.org/mdgs/)

Even with this commitment, many countries have failed to implement effective programs to reduce maternal mortality and morbidity, and women around the world continue to die or suffer from the complications of pregnancy and childbirth. There are many direct causes of the maternal health situation and a number of underlying factors at the individual, community, and countrywide levels. Complex socio-economic factors, ignorance, and tradition combine together at all levels to create high morbidity and mortality for women of reproductive age.

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

It is on the background of conflict, drought and famine, increased food prices, under-development, poor governance, limited humanitarian access, extreme food insecurity, water shortages and acute malnutrition that thousands of Somalis, 80 percent of them women and children, flee their country to find food and shelter in Kenya, Ethiopia, and Djibouti. According to the United Nations Food Program, one in five women of childbearing age is likely to be pregnant in such a crisis situation. Sadly, providing emergency relief for millions of people over a prolonged timeframe puts the reproductive health care of pregnant women low on the priority list (Every Mother Counts, 2011).

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

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

in Somalia – including failure to attend to antenatal care– which formed the centerpiece of this research project.

While the majority of Somali population and asylum-seekers in Kenya live in designated camps, they often seek to make their way to urban areas to escape the harsh living conditions of camps and search for better opportunities, especially given the protracted nature of the conflict in Somalia. (UNHCR, 2011)

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

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

This research therefore targeted the Somali population living in Nairobi (both immigrants and asylum seekers).

1.2 Statement of the problem

There is a great concern that the progress towards the fifth Millennium Development Goal, "Improve Maternal Health," has been disappointingly slow. This has brought up a pressing need to address the factors that contribute to maternal mortality, one of which is failure to attend to antenatal care services. This health demand is particularly urgent in countries in sub-Saharan Africa, where maternal mortality is disproportionately high compared with developed countries. It's even more crucial for women who have either fled or been evicted from their countries at or around the time of their pregnancy.

This study grew out of an observation made by the researcher during an East African Parliamentary Health Committee tour and available records at Pumwani Maternity by Kigan W (2010) which indicated a great percentage of the babies in the incubators were of Somali origin. Kimani C (2010) also indicate that 67% of Somali women who have given birth in Pumwani had not attended any antenatal care clinics hence bore the most complications during delivery and were prone to still births. Due to the insecurity in the Northern region and the vulnerability of the population, it was not possible to conduct research in Dadaab at this time though it would have added impetus to the study. Studying a more stable Somali population – immigrants in Nairobi – was deemed to be the preferred method for establishing the exact issues that derail them from attending to antenatal services despite the mushrooming health facilities across the city.

This study therefore sought to establish the factors influencing attendance to antenatal care services in Kenya, the case of Somali women in Eastleigh Nairobi County, Kenya

1.3 Purpose of the study

The purpose of this research project was to establish factors influencing attendance to antenatal care services in Kenya, the case of Somali women in Eastleigh, Nairobi County.

1.4 Objectives

1. To establish the extent to which presence of Traditional Birth Attendants (TBAs) influence women's attendance to antenatal care services in Kenya, the case of Somali in Eastleigh Nairobi County.
2. To assess the extent to which level of maternal awareness influences women's attendance to antenatal care services in Kenya, the case of Somali in Eastleigh Nairobi County.
3. To determine how cultural beliefs towards modern reproductive services influences women's attendance to antenatal care services in Kenya, the case of Somali in Eastleigh Nairobi County.
4. To establish how economic status influences women's attendance to antenatal care services in Kenya, the case of Somali in Eastleigh Nairobi County.

1.5 Research Questions.

1. To what extent does the presence of Traditional Birth Attendants influence women's attendance to antenatal care services in Kenya, the case of Somali in Eastleigh Nairobi County
2. To what extent does the level of maternal awareness influence women's attendance to antenatal care services in Kenya, the case of Somali in Eastleigh Nairobi County
3. How do cultural beliefs towards modern reproductive services influence women's attendance to antenatal care services in Kenya, the case of Somali in Eastleigh Nairobi County

4. How does economic status influence women's attendance to antenatal care services in Kenya, the case of Somali in Eastleigh Nairobi County

1.6 Significance of the study

The study is a major step forward in objectively improving the maternal health across the marginalized groups comprising of immigrants especially in Nairobi Kenya through the identification and subsequent development of appropriate antenatal service provision programs. These programs will enable these communities change attitudes thus reducing the rate of maternal morbidity and mortality among Somali women.

The findings of this study will be useful to maternal health care providers who are key stakeholders in the realization of the Millennium Development Goal number 5 in relation to the antenatal care of Somali immigrants and refugees so as to provide accessible competent care.

The Ministry of Health and other health institutions can also use this study to clearly understand the antenatal needs of Somali women in Kenya to relevantly put in remedies to mitigate the challenges undergone by the subject under his study. The UNHCR can also use the findings of this study to provide relevant awareness programs to Somali families for them to better understand the value of modern antenatal services and maternal facilities.

This study also tried to fill the gaps in understanding the status of Somali women using Health care services for delivery by identifying determinants of facility delivery in Nairobi and their change over time. By doing so, the findings could inform interventions aimed at improving institutional service provision improvements around the County.

1.7 Delimitation of the study

The study was conducted in Eastleigh, Nairobi County. It is 3 Kilometers to the east of the Nairobi Central Business District. The estate is entirely a Somali zone with heavy Somali investments, many mosques and Somali schools. Nairobi is the Capital City of Kenya with a population of approximately 3,138,369 (KNBS, 2010). There are approximately 507, 540 Somali in Kenya, 51% of whom are women. Among these comprises of (18,844) residing in Nairobi County (UNHCR 2013) .This research concentrated on women of Somali origin aged 15-45 years.

1.8 Limitations of the study

The greatest challenge was convincing Somali women to open up and share their thoughts on sensitive and personal topics related to their private life, considered to be a taboo in their culture. To address this, the researcher spent as much time as possible learning more about Somali culture. He also used a Somali research assistant who introduced him to the Somali culture and lifestyles. That way the target population was able to open up and give relevant information.

Given that some of the migrant Somali refugees in Nairobi are unregistered and illegally in Nairobi and the current operations where they feel targeted, it was difficult to win the confidence of these women and convince them that this was purely for their own good as they fear repatriation back into the refugee camps if caught. To address this, the researcher used one of their most trusted confidants to introduce him to them. Interviewing the women in Somali language with the help of a translator helped the participants feel more comfortable talking about sensitive subjects. Also every participant had the option not to answer any question they did not

wish to give personal information about. The researcher did not ask for any participant's name to ensure their complete anonymity throughout the process.

1.9 Assumptions of the study

It is assumed that Somali community in Eastleigh maintains a network hence identified snowballing as the most effective way of data collection.

1.10 Definitions of significant terms

Traditional Birth Attendant- a person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or through an apprenticeship to other TBAs (WHO 1992)

Awareness- the ability to perceive, to feel, or to be conscious of events, objects, thoughts, emotions, or sensory patterns

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

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

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

Economy - the wealth and resources of an individual, a country or region, especially in terms of the production and consumption of goods and services.

Apathy-when people do not care, or when they feel so powerless that they do not try to change things, to right a wrong, to fix a mistake, or to improve conditions.

Dependency- Dependency results from being on the receiving end of charity. In the short run, as after a disaster, that charity may be essential for survival. In the long run, that charity can contribute to the possible demise of the recipient, and certainly to ongoing poverty.

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

1.11 Summary.

There has been a rise in global efforts to improve the state of maternal health worldwide. Initiatives have been directed primarily to maternal mortality in developing countries. This study sought to establish the factors influencing women's attendance to antenatal care services in Kenya particularly the Somali in Eastleigh Nairobi County. It sought to study the influence of TBAs, reproductive care awareness, socio-cultural attitudes and economic status in antenatal care seeking behavior.

The purpose of this research project was to establish the influencing factors to attendance to antenatal care services in Kenya, the case of Somali women in Eastleigh Nairobi County. The study will be a major step forward in objectively improving the maternal health across the Somali population in Nairobi Kenya through the identification and subsequent development of accessible antenatal service provision programs. The study was conducted in Eastlegh, Nairobi County. However, the biggest challenge was to have Somali women open up and share their thoughts on sensitive and personal topics related to their private life, considered to be a taboo in the culture.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

This chapter reviewed literature on Traditional Birth Attendants, maternal awareness, social cultural beliefs and economic status as influencing factors to attendance to antenatal care services in Kenya, the case of Somali women in Eastleigh Nairobi County. Conceptual and Theoretical Frame works were also presented here.

2.2 Traditional Birth Attendants and attendance to antenatal care

Traditional birth attendants retain an important role in reproductive and maternal health in Tanzania. The Tanzanian Government promotes TBAs in order to provide maternal and neonatal health counseling and initiating timely referral, however, their role officially does not include delivery attendance. Yet, experience through Dawit.A (2005) illustrates that most TBAs still often handle antenatal mothers and subsequently complicated deliveries. In a study to describe women's health-seeking behaviour and experiences regarding their use of postnatal care (PNC); and their rationale behind the choice of place and delivery in Tanzania Pfeiffer & Mwaipopo (2013), using qualitative and quantitative interviews, found out that in the rural areas of Dar es Salaam where an adequately trained health workforce and well-equipped health facilities are not yet a reality, home deliveries with the assistance of either a TBA or a relative was rampant.

In a systematic review of qualitative and quantitative studies conducted in developing countries and published between 1990 and 2006 to identify and analyse the main factors affecting the utilization of antenatal care in developing countries, Simkhada B. (2008) found out that the following factors affect antenatal care uptake: maternal education, husband's education, marital status, availability, cost, household income, women's employment, media exposure and having a

history of obstetric complications. Cultural beliefs and ideas about pregnancy also had an influence on antenatal care use. Parity had a statistically significant negative effect on adequate attendance. Whilst women of higher parity tend to use antenatal care less, there is interaction with women's age and religion. Only one study examined the effect of the quality of antenatal services on utilization. None identified an association between the utilization of such services and satisfaction with them.

Skilled attendants during labor, delivery, and in the early postpartum period, can prevent up to 75% or more of maternal death. However, in many developing countries, very few mothers make at least one antenatal visit and even less receive delivery care from skilled professionals. Shiferaw S, (2013) sought to understand why women might continue to prefer home delivery even when facility based delivery is available at minimal cost in Ethiopia. Using a mixed study design employing a cross sectional household survey among 15-49 year old women combined with in-depth interviews and focus group discussions, the study revealed that 71% of mothers received antenatal care from a health professional (doctor, health officer, nurse, or midwife) for their most recent birth in the one year preceding the survey. Overall only 16% of deliveries were assisted by health professionals, while a significant majority (78%) was attended by traditional birth attendants. The most important reasons for not seeking antenatal care services were the belief that it is not necessary (42%) and not customary (36%), followed by high cost (22%) and distance or lack of transportation (8%). The group discussions and interviews identified several reasons for the preference of traditional birth attendants over health facilities. Traditional birth attendants were seen as culturally acceptable and competent health workers hence carrying great influence .Women reported poor quality of care and previous negative experiences with health

facilities. In addition, women's low awareness on the advantages of skilled attendance at delivery, little role in making decisions (even when they wish), and economic constraints during referral contribute to the low level of service utilization.

In Uganda, lack of resources and skilled staff to improve quality and delivery of maternity services, despite good policies and concerted efforts, have not yielded an increase in utilization of those services by women or a reduction in the high ratio of maternal deaths. In a study conducted by Kyomuhendo G.B, (2003) in Hoima, a rural district in western Uganda, whose aim was to enhance understanding of why, when faced with complications of pregnancy or delivery, it was found that women continue to choose high risk options leading to severe morbidity and even their own deaths. The findings demonstrate that adherence to traditional birthing practices and beliefs that pregnancy is a test of endurance and maternal death a sad but normal event, are important factors. The use of primary health units and the referral hospital, including when complications occur, was considered only as a last resort especially for a majority of women who never sought antenatal services during their pregnancy. Lack of skilled staff at primary health care level, complaints of abuse, neglect and poor treatment in hospital and poorly understood reasons for procedures, plus health workers' views that women were ignorant, also explain the unwillingness and reluctance of women not only to seek antenatal services but also to deliver in health facilities and seek care for complications.

A study by Pathak P.K (2010) indicated that the level of education influences maternal health seeing behavior. In the Nepal study, the percentage of deliveries in a health facility was nearly double for women at the highest paid women (who were also educated) compared to unemployed women. In addition, according to the analysis of DHS data in six sub-Saharan countries cited

above, women's higher level of earning was associated with an increase in the decision to seek healthcare. In Malawi, Tanzania, and Ghana, living in urban areas economically empowered women and increased the probability of a woman having her most recent birth in a health facility.

Titaley (2010) in a qualitative study using focus group discussions (FGDs) and in-depth interviews to explore the perspectives of community members and health workers about antenatal care services and use of delivery care services in six villages of West Java Province, Indonesia found out that the use of traditional birth attendants and home delivery were preferable for some community members despite the availability of the village health centre in the village. Physical distance and financial limitations were two major constraints that prevented community members from accessing and using trained attendants and institutional deliveries. A number of respondents reported that trained delivery attendants or a antenatal care services were only aimed at women who experienced obstetric complications. The limited availability of health care providers was reported by residents in remote areas. In these settings the village birth attendant, who was sometimes the only health care provider, frequently travelled out of the village. The community perceived the role of both village midwives and traditional birth attendants as essential for providing maternal and health care services hence saw no essence of seeking antenatal services from health centers.

In Mexico, traditional birth attendants (TBAs) are an essential resource for health care, especially in small rural communities where they attend approximately 45% of all deliveries. Both rural and urban women seek care with the TBAs because, amongst other things, they share the same cultural codes. In this study, qualitative and quantitative methods were used to analyze the concepts, resources and process of care during birth in rural areas of the state of Morelos.

Results show that the socio-economic characteristics of the TBAs are similar to those of the patients, that they share the same precarious living conditions, and the resources to which they have access for providing care during births. When choosing a TBA as a health care provider, both the economic aspect and the importance of a shared symbolism come into play. It observed advantages in some of the traditional practices which should be incorporated into the medical system, for example protection through the massage of the perineum at the moment of expulsion. Nevertheless, there are inadequacies for which the implementation of training programs is fundamental, before articulate primary care programs using the TBAs can be promoted (Xochitl C.C ,1996)

Richard,Stella N & Pascal M (1998) carried out a study aimed at establishing reasons for the use or non-use of antenatal care services and malaria treatment among pregnant women living in rural areas in Uganda. Focus group discussions with pregnant women, in-depth interviews with key informants (Traditional Birth Attendants (TBAs) and local health workers) and a structured questionnaire administered to pregnant women were used to collect the relevant information. The study established that antenatal care attendance was irregular and few women knew that the purpose of attending antenatal care was to monitor both the growth of the baby and the health status of the woman. Chiang C (2013) established that parity significantly influenced antenatal care attendance, but level of education, religion and marital status did not. Fifty-five per cent of the women stated that they had delivered outside the formal health delivery system despite antenatal care attendance. All women in their second pregnancy had delivered their first child in the village, despite TBA training to the contrary. Most of the women delivering away from health care centers said that they were more comfortable delivering under a traditional birth attendant than in the health center .(Campbell-Grossman C 2009).

2.3 level of Awareness and attendance to antenatal care

An investigative study by Comerasamy.H et al (2005) on the Impact of health centre (HC) availability on the knowledge, opinion and practices related to maternity care and pregnancy outcome it found out that knowledge of the respondents about the components of ANC was poor in the villages under study. Traditional birth attendants (TBAs) conducted delivery in 76.1% cases in sub-centre (SC), 75.6% in villages without a HC compared to 49.8% in primary health centre (PHC) village. However, preference for TBAs in PHC village was 14.9%, in SC village 33.5%, and in villages without HC 36.3% .Among respondents having better awareness about ANC components, preference and utilization of modern delivery attendants was found to be higher. For maternity illnesses, consultation rate of government functionaries was 67.9% in PHC village, 52.2% in SC village and 55.8% in villages without a HC. Knowledge of modern maternity services was found to have significant influence on the health seeking behavior and pregnancy outcome

A study in Guatemala to identify factors that influence attendance to antenatal services for women's health among indigenous Mayan populations observed that Women's support groups (WSGs) provided an enabling environment in which women could form friendships, bond, discuss concerns about their reproductive health, and identify concrete ways of addressing them. Using qualitative anthropological methods involving observations, key informant interviews and focus group discussions (FGDs), the study found out that learned behavior of negotiation with key decision-makers and/or opinion leaders was an effective tool for convincing such individuals of the value of accessing facility-based care as Sicchia S.R and Maclean H. (2006) indicates. It's therefore imperative that women join these focus groups to boost their knowledge on the impact of attending to these services.

In a study carried out to determine the barriers to attendance to maternal health services in northwestern Nigeria using a cross-sectional study of 150 mothers , Egbewale B.E and Bamidele J.O (2009) discovered that despite living near a health facility, most of the mothers did not utilize maternal health services. This, the study established, was contributed by the fact that many expectant mothers lacked information on the essence of visiting clinics with "after all am not sick" attitude. This survey showed that in a 100 women, over 80% sought medical attention and utilized health services when sick but had almost negligible regard for the same when expectant. From this study it clear that while there is dire need to raise awareness on the utilization of maternal health services, bring it closer to the mothers and make it more affordable, there is a more pressing need to improve its quality, especially through the alleviation of negative attitude of health care providers.

The provision of antenatal care and the promotion of institutional childbirth have the potential to reduce maternal and neonatal morbidity and mortality. Despite this, high maternal and infant mortality is still being recorded in the developing countries and researchers still report low utilization of maternal health care services during and after pregnancy in different communities in Nigeria. A cross-sectional descriptive study carried out by Egbewale B.E and Bamidele J.O ibid (2009) to examine the current level of utilization of maternal health care in some rural and urban communities of South Western Nigeria. The study which used house-to-house survey with semi-structured questionnaire to interview targeted adult women who were either pregnant or already had a child before. Information was collected on demographic characteristics and utilization of maternal health care services. The study established that most of the respondents (94.8%) who delivered in health care facilities had attended antenatal care clinics during their expectancy period .This study revealed a higher level of utilization of maternal health care

services in the communities under study than earlier reported in Southwestern Nigeria where there were fewer awareness programmes. From this study the researcher recommends that continuous and sustained community education and mobilization as an essential tool through which women and their families learn about the need for special care during pregnancy and childbirth under trained health personnel.

Mwaniki, Kabiru and Mbugua (2002), observes clinical adherence to maternity services as an important maternal health indicator and a life saving venture. Increasing the proportion of mothers who are cared for in health facilities during pregnancy, childbirth and puerperium reduces the health risks to mothers and their children. In a Cross-sectional descriptive study carried out in four rural health centers in Mbeere district to determine the utilization of antenatal and maternity service it emerged that the proportion of mothers who utilized health facilities for antenatal and maternity services was 97.5% and 52%, respectively. The study established that utilization of health facilities for maternity services was significantly influenced by the level of awareness on the role played by antenatal care services and distance to health facility in that, as number of awareness increased, utilization of maternity services increased. These findings therefore associate dissemination of relevant information regarding antenatal care to the rise of mothers seeking for the same; hence the same should be encouraged.

The vast majority of global stillbirths occur in low- and middle-income countries, and in many settings, the majority of stillbirths occur antenatally, prior to the onset of labour. Poor nutritional status, lack of antenatal care and a number of behaviours increase women's risk of stillbirth in many resource-poor settings. Interventions to reduce these risks could reduce the resulting burden of stillbirths, but the evidence for the impact of such interventions has not yet been comprehensively evaluated. a systematic review of interventions that could plausibly impact

stillbirth rates by Yakoob M.Y et al (2009) concluded that antenatal care is widely used in low- and middle-income countries, and provides a natural facility-based contact through which to provide or educate about many of the interventions we reviewed. The impact of broader socially mediated behaviors, such as fertility decision-making, access to antenatal care, and maternal diet during pregnancy, are poorly understood, and further research and appropriate interventions are needed to test the association of these behaviors with stillbirth outcomes. Many ante partum stillbirths are potentially preventable in low- and middle-income countries, particularly through dietary and environmental improvement, and through improving the quality of antenatal care - particularly including diagnosis and management of high-risk pregnancies - that pregnant women receive. This majorly depends on the level of information mothers have.

Accessibility to information on maternal health through radio and other media has a positive association with antenatal attendance mannerisms. In a study conducted in Amhara region North shoa zone, Gele A.A (2013) revealed that women in households that possessed a radio were more than three times as likely as households without a radio to go attend to antenatal services and deliver in a health facility. This shows that many mothers did not have enough information on the importance; otherwise much mortality would have saved.

A study aimed at examining the attendance to antenatal care and its association with infant care practices in Nepal using demographic and Health Survey by Neupane and Nwaru (2014) found out that, children of mothers with no antenatal care were at increased risk of neonatal death. Compared to women with no antenatal care, those with more than three visits were more likely to immunize their children and more likely to initiate breastfeeding within one hour after birth .Having skilled attendants at antenatal care and at birth was also associated with better infant care practices. The study concludes that adequate antenatal care utilization may

represent a key preventative strategy in neonatal death. Public health awareness programs and interventions are needed to increase the utilization of antenatal care as well as delivery assisted by skilled attendants.

Quality antenatal care (ANC) reduces maternal and neonatal mortality and improves health outcomes, particularly in low-income countries. Quality of ANC is measured by three dimensions: number of visits, timing of initiation of care and inclusion of all recommended components of care the World Health Organization's recommends initiation of ANC within the first four months of pregnancy and at least four ANC visits during the course of an uncomplicated pregnancy. In a Demographic and Health Survey aimed to identify factors associated with attendance at four or more ANC visits and receipt of good quality ANC, Joshi , Torvaldsen , Hodgson & Hayen (2014) established that half the women had four or more ANC visits and 85% had at least one visit. Older age, higher parity, and higher levels of education and household economic status of the women were predictors of both attendance at four or more visits and receipt of good quality ANC. Women who did not smoke, had a say in decision-making, whose husbands had higher levels of education and were involved in occupations other than agriculture were more likely to attend four or more visits. Other predictors of women's receipt of good quality ANC were receiving their ANC from a skilled provider, in a hospital, living in an urban area and being exposed to general media. It concludes that continued efforts at improving access to quality ANC are required. In the short term, less educated women from socioeconomically disadvantaged households require targeting. Long-term improvements require a focus on improving female education.

A retrospective cohort design study by Tesch and Creswell (2009) study to determine the risk of adverse obstetric and perinatal outcomes among refugee women in Toronto established that

Multiparous refugee women had a significantly higher rate of delivery by Caesarean section (36.4%), and a 1.5-fold increase in rate of low birth weight infants when compared with non-refugee women. In subgroup analysis by region of origin, women from Sub-Saharan Africa had significantly higher rates of low birth weight infants and Caesarean section than non-refugee control subjects. Further, compared with non-refugee control subjects, refugee women had significantly increased rates of prior Caesarean section, HIV-positive status, homelessness, social isolation, and delays in accessing antenatal care. It recommends that targeted public health interventions towards meeting the needs for obstetric care of this vulnerable population be put in place. The availability of these services should always be communicated across the target population.

In a study carried out by Stapleton H. (2013) to establish the experiences for women from refugee backgrounds, attending a specialist antenatal clinic in a tertiary Australian public hospital could be improved it was found out that providing comprehensive and culturally responsive maternity care for women from refugee backgrounds was achievable, however it is also resource intensive. Many respondents highly regarded antenatal services but continuity of care throughout the antenatal period was only valued by newly arrived women as it afforded them security and support to negotiate an unfamiliar Western maternity system. Positive experiences decreased however; as women transitioned from the clinic to labour and postnatal wards where they reported that their traditional birthing and recuperative practices were often interrupted by the imposition of Western biomedical notions of appropriate care. The centrally located clinic was problematic, frequently requiring complex travel arrangements. Appointment schedules often impacted negatively on traditional spousal and family obligations. This created a

negative impression towards many refugee women wishing to seek for the services hence discouraged them.

2.4 Cultural beliefs and attendance to antenatal care

Gele & Sundby (2013) describes antenatal period as a very crucial moment for the mother and the developing baby which calls for the best health interventions. It's however not the case in most cases due to a raft of factors among them the attitudes and perceptions associated with such services. A study was carried out to evaluate the effects of different methods of anticipatory guidance presentation on the change of knowledge and attitude of expectant women regarding antenatal healthcare to the mother and unborn baby. The quasi-experimental study by Ramazani N (2014) targeted 90 pregnant women who attended one health center in Zahedan, Iran; they were divided into direct intervention, indirect intervention and control groups. A self-reported questionnaire was completed before intervention. Immediately after the intervention, the questionnaire was completed by intervention groups and two months later by all participants then difference in the scores at start and end was calculated. The study established a tremendous change in scores in terms of antenatal seeking behavior that went with knowledge relevant to maternal, infant and toddler's health. Anticipatory guidance presentation led to change in the score of knowledge about maternal, infant and toddler's oral health and attitude towards maternal oral health in comparison to no presentation. The direct presentation had superiority over indirect in increasing knowledge about maternal and antenatal healthcare which subsequently rose the number seeking antenatal services. The study recommended intensive lobbying on matters concerning antenatal care to dispel some of the unfounded perceptions that impended maternal service provision (Degni & Ojanlatva ,2006).

Although antenatal care coverage in Ghana is relatively high compared to many other developing countries as per USAID (2008), there exist gaps in the continued use of maternity care, especially attendance to antenatal care services and skilled assistance during delivery. Many expectant women seek care from different sources aside the formal health sector. This is due to negative perceptions resulting from few poor service quality experiences in health facilities. Moreover, the socio-cultural environment plays a major role for this care-seeking behavior. In a qualitative study, using focus groups, to examine beliefs, knowledge and perceptions about pregnancy and delivery and care-seeking behavior among pregnant women in urban Accra, Ghana, Dako-Gyeke P (2013) found out that perceived threats, which are often given socio-cultural interpretations, increased women's anxieties hence driving them away from seeking maternal health care. Crucially, care-seeking behavior among pregnant women indicated sequential or concurrent use of biomedical care and other forms of care including herbalists, traditional birth attendants, and spiritual care. Use of multiple sources of care in some cases disrupted continued use of skilled provider care. This study concluded that socio-cultural interpretations of threats to pregnancy mediate pregnant women's use of available healthcare services. Most of these interpretations are misconceived and have no factual backing as observed by Dynes M, Stephenson R, Rubardt M and Bartel D (2012).

A study carried out by Filippi V (2006) to determine the knowledge and attitudes among women in a high-income developing country regarding pregnancy and antenatal care indicated that cultural influences highly dictated how and when expectant women sought antenatal clinics. Women who participated in a study by Alkaabi M.S (2014) independently completed questionnaires regarding their preference to attending to antenatal care "*ceteris peribus*". The questionnaire enquired about age, level of education, Internet use, marital status, employment

and opinion on the impact of antenatal care services during pregnancy. It also included questions regarding their knowledge of ultrasound, the effects of sexual activity and other exercise during pregnancy, breast feeding, and premature delivery. The collected data were subjected to statistical analysis using SPSS. The study was conducted across 205 women where 115 women (56.1%) thought that the most important benefit of ultrasound was to discover fetal abnormalities and 75 (36.6%) thought that regular exercise was not harmful during pregnancy. Of the total respondents 116 (56.6%) of 205 thought that sex during pregnancy was harmful to the fetus or did not know.

The main objective being to establish Knowledge and attitudes about pregnancy and importance of antenatal services, 143(62%) confirmed that they had never sought antenatal care despite being aware of their importance and their ability to afford. They cited alleged mistreat and unfriendliness of the service provides as the main reason they stayed away from these facilities. Most of the respondents said they had never experienced the same but had friends who had undergone the ideal. This confirmed that relevant information among Emirati women is low. It is therefore important to have effective informational classes that focus on educating women about issues related to pregnancy and antenatal care to dispel unfounded perceptions that create an impression leading to negative attitude towards these key services provided. (Finlayson & Downe ,2013)

2.5 Economic status and attendance to antenatal care

The use of maternal health care is typically patterned on socioeconomic and cultural contours. However, there is no clear perspective about how socioeconomic differences over time have contributed towards the use of maternal health care in India. Pathak , Singh and Subramanian (2010) using data from National Family Health Survey (NFHS) conducted during 1992-2006,

analysed the trends and patterns in attendance of antenatal care in first trimester with four or more antenatal care visits and skilled birth attendance (SBA) among poor and non poor mothers. The study reveals that the use of PNC and SBA remains disproportionately lower among poor mothers in India irrespective of area of residence and province and availability of health care services. Choudhury N and Ahmed S. (2011) carried a study which indicated that despite several governmental efforts to increase access and coverage of delivery services to poor, it is clear that the low economically empowered mothers do not use SBA and even if they had SBA, they were more likely to use the private providers perceived to be cheaper.

Several studies have shown that women's use of health facility delivery services is influenced by their socioeconomic status. A study in rural India by Pathak et al (2010) showed that antenatal care services is much more common for first births than for subsequent births. This analogy was based on the fact that most women were likely to either lose their jobs or retire during their subsequent births hence lowering their economic muscles .Regarding age at delivery, another study in rural Somalia, revealed that institutional deliveries were more common in comparatively younger age groups who are better than their peers economically. (Gele,2013)

A study in Kathmandu, Nepal by Yakoob M.Y (2009) showed that 70 percent of women age 20-34 had their most recent birth in a health facility compared to 58 percent of women aged 35. The same study revealed that about 79 percent of women with a first pregnancy and 70 percent of women with a second pregnancy delivered in a health facility compared with 50 percent of women with a fourth or higher-order pregnancy The study established that home based services are more common among poorer than wealthier women. In the Nepal study, a higher percentage of women with a higher income level had at least three antenatal visits and gave birth in a

hospital compared to those with a lower income who despite understanding the dangers of local service providers couldn't afford health facilities.

A study was carried out among expectant mothers in Ghana by Song H (2013) which established that women from households in the highest income quintile were more likely to demand institutional maternal services, by 18 percentage points, compared with women in the lowest wealth quintile whose attendance to these maternal services was not a priority. Inter Press Service, (2011) shows exposure to modern care givers as another important factor associated with attending to antenatal care centers and choice of place of delivery. The same study in Ghana found that women who had an income or hailed from working families were more likely to have antenatal care services (ibid).

A maternal health care service utilization study conducted in three states of South India with different social settings also found that mass media exposure had a positive association with seeking antenatal facilities .This media exposure was associated with the level of wealth since the better economic standard, the more one was exposed to mass media.(Neupane & Nwaru,2000).

Antenatal care (ANC) utilization is a factor associated with antenatal care services which in turn determines the condition of the new born baby. This attendance mostly relies on the economic status of the mother. A study among expectant mothers in Ghana indicated that women with at least four ANC visits were more likely to attend to antenatal care hence having little complications during their pregnancy. A similar finding was observed in a community-based study by Otieno P.A (2010) among rural women in western Kenya. In this study, among women who did not visit a antenatal clinic only 1.6 percent delivered in a health facility compared with 10 percent among women who made one to three visits, and 27 percent among women who

made four or more visits .The cross cutting factor that derailed most of the women from attending antenatal clinics is that most of them felt that the services where too expensive for them. This according to the population targeted in western Kenya in the study is complicated by the fact that antenatal care visits are not a onetime thing but a series which makes it more expensive and unaffordable. They resulted to seeking traditional attendants who are unskilled incase the development of the baby is in jeopardy.

In Ethiopia, several studies have also shown that antenatal care service utilization is a strong determinant of utilization of antenatal care services that relies on economic status. Analysis of 2005 EDHS data showed that seeking assistance during delivery was strongly associated with use of ANC services which heavily relied on the economic status of the mother in question. Moreover,Filippi P. (2006) in a study from Amhara region North Shewa zone showed that women who had made at least one ANC visit were at least six times more likely than women with no ANC visits to give birth at health facility and largely depended on their economic level. In addition, women with five or more ANC visits were at least two or three times more likely to use a health facility for delivery compared with women with two to four visits, or only one visit. Mothers with at least five ANC visits during their last pregnancy were also significantly more likely to give birth in a facility than mothers with only one ANC visit. Concerning the reasons for not using modern health services, in the same study 44 percent of respondents reported that they were not seriously ill, while 15 percent said they were too busy with household chores, and 41 percent cited the high cost of the facility as an impediment to them as observed by (Gelle ,2013).

Determinants of low utilization of antenatal care services in Ethiopia include maternal age, birth order of the child, low educational level, low income, and rural-urban according to Ramazan N

(2014). According to the 2005 EDHS, births by younger working mothers (under age 35), first births, and births to women with jobs are more likely seek antenatal care and subsequently be assisted by a trained health professional .Further, the community-based study in North Gonder revealed that the higher the level of mothers' education the more likely mothers were to attend to antenatal clinics since education was also associated with availability of jobs hence better economic status..

Sanneh (2014) carried out a collaborative approach multistakeholder study involving the government, World Health Organization, United Nations Children Emergency Fund, and the Medical Research Council in rural Gambia to establish attendance to basic health care which was termed as one of the hindrances to the antenatal care access among the poor hence subjecting them to the poverty penalty of mortality and morbidity. It also focuses on contributing to the Bottom of the Pyramid in a general sense, in addition to meeting the health needs of communities where people live on less than $1 a day. Leedam E (1985) suggested strengthened multistakeholder responses and better-targeted, low-cost prevention, and care strategies within health systems to address the health burdens of poverty-stricken communities. In this study, it was established that where antenatal care seekers and antenatal care coverage was high, there was great reduction of mortality. It was therefore recommended that strategies addressing health problems in poor communities are required to achieve 'Millennium Development Goals'. In particular, actual community visits to satellite villages within a district (area of study) are extremely vital to making health care accessible and affordable. (Kyomuhendo,2003).

A study by Tesch and Creswell (2007) through focus groups and 16 Midwestern community leaders working or volunteering with the Hispanic population was meant to get their opinions

and examine needs, concerns, and social support of Hispanic, single, low-income mothers during the transition to motherhood through the eyes of community leaders serving this population in the U.S. The process of word and context interpretation was completed using a combination of techniques. Data was compared to field notes and debriefing summaries were completed during focus group discussions. Four themes and 12 subthemes evolved from Sicchia S.R & Maclean H. ,(2006) group discussions which focused on mothers' social support, interactions with health care providers, barriers in trust, practical life issues.

Their economic status was cited as the greatest impediment to accessing these services. It recommends further research on interventions that effectively deliver information, lower health care barriers, and meet social support needs of Hispanic low-income mothers and their infants. Another study by Egbewale B.E (2009) had great population of the target group indicating that they had information on the importance of antenatal care services and subsequent health facility delivery services but were unable to raise the funds required to meet the cost.

Song H. (2013) conducted a Cross-sectional study to evaluate maternal and child care practices in areas with extreme poverty in Peru. The research conducted across 540 households selected at least one child younger than 36 months (475 households) and/or a pregnant women (80 households), in rural areas of Cajamarca, Amazonas, Huanuco, Ayacucho, Huancavelica, Apurimac, Cusco, Puno and Ucayali noted that 69.0% of the mothers reported having had their first antenatal care in the first trimester; 65.3% reported having completed more than six check-ups throughout the pregnancy; 81.1% reported having given birth in a health facility, and only 31.0% chose a method of family planning within 42 days postpartum.It established that the greater percentage of women seeking health services were either working or from paid families. Through Leedam E,(1985) study, a baseline has been established on which a strategy can be

designed and implemented to improve best practices for maternal and child care as part of the "Programa de Apoyo" within the Health Sector Reform which targets to provide affordable health services to expectant women from poor families.

Song H ibid (2013) also conducted an investigatory study to examine the information needs, information-seeking behaviors, and perceived informational support of low-income pregnant women. Accordingly, the study was carried on across 63 expectant women enrolled in a subsidized antenatal care program in Milwaukee, Wisconsin, during two time periods: March-May 2011 and October-December 2011. Results indicated that participants relied heavily upon interpersonal sources of information and financial support, especially family and the father of the baby; rarely used the Internet for health-related information; and desired information beyond infant and maternal health, such as finding jobs and accessing community/government resources. Participants who used family members as primary sources of information also had significantly increased levels of perceived informational support and reduced uncertainty about antenatal and other maternal issues.

Neupane & Nwaru (2014) carried out a cross sectional study which established findings with implications for the dissemination of pregnancy-related health information among low-income expectant women who were found to only rely on information from close associates hence missing on very vital information in other platforms. The study found out that financial instability hindered them from access to vital information regarding antenatal and delivery services hence not seeing the essence of attending to these services. The association between low income and maternal health outcomes needs to be addressed since most of these poor pregnant

women have become victims of maternal related fatalities and accidents which would adequately been addressed if they accessed information just like their peers.

In a thematic approach research carried out in Ethiopia by Shiferaw (2013), it was established that there were negligible numbers attending to health care which contribute to maternal complications. The study cited delay in; decision to seek medical care, reaching health facilities and receiving adequate obstetric care as key contributing factors to maternal deaths in low-income countries. The study observed this as a major contributor to the worldwide death toll of mothers with a maternal mortality ratio of 676 per 100,000 live births. The conclusion of the study suggested to the Ethiopian Ministry of Health to launch a community-based health-care system to tackle maternal mortality. Three themes emerged from the analysis: the struggle between tradition and newly acquired knowledge, community willingness to deal with geographical barriers, and striving to do a good job with insufficient resources. These themes represent the three steps in the path towards receiving adequate antenatal care services and care at a health facility. Of the themes, increased community awareness, organization of the community and hospital with specialized staff were recognized as facilitators.

Chiang C (2013) carried out a cross-sectional study to examine potential demand-side barriers to women's attendance to clinics in rural southern Egypt (Upper Egypt) during their expectancy. It involved face-to-face interviews with a structured questionnaire on 205 currently-married women with an aim of inquiring about their use of health facilities: regular antenatal care (ANC) during the last pregnancy they had and medical treatment services when they suffered from common illness. Key observation was on their take on the use of health services across their expectancy and whether this was influenced by culture, finances, or lack of information. The study confirmed distance and transportation to health facilities prevented about 30 % of the

women from seeking antenatal services. 42% of them felt the that the health offered were too expensive to afford While a small number cited use of Traditional birth Attendants as having satisfied them hence saw no need of health services. The study concluded that lack of enough resources was the main impediment to health despite the Egyptian government successfully extending basic health service delivery networks throughout the country; women in rural Upper Egypt were still facing various barriers to the use of the services, especially financial constraints. In a retrospective study conducted to explore the relationships between insurance status and various antenatal outcomes Wilson-Mitchell and Rumens J.A (2013) examined and compared antenatal outcomes for 453 uninsured and provincially insured women who delivered at two general hospitals in the Greater Toronto Area between 2007 and 2010. Data on key antenatal health indicators were collected via chart review of hospital medical records. The researcher conducted comparisons between regional statistics and professional guidelines where available. It established that new immigrant, refugee claimant, and migrant women face various barriers to healthcare and antenatal services due to the lack of public health insurance coverage. Four-in-five uninsured pregnant women received less-than-adequate antenatal care due to financial inability. More than half of them received clearly inadequate antenatal care, and 6.5% received no antenatal care at all. Uninsured mothers experienced a higher percentage of caesarian sections due to abnormal fetal heart rates and required more neonatal resuscitations and failure to attend to antenatal care where such dangers would have been addressed. This study concludes that pregnant women under insurance cover had more chances of seeking antenatal care and had greater chances of delivering in a healthy facility with little challenges

2.6 Theoretical Framework

This study adopted the Health Belief Model. The health belief model is a psychological health behavior change model developed to explain and predict health-related behaviors, particularly in regard to the uptake of health services (Janz & Marshall, 1984). The model was developed in the 1950s by social psychologists at the U.S. Public Health Service (Rosenstock, 1974) and remains one of the most well-known and widely used theories in health behavior research. It suggests that people's beliefs about health problems, perceived benefits of action and barriers to action,and self-efficacy explain engagement (or lack of engagement) in health-promoting behavior (Janz & Marshall, 1984). A stimulus, or cue to action, must also be present in order to trigger the health-promoting behavior. This model hypothesizes that health-related action depends upon the simultaneous occurrence of three classes of factors:

1. The existence of sufficient motivation (or health concern) to make health issues salient or relevant.
2. The belief that one is susceptible (vulnerable) to a serious health problem or to the sequelae of that illness or condition. This is often termed perceived threat.
3. The belief that following a particular health recommendation would be beneficial in reducing the perceived threat, and at a subjectively-acceptable cost. Cost refers to perceived barriers that must be overcome in order to follow the health recommendation.

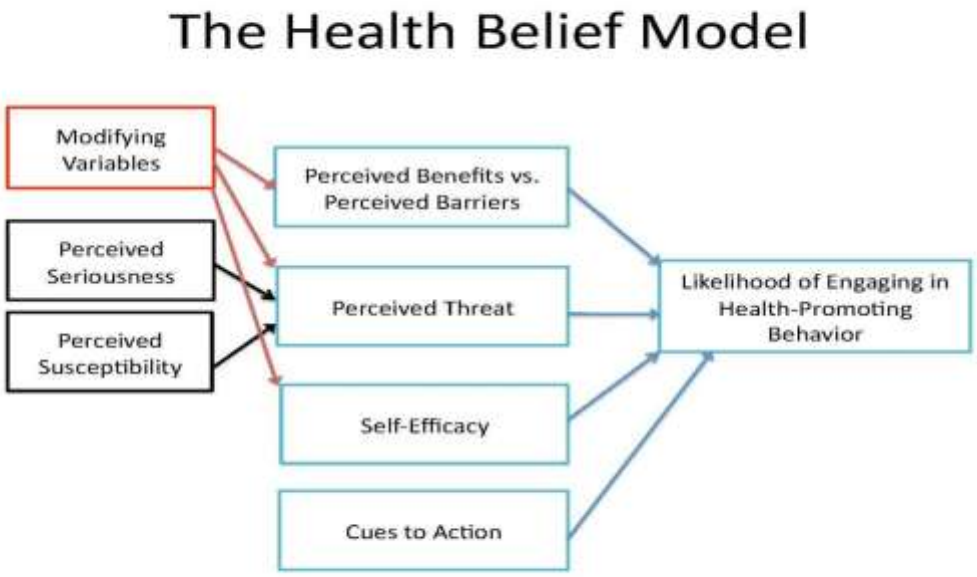

Figure 1: Theoretical Framework

Source: Adapted from Nutbeam and Harris, 1998

2.7 Conceptual Framework

Dynes M(2012) defines a conceptual framework as an analytical tool with several variations and contexts. It is used to make conceptual distinctions and organize ideas. Strong conceptual frameworks capture something real and do this in a way that is easy to remember and apply. Figure 2 shows the conceptual framework for this study.

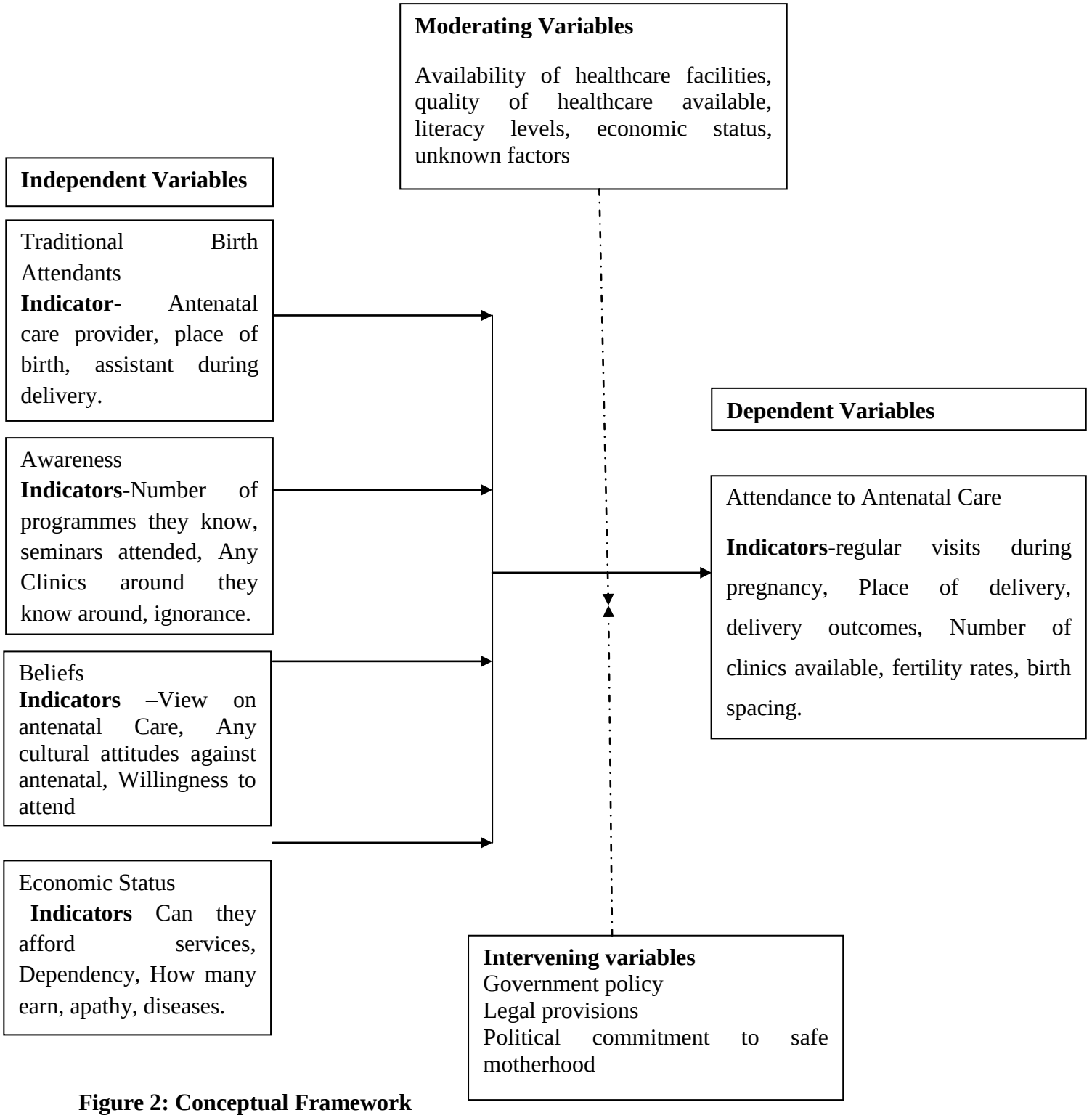

Figure 2: Conceptual Framework

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

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

3.2 Research Design

The study was conducted as a cross sectional survey using both qualitative and quantitative designs. This design was favored because childbirth experiences could be quite painful, and the questions highly personal and sensitive to answer. Therefore, answering the questions in a language they understand too well helped the researcher to establish personal contact with the respondents and created an easy environment in which they felt comfortable to share their experiences. Second, this design is best for this study since neither follow-up nor any inquiry into the past was necessary; the investigator met the respondents once and gathered all the information in one encounter.

3.3 Target Population

The target population of the study was the Somali women in Nairobi. As earlier noted in this paper, there are approximately 46,000 Somali residents in Nairobi, most of who live in Eastleigh (UNHCR 2010). Among these, women form 56% (25,760) .The targeted women were 18,844 (73.15%) whose ages range between 15-45 years.

3.4 Sampling procedure

This research adopted Cluster Sampling Technique where the entire population was divided into groups, or clusters according to their locations within the Sub County and a random sample of these clusters selected. All observations in the selected clusters were included in the

sample or simple random sampling techniques were used to pick out the individuals included from each cluster as recommended by (Caswell F 1989). This method was considered because it was very difficult to know the exact numbers of individuals in this targeted population given their status.

3.4.1 Sample size determination

According to http://www.raosoft.com/samplesize.html, the population size of 18,844 at 90% response distribution with a margin error of 5% and confidence level of 95%, the sample size would be **138**. This study adopted this sample size. For this study, this number was taken to be adequate representation of the population

3.4.2 Sample selection

Non-Probability sampling was used to select the sample for this study. A female Somali research assistant helped to randomly select the first participants. After the first participants were selected, the study used snowball to identify remaining participants. An important part of the recruiting process was solicitation of informed consent.

3.5 Methods of Data collection

Data was collected using self administered questionnaires. The researcher had questionnaires designed in a way that the questions administered were related to each other. The questions design considered the nature and need of the respondents to determine the sequence of questions and the organization of the schedule. In order to achieve this, the researcher had to ensure that the question process quickly awakened interest and motivated the respondent to participate in the interview with ease, the respondents were not confronted by early requests for information that might have been considered personal or ego threatening since the questioning process began with simple item and moved to the more complex and from general items to the more specific issues.

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

Data was collected by the researcher over a period of four weeks. The Research Assistant first read the letter of transmittal to the respondent and clarified all the concerns of the respondents before administering the questionnaires.

3.5.1 Validity of the instruments used

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

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

3.5.2 Reliability of the instruments used

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

3.6 Data analysis techniques

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

3.7 Ethical considerations

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

Some of the questions in the questionnaire might have been uncomfortable for some respondents to answer. It was made clear at the beginning of every interview that some of the questions could have been embarrassing and that all the information provided was completely voluntary and that the interview could be stopped at any time or a question skipped.

In addition, questionnaire length was kept as short as possible while still maintaining the quality of the data so as not to take too much valuable time away from the respondents. At the end of every interview, respondents were appreciated with a small gift such as a bar of soap, although they were not to know at the beginning that they would be receiving this gift so as to ensure voluntary participation

3.8 Operationalization of the study

Table 3.1: Operationalization table

Objective	Variable	Indicators	Measurement	Measurement Scale
To establish the influence of presence of Traditional Birth Attendants (TBAs) in antenatal services seeking behavior among Somali women in Eastleigh, Nairobi.	**Independent** Reliance on TBAs in pregnancy and delivery	Visits to antenatal clinics Complications before labor Place of delivery Assistance during delivery Complications during labor and delivery Post birth complications Pregnancy outcome	No. of occurrence No. of occurrence Name Name No. of occurrence No. of occurrence No. of occurrence	Ordinal Ordinal Nominal Nominal Ordinal Ordinal Ordinal
To investigate the extent to which level of maternal awareness influences attendance to antenatal care by the Somali women in Eastleigh, Nairobi County.	**Independent** Level of awareness	Mass media utilization literacy levels Government maternal campaigns ignorance	No. of occurrence No. of occurrence No. of occurrence No. of occurrence	Ordinal Ordinal Ordinal Ordinal
To investigate how Cultural beliefs towards modern reproductive services affect antenatal seeking behavior among the Somali women in Eastleigh, Nairobi.	**Independent** Cultural attitudes	Willingness Cultural beliefs	No. of occurrence No. of occurrence	Ordinal Ordinal
To find out how economic status contribute to the number of Somali women in Eastleigh ,Nairobi who attend antenatal services and care	**Independent** Economic status	Unemployment Level of income Place of residence	No. of occurrence No. of occurrence Name	Ordinal Ordinal Nominal

3.9 Summary

This chapter details the methods of data collection, analysis and presentation used in the study. It focuses on Research design, Target population, Sampling procedure, Methods of data collection, Validity of the instruments used, Reliability of the research findings and data analysis techniques used in the study. The study was conducted as a cross sectional survey and the target was Somali women aged 18-55 years. The validity of the instruments used for data collection were tested by a pre test of the questionnaires at the School of Communication at Daystar University, Nairobi Campus over a period of two days, two weeks prior to embarking on the actual study where questions that were not clear were modified in order to improve on the validity of the responses later obtained through the questionnaires.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTEPRETATION

4.1 Introduction

This chapter presents the findings of the study on factors influencing attendance to antenatal care services in Kenya, the case of Somali women in Eastleigh Nairobi County, Kenya.

It is organized based on the themes of the study; Traditional Birth Attendants, maternal awareness, Cultural beliefs and economic status and their influence on the antenatal seeking behavior among the Somali women. The results are presented in tables and discussion is given after each table.

4.2 Response return rate

A sample size of 138 respondents was targeted based on http://www.raosoft.com/samplesize.html, sample size calculation. The researcher therefore administered **138** questionnaires to the respondents. However, **118** questionnaires were returned giving a response rate of 85.5%. According to Timothy & Linda, **80**% is a de facto standard questionnaire return rate on which reliable data can be received for a study.

4.3 Background characteristics

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

Table 4.1: Background characteristics of respondents

Characteristics	No. of respondents	Percentage %
Ages of respondents (Years)		
15-20	30	25.40
21-34	45	38.12
35-40	25	21.21
41-45	10	8.53
Above 45	8	6.80
Totals	**118**	**100**
Religion		
None	6	5.1
Muslim	85	72.0
Christian	15	12.8
Traditional	12	10.2
Totals	**118**	**100**

Level of Education		
None	60	50.8
Primary	25	21.2
Secondary	20	17.0
College and above	13	11.0
Totals	**118**	**100**
Area of Residence		
Eastleigh	80	67.8
Majengo	13	11.07
Pumwani	10	8.5
Kamukunji	15	12.7
Totals	**118**	**100**

Majority of the respondents (38.12%) were aged between 21-34 years. Only 8.53% of the respondents were aged between 41-45 years while 6.80 % were above 45 years of age. 25.40% of the respondents were aged between 15-20 years while 21.21% were aged between 35-40 years. This sample was appropriate for this study because majority lie within the reproductive age. Therefore it was believed that the respondents would give reliable and firsthand accounts of their reproductive experiences within the Somali cultural setup.

Religion was considered a key factor in this study hence the respondents were also asked to give their religions. 72.0% of the respondents were Muslims while only 5.1 % identified themselves with no religion therefore gave no preference. 12.8 % of the respondents were Christians while 10.2% practised traditions. These findings confirm a presumed fact that Somali

population is predominantly Muslim. Muslim as a religion is therefore considered an influence in so many issues of life across the Somali population hence this study considered it a great determinant on the maternal care seeking behavior across the target population.

The respondents were asked the education level they had attained. Majority of the respondents (50.8%) were illiterate compared to 49.2% who could read and write. For those who had attended school, majority (21.2%) had primary level education while 17% and 11% had attained Secondary and tertially education respectively. Levels of literacy are known to influence maternal choices among women. This sample was appropriate for this study because a majority of the respondents are illiterate or semi-illiterate and therefore education does not influence their reproductive choices. This is the proportion that greatly believes that attendance to clinical services during pregnancy is not of much essence and can be sought elsewhere as long as there are no complications during pregnancy.

Proximity to the clinics was considered a very crucial component of this study hence the respondents were asked where they resided across the delimitation. Majority (80%) of the respondents resided in Eastleigh locations while the lowest (10%) number lived in Pumwani location.13% resided in Majengo with 15% residing in Kamukunji locations. The study indicated majority of those residing in Pumwani Location had attended antenatal clinics regularly compared to those from Eastleigh.

4.4 Traditional birth attendants

The study sought to establish the extent to which traditional birth attendants (TBAs) influence maternal health among Somali women in Eastleigh Nairobi.

4.4.1 Pregnancy history of the respondents

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

Table 4.2: Pregnancy history

Response	No. of respondents	Percentage %
Yes	100	84.7
No	8	6.8
No response	10	8.5
Totals	**118**	**100**

A majority of the respondents (84.7%) had been pregnant in their life time. Only 8 women, 6.8 % of the respondents, had never been pregnant while 8.5% opted not to answer. These findings show that the sample is suitable for the study because most of the respondents have had pregnancy experiences and their responses would be reliable in so far as their experiences with TBAs are concerned

4.4.2 Pregnancy status

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

Table 4.3: Pregnancy status of respondents

Response	No. of respondents	Percentage %
Yes	18	15.3
No	90	76.3
No response	10	8.4
Totals	**118**	**100**

Of all the respondents, 15.3% confirmed to be pregnant at the time the study was carried out while 10 women (8.4%) did not respond. 76.3% were not pregnant then.

4.4.3 Antenatal care attendance

To get responses on their health seeking behavior during pregnancy, the respondents who had been pregnant before were asked if they had been attended by anybody for antenatal care. Findings are shown in table 4.4

Table 4.4: Antenatal care attendance

Response	No. of respondents	Percentage %
Yes	75	63.6
No	35	29.7
No response	8	6.8
Totals	**118**	**100**

63.6 % of pregnant women reported that they had sought services from different quarters during their pregnancies. 29.7% of the pregnant respondents reported that they had not sought any antenatal care while 8 women (6.8%) declined to answer. This could be attributed to ignorance given the high levels of illiteracy among the Somali women. Some of these women are also live underground lives, failing to make use of available healthcare systems with fear of repatriation back to the camps hence endangering their lives and those of their unborn babies.

4.4.4 Antenatal care provider

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

Table 4.5: Antenatal care provider

Response	No. of respondents	Percentage %
Nurse/midwife	30	25.4
TBA	84	71.2
Other	3	2.5
No response	1	0.8
Totals	**118**	**100**

25.4 % of the pregnancy experienced women who had sought antenatal care reported that they got their antenatal care from a either a nurse or a skilled midwife, while 2.5 % reported that they got their antenatal care from friends and relatives. A majority of the women (71.2%) reported that they had sought for the services of traditional birth attendants. These findings show that despite consulting nurses and skilled midwives for antenatal care, many women still seek out

for the services of TBAs. This could be due to the amount of trust these women have in services of TBAs and are at home with cultural means of antenatal healthcare.

4.4.5: Services by TBA in delivery

In assessing dependence of women on the services of TBAs, the respondents were asked whether they relied on a TBA in delivery in their last pregnancy. Findings were presented in table 4.6

Table 4.6: Services by TBA in delivery

Response	No. of respondents	Percentage %
Yes	96	81.4
No	10	8.5
Don't remember	12	10.2
Totals	**118**	**100**

Majority of the respondents (81.4%) reported that they were assisted by TBAs in their last delivery while 8.5% got help from relatives and friends. 10.2% did not respond.

The above scenario signifies an attitude that antenatal period is a natural phenomenon that has always happened even before the advent of modern medicine. Therefore, women view home maternal care with the help of TBAs as natural and culturally appropriate, and await the outcome God has determined. Thaddeus and Maine (1994) found a similar attitude about the normalcy of delivery and recognized this attitude as an important delay in that a normal, natural phenomenon is not something that necessitates planning ahead or spending money for hospital expenses. These cultural beliefs influence women's decision of whether to travel to a health

facility. Bantebya Kyomuhendo (2003) describes these behaviors and beliefs as being rooted in a "fatalistic culture" towards birth in that childbirth is normalized and a natural process that women are supposed to endure and does not require special attention This belief makes women relax from going to health facilities because they are expected to bravely withstand all the complications a pregnancy comes along with.

4.4.6 Expected birth

To find out attitudes towards pregnancy and childbirth in future, the respondents were asked if they wanted to have a baby in the future. Their responses were presented in table 4.7.

Table 4.7: Expected birth

Response	No. of respondents	Percentage %
Want babies in future	80	67.8
Don't Want babies	30	25.4
Don't know	8	6.8
Totals	**118**	**100**

A significant 67.8 % of the respondents indicated that they would wish to have children in future. These results show that a majority of the respondents are still within the child bearing age and therefore suitable for this study. 25.4% reported that they would not wish to have babies in future while 6.8 % gave no response.

4.5 Maternal awareness

This part presents data relating to the women's level of awareness of the antenatal care services available; whether they utilize them or not.

4.5.1 Awareness of services offered

To find out how much they knew about maternal services available, the respondents were asked if they were aware of any services offered during pregnancy and the responses presented in table 4.8

Table 4.8: Awareness of services offered

Response	No. of respondents	Percentage %
Yes	37	31.4
No	75	63.6
No response	6	5.1
Totals	**118**	**100**

Majority of the women (63.6%) indicated that they were completely unaware of any ante natal care services offered despite the mushrooming Bill Boards and Radio advertisements. This factor can be attributed to the fact that most of the target populations were illiterate and also did not own either a TV or radio which transmits this important information. Only 31.4% said they were aware of the available services during pregnancy and they were utilizing them.6 women did not give their response.

4.5.2. Services aware offered during pregnancy

Among the respondents who were aware of some services offered during antenatal period and therefore attended clinic, an enquiry was done to study the extent of their knowledge on those

services. They were asked to indicate the services they were aware were offered during clinical visits in preparation for birth and the responses recorded in table 4.9

Table 4.9: Services are you aware offered during pregnancy

Response	No. of respondents	Percentage %
Scanning	52	44.1
Physiotherapy	39	33.1
None	27	22.8
Totals	**118**	**100**

44.1% indicated that they had been scanned during their visits while 33.1% indicated physiotherapy as a service they were well aware of.22.8% knew there were services offered but did not seem to know what specifically they were; the latter could be assumed to be the semi illiterate who had gotten the information from friends and had attended to the services but did not know the exact service they were given. These respondents are a great presentation of the target population.

4.5.3. Media of information for awareness

Due to the different levels of awareness across the respondents, the research deemed it fit to find out the different channels through which the responds had gotten the information on maternal issues through so as to establish what contributed to the disparities. The respondents were therefore requested to indicate how they had gotten information about the existing services for antenatal care. The responses were recorded in table 4.10

Table 4.10: Media of information for awareness

Response	No. of respondents	Percentage %
Radio/TV	30	25.4
Friends	64	54.2
Written	15	12.7
No response	9	7.6
Totals	**118**	**100**

Majority (54.2%) of the respondents indicated they had gotten information from either friends or family members while 25.4 % had heard through radio or TV. Only 12.7% had gotten the information through written materials like brochures, journals, newsletters, Bill boards.7.65 were not sure how they got the information though they appreciated at least knowing of some services offered. The fact that most had gotten information through friends and relatives despite the ever mushrooming advertisements shows that most people from this cultural background trust what is verbally communicated across their networks than information from external sources.

4.5.4 .Use of antenatal care Information

The results on awareness clearly indicated majority of the Somali women were aware of at least a service offered during their pregnancy periods. Despite this information, many indicated they had not been consistently visiting clinics during this crucial period. The researcher therefore sought to understand whether they intended to use the information they had to attend to antenatal care in their subsequent pregnancies. The findings were recorded in table 4.11

Table 4.11: Use of antenatal care Information

Response	No. of respondents	Percentage %
Ready	34	28.8
Not ready	54	45.8
No idea	30	25.4
Totals	**118**	**100**

Despite the information having reached them, majority of the women conducted were still not ready to attend to antenatal services with 45.8% appreciating they were aware of the services but were still reluctant to attend to those clinics. Only 28.8% of the respondents seemed ready to attend to clinics; some of whom had not done it before. Surprisingly, 25.4% did not know whether they should or even why it was necessary for them so they opted not to answer. The reluctance to attend to these services was pegged on a feeling that the services provided were not as friendly as the one they got from the Traditional Birth attendants and Midwives whom they also indicated were relatively cheaper and flexible.

4.6 Cultural beliefs

This part presents data relating to how the Somali cultural beliefs, values and attitudes influence antenatal clinics attendance during pregnancy.

4.6.1 Communal influence

To find out how cultural attitudes and beliefs informed their ante natal clinic attendance they were asked whether people in their localities discouraged expectant women from attending clinics and the responses tabulated in table 4.12

Table 4.12: Communal influence clinics

Response	No. of respondents	Percentage %
Yes	65	55.1
No	42	35.6
Not sure	11	9.3
Totals	**118**	**100**

The population under study is presumed to maintain a very close social network especially due to its uniqueness and the organization where communal harmony is embraced. It's therefore expected that most a decisions are made on community level and even most of individual decisions are informed and influenced by the community. These decisions go to the extent of personal matters like health and marital issues. This is confirmed by the number of women who said they had been discouraged by the community from attending to clinics despite having been informed how vital that is during antenatal period. A significant 55.1% of women reached indicated that they had directly been discouraged from seeking antenatal services compared to 35.6% who made independent decisions on the matter.3% were not sure whether they were discouraged or not.

4.6.2. Antenatal care Attendance

The researcher sought to find out whether the respondents had people they witnessed attending to antenatal care services. The results were recorded in table 4.13

54.2% of the respondents confirmed having witnessed pregnant mothers attend to antenatal services though not many of them knew exactly what services were sought.38.1% of the

respondents had no idea of any of their friends or family who had sought antenatal care services which confirmed they were also unlikely to seek for the same.9 women(7.6%) never responded.

Table 4.13: Antenatal care Attendance

Response	No. of respondents	Percentage %
Yes	64	54.2
No	45	38.1
No response	9	7.6
Totals	**118**	**100**

4.6.3. Service provider

With majority of respondents confirming that their friends and families had sought antenatal services, it was imperative to know where exactly they sought these services from. The responses were as indicated in table 4.14

Table 4.14: Service provider

Response	No. of respondents	Percentage %
Clinic	30	25.4
TBA	82	69.5
No response	6	5.1
Totals	**118**	**100**

A majority of those known to have sought for antenatal services had more trust in Traditional Birth Attendants than the other service providers under study.69.5% of the respondents said that their friends had visited a TBA for the services compared to a dismal 25.4% who were known to have sought these services from medical centres.5.1% never responded. This is an indication that cultural attitudes and values play a significant role in the maternal seeking behavior across the Somali women. As the results indicate, a great number feel it is more acceptable in their norms and culture to have these services provided by the unskilled Traditional Birth Attendants.

4.6.4. Antenatal care and religion

Religion is believed to play a key role especially in the Somali culture and norms therefore it was imperative to understand the extent to which this happens. The respondents were asked to indicate whether their religion(s) allowed them to seek for antenatal services during their pregnancy period. The responses were as tabulated in table 4:15

Table 4.15: Antenatal care and religion

Response	No. of respondents	Percentage %
Yes	43	36.4
No	48	40.7
No response	17	14.4
Totals	**118**	**100**

The highest number of respondents (40.7%) indicated that religion had no issue with them seeking antenatal services. However a significant number of 36.4% felt that their religions did

not support these services though they couldn't substantiate. A great number (14.4%) did not take any position something that showed that these sensitive matters might not have discussed clearly and openly in their religious places or they considered religious matters so sensitive to discuss.

4.6.5. Problems associated with antenatal care services

A significant number of respondents had shown reluctance of attending to antenatal care services. It was important to find out whether there were cases where they, their friends or family members had attended and gotten any problem as a result of the services provided. The respondents were asked to indicate any problem they associated with antennal care and results captured in table 4.16

Table 4.16: Problems associated with antenatal care services

Response	No. of respondents	Percentage %
Yes	15	12.7
No	85	72.0
No response	18	15.3
Totals	**118**	**100**

Most of the respondents (72.0%) did not have any case scenario of a problem associated with antenatal care provision. Only 12.7% had felt that most of their friends had suffered physiological trauma after visiting these clinics due to mistreatment by care givers. A number of

women (15.3%) did not respond. This indicated that the reluctance of the Somali women to attend to antenatal care services is not informed by any problem associated with the services but by an attitude created in association with their culture

4.7 Influence of economic status on attendance of antenatal care

This section seeks to present data on how economic status of the respondents influenced their attendance of antenatal care.

4.7.1. Income generating activity

The respondents were asked whether they were presently involved in any income generating activity. Their responses were recorded in table 4.17

Table 4.17: Income generating activity

Response	**No. of respondents**	**Percentage %**
Yes	25	21.2
No	85	72.0
No response	8	6.8
Totals	**118**	**100**

Most of the Somali women involved in the study were not involved in any income generating activity hence depended on their spouses or families economically.72.0% said they depended on other people with only a 21.2% either working or involved in business which gave them financial independence.6.8% did not disclose their economic status. This dependency is a major

impediment to women especially child bearing age since they can only attend to antenatal services only when provided for.

4.7.2. Monthly income

Maternal health is a key segment in every mothers life hence should be considered as such. In most circumstances this is not the case due to other issues of more priority like food and shelter. Availability of this key service doesn't guarantee utilization especially where income is outweighed by basic needs. The researcher sought to know the average earned by the Somali women in an effort to determine their affordability of the services available. Their responses were recorded in table 4.18

Table 4.18: Monthly income

Response	No. of respondents	Percentage %
Below 15,000	65	55.1
15,001-25,000	40	33.9
25,001-35,000	10	8.5
Above 35,00	3	2.5
Totals	**118**	**100**

More than half (55.1%) of the women involved in the study indicated that they earned below 15,000 Kenyan Shillings with only 8.5% earning an average of 30,000 per month.33.9% earned an average of 20,000 while 3 of the respondents did not answer. This data confirms the fact that

even the few Somali women involved in income generating activities can barely afford consistent antenatal services without getting support from other quarters.

4.7.3. Affordability of antenatal services

The respondents were asked whether they felt the antenatal services available were affordable. The responses were as indicated in Table 4.19.

Table 4.19: Affordability of antenatal services

Response	No. of respondents	Percentage %
Can afford	24	20.3
Can't afford	80	67.8
Don't know	14	11.9
Totals	**118**	**100**

80% of the respondents felt that the antenatal services were very expensive for them compared to 20.3% who felt they can sufficiently cater for those services indepedently.11.9% did not respond since they had no or very little knowledge about antenatal care services. This big percentage of women who cannot afford quality health care during their pregnancy confirms why there is still reliance of the services of the semi skilled and unskilled birth attendants hence putting their lives to great risks.

4.7.4 Inattendance to antenatal care

The respondents were asked whether they knew anybody; either from their families or friends who did not seek antenatal care services during their pregnancy. The responses were recorded in table 4.20.

Table 4.20: In attendance to antenatal care

Response	No. of respondents	Percentage %
Yes	85	72.0
No	25	21.2
No response	8	6.8
Totals	**118**	**100**

A majority of respondents (72.0%) said they knew at least a woman who had not sought antenatal services during their pregnancy. Only 21.2% said they had no knowledge of any woman who had not sought these services with 6.8% not responding. This high number of women known to have failed to attend antenatal clinics is a major concern and an issue that replicates across the Somali women.

4.7.5. Reason for non-attendance

This question sought to establish exactly why some women did not attend antenatal clinics during their pregnancy despite knowing the importance. The respondents were then asked why they thought expectant women failed to attend. The responses were recorded in table 4.21

Table 4.21: Reasons for non-attendance

Response	No. of respondents	Percentage %
Could not afford	90	76.3
No facilities	18	15.3
Can't remember	10	8.5
Totals	**118**	**100**

A majority of the respondents (76.3%) felt women did not attend to antenatal clinics because it was too expensive for them hence could not afford.15.3% said those who failed to attend did not know of the facilities provided hence sought assistance elsewhere while 8.5% did not remember the reasons their families and friends did not attend to antenatal clinics. Whether factual or fiction, there is a common belief among the Somali women that antenatal services are too expensive to afford hence shy away and seek assistance from other quarters.

4.7.6. Income generating activity involvement

The respondents were asked whether those they knew could not afford the services were involved in any income generating activity at the time of their pregnancy. The responses were recorded in table 4.22

Table 4.22: Income generating activity involvement

Response	No. of respondents	Percentage %
Activity	10	8.5
No activity	95	80.5
No response	13	11.0
Totals	**118**	**100**

Only 8.5% of the respondents indicated that they were aware of women generating income but could not afford these services while 80.5% indicated that those who could not afford were not involved in any income generating activity.11% did not respond.

This clearly indicated that the ability to cater for these services is dependent on financial stability and independence in decision making.

CHAPTER FIVE

SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

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

5.2 A summary of findings

Majority of the respondents were within the active ages of reproduction. The highest number of respondents ((38.12%) were between 21-34 years considered to be the most active in terms of reproduction stage. 72% of the respondents were Muslims while a majority, 50.8%, had not attended any school.

5.2.1 Traditional Birth Attendants

71.2 % of the respondents reported that they had directly relied on the services of TBAs, most of whom are untrained, for antenatal care. There was a strong correlation between attendance of antenatal care and the final delivery aid with 81.4% of the respondents reporting that they also relied on the same service providers during their delivery period. This can be attributed to the fact that the respondents exhibited great confidence and trust in the TBAs than any other service provider despite the risks and complications related to it. This can be risky especially in cases where the maternal complications are life threatening and need urgent specialized attention.

With regard to their pregnancy status, majority (84.7%) of the respondents indicated that they have had pregnancy before with 15.3% being pregnant at the time of the study.67.8% of the respondents expressed willingness to have babies in future and therefore the combination of the past, present and future pregnancy status and expectations placed the respondents as the most relevant source of data for this study.

Impact of TBAs on Somali women's ante natal behavior is also reflected in the number of the pregnant women who deliberately had never sought services elsewhere despite the impending dangers. This is a very risk scenario because the number of experienced and skilled midwives cannot match the demand hence Somali women put their lives and that of their unborn

babies at risk. TBAs inability to prescribe relevant medical care can also lead to birth complications and fatalities. These fatal outcomes can be prevented or reduced further if women got the right care during pregnancy and delivery.

5.2.2 Maternal awareness

Despite the importance and essence of health services, they cannot be fully utilized if the targeted groups are not sensitized on the importance of utilizing them. In this study, 63.6% of the respondents indicated that they were unaware of any ante natal care services offered even though they appreciated they needed such services. This could easily be associated with the high illiteracy levels of the Somali women who despite having so many information materials like billboards and even public announcements made over the radio and televisions they were not aware of how antenatal care could be of help to them. The 31.4% who said they were aware of the available services during pregnancy acknowledged how useful they were and indicated that they had shared the information with their counterparts most of whom did not seem interested.

The respondents who had antenatal care knowledge appreciated having received services like scanning and physiotherapy which was of great help across the entire antenatal period and never had they gotten any complications or lost any pregnancy. Surprisingly, 22.8% were aware there were services offered but did not seem to know nor were they interested on how the same could benefit them. This could be attributed to the fact that 54.2% of these respondents had gotten information from either friends or family members which they did not seem to take as serious.

Majority of this group were illiterate and could neither read any informational materials nor follow the mushrooming advertisements on antenatal care services. Unfortunately, as earlier noted majority of Somali women who responded are illiterate hence the penetration of

information proved to be very hard. No wonder 45.8% appreciated the services but indicated they were not ready to attend to those clinics rather they trusted midwives and Traditional Birth Attendants whom they felt offered friendly services.

5.2.3 Cultural beliefs

Cultural values, beliefs, attitudes and perceptions seem to influence so many decisions across the Somali community including matters of maternal health. In this study, 55.1% of the respondents indicated that they had directly been discouraged from seeking antenatal services either by their immediate family members or by influential persons in their lives. The population is assumed to maintain such a close social network hence most of the decisions made cut across the community against which is considered a taboo.

To ascertain the fact that most women from the Somali community viewed attending antenatal clinics as a taboo, the study recorded 54.2% of respondents who despite having knowledge of other pregnant mothers seeking antenatal services, they had no idea what services were sought for. This confirms that these issues are not openly discussed across this community but treated as a private affair. 69.5% of the respondents said that their friends and family members had visited a TBA and midwives to seek antenatal services. Religion did not seem to have any negative impact on the antenatal seeking behavior of the Somali women with those claiming it was an issue lacking any substantial reason for the same. 72.0% did not have any case scenario of any problem they could associate with antenatal care provision even where they did not attend to the services.

5.2.4 Economic status

Maternal care services are not exclusively free in Kenya. It’s therefore easier to access these services for mothers who are in a position to cater for the costs than those who go in the pretext of free service. This fact was established in this study with 72.0% of the respondents indicating

they were not involved in any income generating activity hence depended on other people financially hence had no authority over finances . This dependency is a major impediment to women, especially child bearing age, since they can only attend to antenatal services only if and when provided for.

It's worth noting that for many people health is not a primary priority especially in maternal matters which are not considered to be sickness. This therefore makes antenatal visits a secondary priority which can only be met after other prioritized issues. 55.1% of the respondents involved in any income generating activity earned below 15,000 Kenyan shillings which is barely sufficient to cater for needs like food and rent which obviously take precedence. It's therefore a common phenomenon across the Somali women that antenatal services are out of their reach with 80% of the respondents claiming that it was too expensive for them to afford hence opting for other measures despite having knowledge on the risks involved. They respondents indicated that majority of the pregnant women they ever knew to have attended antenatal clinics were either earning or from an economically stable family. It was established that the financially independent women visited clinics more consistently than those that relied on a secondary support. Of all those that had never attended any antenatal clinic, none of them was involved in any income generating activity.

5.3 Conclusions

From the study findings discussed above, the following conclusions were made; TBAs, cultural attitudes and beliefs, level of antenatal care awareness and economic status were found to affect the antenatal care behavior among the Somali women. These factors are therefore

important intervention points for the government as well as the Non Governmental Organizations in the effort to minimize maternal mortality and morbidity among Somali women.

Cultural beliefs and misconceptions play a key role in continued use of TBAs in provision of antenatal care and even determining birth place which greatly determines the outcome of that pregnancy. Many Somali women hold misconceptions about only needing to go to the hospital in case of antenatal complications which hinder them from improving their health behavior. Health education about the importance of attending antenatal services could greatly benefit Somali women and help them start the process of changing their reproductive health-seeking behavior.

Economic independence is a great influence in the way Somali women seek antenatal care. There should therefore be a way to make sure that Somali women are in an income generating activity and this should be inculcated at early stages of life where they should be encouraged to seek formal education, Train them on entrepreneurship, help them understand how they can benefit from women funds and be self sustainable.

5.4 Recommendations

The following recommendations were put forward based on the study findings discussed in this study. First, having established that TBAs among the Somali community are key maternal influencing factors, there should be a curriculum to have them trained to be able to recognize maternal complications, and learn more reproductive health information to be able to better inform pregnant mothers about good practices during pregnancy, refer those with high-risks for complications, and conduct deliveries in cases where women cannot access health centers. It is vital that someone with training be available in the community for emergency antenatal services.

Secondly, community sensitization programs should be increased and be implemented through the local administration, folk theatres, cultural groups, youth and women's organizations, schools and extension services. The fact that most Somali women got information through friends and relatives despite the ever mushrooming advertisements shows that most people from this cultural background trust what is verbally communicated within their networks than information from external sources hence more open *barazas* should be conducted. Trained TBAs and health workers can also be mobilized to transmit health messages to women who in turn will serve as agents of change in their own communities.

Thirdly, there should be concerted and strengthened actions towards economically empowering women to help them afford the services available during expectancy. They should be trained on proper management of their funds based on the fact that most Somali women earn so little to cater for all their needs. The clinics should also put in place mechanisms that can routinely monitor how women seeking antenatal care are treated so as to allay fears that most health service providers are unfriendly and might cause a pregnant mother lose the baby. Other governmental and non-governmental organizations and various public associations, such as Women's Associations should also be actively involved in endeavors aimed at eliminating these harmful beliefs.

Lastly, religious leaders should partner with the government in preaching on the vitality of attending to antenatal care so as to make it look like a taboo if one does not attend. The community should be collectively sensitized and those that comply could be motivated with at least a post natal baby kit to make them want to attend to these services in their subsequent pregnancies.

5.5 Suggestions for further research

This study had a relatively small sample size of 118 participants given the short period of time that was available to complete the research. It would be more beneficial to attempt to replicate the study with a much larger sample size.

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

It would also be beneficial to carry out the study across many other cultural backgrounds and demographics so as to come up with relevant measures to conclusively address this menace.

REFERENCES

Alkaabi M.S, (2014).*Women's knowledge and attitude towards pregnancy in a high-income developing country*. J Perinat Med.

Becker M.H.& Janz N.K.,(1984). *"The Health Belief Model: A Decade Later". Health Education* 11 (1):1–47.doi:10.1177/109019818401100101.Retrieved12/2/2014.

Berg JA, Woods NF. *Global women's health: a spotlight in care giving*.Nurs Clin North Am 2009;44:375–84.

Bloom SS, Wypij D, Gupta MD.(2006) *Dimensions of women's autonomy and the influence on maternal health care utilization* north Indian City. Demography 200

Campbell-Grossman C, Hudson D.B, Keating-Lefler R, Yank J.R, (2009) .*Community leaders' perceptions of Hispanic, single, low-income mothers' needs,concerns,social support, and interactions with health care services*. Issues Compr Pediatr Nurs. ;32(1):31-46. doi: 10.1080/01460860802610194.

Chalo, R.N., Salihu, H.M., Nabukera, S., & Zirabamuzaale, C. (2005) *Referral of high-risk pregnant mothers by trained traditional birth attendants,* Buikwe County, Mukono District, Uganda. *Journal of Obstetrics and Gynaecology*, *25*(6), 554-557.

Chiang C, Labeeb SA, Higuchi M, Mohamed AG, Aoyama A(2013).*Barriers to the use of basic health services among women in rural southern Egypt* . Nagoya J Med Sci.

Choudhury N & Ahmed S. (2011). *Maternal care practices among the ultra poor households in rural Bangladesh: a qualitative exploratory study*. BMC Pregnancy Childbirth. 2011 Mar 1;11:15. doi: 10.1186/1471-2393-11-15.

Comerasamy, H., Read, B., Francis, C., Cullings, S., & Gordon, H. (2003). *The acceptability and use of clinics; a prospective study of Somalian women's attitudes*. *Journal of Obstetrics and Gynaecology, 23* (4), 412-415.

Dako-Gyeke P, Aikins M, Aryeetey R, McCough L, Adongo PB .(2013).*The influence of socio cultural interpretations of pregnancy threats on health-seeking behavior among pregnant women* Accra, Ghana. MC Pregnancy Childbirth. 2013 Nov 19;13:211. doi: 10.1186/1471-2393-13-211.

Dawit A,Eshetu W, Masresha G, Misganaw B,(2005). *Harmful Traditional Practices.* The Carter Centre

Degni F, Koivusilta L, Ojanlatva A. (2006). *Attitudes towards and perceptions about medical care use among married refugee women of Somali descent living in Finland*.

Docherty SL, Lowry C, Miles M.S,(2007).*Poverty as context for the parenting experience of low income Lumbee Indian mothers with a medically fragile infant*. Neonatal Netw. Nov Dec;26(6):361-9

Dynes M, Stephenson R, Rubardt M, Bartel D. (2012) *The influence of perceptions of community norms on current clinical use among men and women in Ethiopia and Kenya. Health Place*.. doi: 10.1016/j.healthplace.2012.04.006. Epub 2012 May 1.PMID:22579117

Egbewale B.E, Bamidele J.O,(2009).*Demographic profile of mothers and their utilization of maternal health-care services*, Osun State, Nigeria. Niger Postgrad Med J. Jun;16(2):132-

USAID. (2008). *Somali refugee attitudes, perceptions and knowledge of reproductive health, family planning and gender-based violence.*02(4563.345)

Filippi V, Ronsmans C, Campbell OMR, Graham WJ, Mills A, Borghi J, Koblinsky M, Osrin D. (2006) *Maternal health in poor countries: the broader context and a call for action*. Lancet. 2006;368(9546):1535–1541. doi: 10.1016/S0140-6736(06)69384-7.

Finlayson K, Downe S. (2013) *Why do women not use antenatal services in low- and middle income countries?* A meta-synthesis of qualitative studies. PLoS Med. 2013 Jan;10(1):e1001373. doi: 10.1371/journal.pmed.1001373. Epub 2013 Jan 22.

Fisher,R.P,Quigley,K.L,Brock P,Chin D,& Cutler,B.L,(1990). *The effectiveness of the Cognitive interview in description and identification tasks*. America Psychology Law Society,Williamsburg,Virginia.

Gele AA, Sundby J. (2013). *Attitudes toward female circumcision among people in the Hargeisa district*.Oslo and Akershus University College of Applied Science [Accessed April 17, 2013]. Available at BMC Res Notes.

Inter Press Service. (2011). Kenya: *Dadaab – a daily prayer for complication-free births.* Africa News.

Joshi C, Torvaldsen S, Hodgson R,& Hayen A.,(2014).*Factors associated with the use and quality of antenatal care in Nepal*: BMC Pregnancy Childbirth. 2014 Mar 3;14:94. doi: 10.1186/1471 2393-14-94.

Kamau Peterson Mubuu (2010). *Socio-cultural factors influencing women's reproductive health* (WRH) in Katolo sub-Location, Kisumu District available from http://erepository.uonbi.ac.ke:8080/xmlui/handle/123456789/18890

Kandasamy T, Cherniak R, Shah R, Yudin M.H, Spitzer R,(2014) *Obstetric risks and outcomes of refugee women at a single centre in Toronto*. J Obstet Gynaecol Can. Apr; 36(4):296 302.

Kenya National Bureau of Statistics, (2010) *Kenya Census 2009*

Kigan, Wycliffe (2010). *Socio-cultural factors influencing birth status among women attending Pumwani Maternity Hospital*, Nairobi. Available fromhttp://erepository.uonbi.ac.ke:8080/handle/123456789/4078

Kimani C.M (2010)..*A view of newly born babies at a nursery in pumwani maternity hospital*.

Kyomuhendo G.B., (2003) .*Low Use of Rural Maternity Services in Uganda: Impact of Women's Status, Traditional Beliefs and Limited Resources*. Makerere University, Kampala, Uganda DOI: http://dx.doi.org/10.1016/S0968-8080(03)02176-1

Leedam E,(1985).*Traditional birth attendants,* Int J Gynaecol Obstet. 1985 Sep;23(4):249-74

Marmot M (2005). *Social determinants of health inequalities.* Lancet 2005;356:1099 104. http://dx.doi.org/10.1016/S0968-8080(05)07432

Mwaniki P.K, Kabiru E.W & Mbugua G.G.,(2002).*Utilisation of antenatal and maternity services by mothers seeking child welfare services*, Mbeere District, Eastern Province, Kenya.ast Afr Med J. 2002 Apr;79(4):184-7.

Neupane S & Nwaru B.I. (2014), *Impact of antenatal care utilization on infant care practices in Nepal*: a national representative cross-sectional survey. Eur J Pediatr. Jan;173(1):99-109. doi: 10.1007/s00431-013-2136-y. Epub 2013 Aug 14.

Otieno P.A, Kohler P.K, Bosire R.K, Brown E.R, Macharia S.W& Stewart G.C.,(2010) *Determinants of failure to access care in mothers referred to HIV treatment programs*,Nairobi, Kenya. AIDS Care 2010;22(6):729–36.

Pathak P.K, Singh A & Subramanian S.V, (2010). *Economic inequalities in maternal health care: antenatal care and skilled birth attendance*, India, 1992-2006. PLoS One. 2010 Oct 27;5(10):e13593. doi: 10.1371/journal.pone.0013593.

Pfeiffer C & Mwaipopo R.,(2013). *Delivering at home or in a health facility? Health-seeking behaviour of women and the role of traditional birth attendants* ,in Tanzania. BMC Pregnancy Childbirth. 2013 Feb 28;13:55. doi: 10.1186/1471-2393-13-55.

Ramazani N, Zareban I, Ahmadi R, ZadSirjan S & Daryaeian M (2014).*Effect of Anticipatory Guidance Presentation Methods on the Knowledge and Attitude of Pregnant Women Relative to Maternal, Infant and Toddler's Oral Health Care,* Mephis.

Richard N, Stella N & Pascal M. (1998).*The Use of Formal and Informal Services for Antenatal Care and Malaria Treatment in Rural Uganda.* Oxford University Press

Rosenstock & Irwin,(1974). *Historical Origins of the Health Belief Model*. *Health Education Behavior* 2 (4): 328–335.doi:10.1177/109019817400200403. Retrieved 12/2/2014

Sara P, Samir E, Pantuliano S., (2010). *Hidden and exposed: Urban refugees in Nairobi,* Kenya HPG Working Paper, Available at www.odi.org.uk/hpg

Sanneh E.S, Hu A.H, Njai M, Ceesay O.M & Manjang B,(2014).*Making basic health care accessible to rural communities.* Kiang West district in rural Gambia. public Health Nurs. (2):126-33. doi: 10.1111/phn.12057. Epub Sep 4.

Schooley J, Mundt C, Wagner P, Fullerton J, O& Donnell M. (2009) *Factors influencing health care-seeking behaviours among Mayan women.* Guatemala Midwifery. 2009 Aug;25(4):411-21. Epub Dec 3.

Shiferaw S, Spigt M, Godefrooij M, Melkamu Y& Tekie M (2013). *Why do women prefer home births in Ethiopia* BMC Pregnancy Childbirth. 2013 Jan 16;13:5. doi: 10.1186/1471 2393-13-5.

Sicchia S.R & Maclean H. ,(2006) .*Globalization, poverty and women's health:mapping the connections*. Can J Public Health 2006;97(1):69–71.

Simkhada B, Teijlingen E.R, Porter M & Simkhada P, (2008) .*Factors affecting the utilization of antenatal care in developing countries: systematic review of the literature.* J Adv Nurs 2008;61(3):244–60.

Song H, Cramer E.M, McRoy S & May A,(2013).*Information needs, seeking behaviors, and support among low-income expectant women*.Women Health. doi: 10.1080/03630242.2013.831019.

Stapleton H, Murphy R, Correa-Velez I, Steel M & Kildea S,(2013).W*omen from refugee backgrounds and their experiences of attending a specialist antenatal clinic*. Australian women Birth. 2013 Dec;26(4):260-6. doi: 10.1016/j.wombi.2013.07.004. Epub Aug 27.

Stewart D.E, Gagnon A.J, Merry L.A & Dennis C.L, (2012).*Risk factors and health profiles of recent migrant women who experienced violence associated with pregnancy*. J Womens Health (Larchmt). 2012 Oct; 21(10):1100-6.

Tesch & Creswell, (2009).*Community leaders' perceptions of Hispanic, single, low income mothers' needs, concerns, social support, and interactions with health care services.* Issues Compr Pediatr Nurs. ; 32(1):31-46. doi: 10.1080/01460860802610194.

Thaddeus, S. & Maine, D. (1994). *Too far to walk: Maternal mortality in context*. Social Science Medicine, *38(8),* 1091-1110.

Timothy J.,& Linda O., (2005) *Survey Response Rate Reporting In The Professional Literature.* Survey Research Laboratory, University of Illinois; Chicago

Tita A.T, Selwyn B.J, Waller D.K, Kapadia A.S& Dongmo S, (2006).*Factors associated with the awareness and practice of evidence-based obstetric care in an African setting,* BJOG. 2006 Sep; 113(9):1060-6.

Titaley C.R, Hunter C.L, Dibley M.J& Heywood P,(2010).*Why do some women still prefer traditional birth attendants and home delivery*.West Java Province, Indonesia. BMC Pregnancy Childbirth. 2010 Aug11;10:43. doi: 10.1186/1471-2393-10-43.

Turan JM, Miller S, Bukusi EA, Sanded J, Cohen CR, (2008). *HIV/AIDS and maternity care in Kenya: how fears of stigma and discrimination affect uptake and provision of labour and delivery services*. AIDS Care 2008;20(8):938–45.

van Eijk A.M, Bles H.M, Odhiambo F, Ayisi J.G, Blokland I.E & Rosen D.H, (2008). *Use of antenatal services and delivery care among women in rural western Kenya*: a community based survey. Reprod Health 2006;3(2):1–9.

Velásquez Hurtado J.E, Solís Alcedo L, Vigo Valdez W.E & Rosas A.M,(2014).*valuating maternal child care practices in extreme poverty areas*. Peru,]. Rev Peru Med Exp Salud Publication.

Wilson-Mitchell K & Rummens J.A. (2013). *Antenatal outcomes of uninsured immigrant, refugee and migrant mothers and newborns living in Toronto, Canada*. Int J Environ Res Public Health. May 31;10(6):2198-213. doi: 10.3390/ijerph10062198. World Health Organization,(2010.).:http://www.who.int/en/.

Xochitl C.C, Cecilia G. B, Xóchitl R G, Rosa M N, Dolores G. H & Ana L. G.,(1996).*Traditional birth attendants in Mexico: Advantages and inadequacies of care for normal deliveries*. doi:10.1016/0277-9536(95)00362-2

Yakoob M.Y, Menezes E.V& Darmstadt G.L, Bhutta Z.A, (2009).*Reducing stillbirths: behavioural and nutritional interventions before and during pregnancy*. BMC Pregnancy Childbirth. May 7;9 Suppl 1:S3. doi: 10.1186/1471-2393-9-S1-S3.

Zetter, R. and Deikun, G. (2010). "*Meeting Humanitarian Challenges in Urban Areas," Forced Migration Review*

APPENDICES

Appendix 1: Letter of Transmittal

Bernard Mwendwa
P.O. BOX 13940-00100
NAIROBI

Date: 26/05/2015
Dear Respondent,
RE: YOUR CONTRIBUTION IN RESEARCH

I am post graduate student at the University of Nairobi. I am currently carrying out a research on **Factors influencing attendance to antenatal care services in Kenya, the case of Somali women in Eastleigh Nairobi County.** You are kindly requested to take part in the study. All the information given will be handled with confidentiality.

Thanking you for your cooperation in the study.

Yours sincerely,

Bernard Mwendwa

M.A. STUDENT

Appendix 2: Questionnaire

RESEARCH QUESTIONNAIRE FOR SOMALI WOMEN IN EASTLEIGH, NAIROBI

Background characteristics

I am doing a study on factors that influence attendance to antenatal care services by Somali women in Eastleigh, Nairobi County, Kenya. I appreciate your taking the time to help us complete the following questions. Your responses are voluntary and will be confidential, which means that we will speak in private and that I will not write your name on the questionnaire. Therefore whatever information you share with me today will not have your name on it, and you can choose to not respond to certain questions or discontinue participation at any time; I'd like to start by asking you some general questions about your daily life here in your household. By household, I mean (provide local definition of household) _____. Are you ready to begin?

This questionnaire will consist of several parts; each part has been designed to provide data and information necessary for achievement of research objectives of this study. Please tick (√) appropriately and provide any other information requested for by the questionnaire appropriately.

Section 1: General Information about the Respondents

1. please indicate your Age bracket

   a) 15-20 ☐ b) 21-34 ☐

   c) 35-40 ☐ d) 41-45 ☐

   d) Above 45 ☐

2. please indicate your highest level of education

   a) None ☐ b) primary ☐

c) Secondary ☐ d) College and above ☐

3. What religion do you practice

a) None ☐ b) Muslim ☐

d) Christian ☐ d) Traditional ☐

4) Which location do you currently reside?

a) Eastleigh ☐ b) Majengo ☐

b) Pumwani ☐ d) Kamukunji ☐

Section 2: Presence of Traditional Birth Attendants (this section of the questionnaire seeks to find out how Traditional Birth Attendants (TBAs) influence women's attendance to antenatal care services in Eastleigh.)

Use a tick (√) for your choice

1) Have you ever been expectant

a) Yes ☐ b) No ☐ c) No response ☐

2) Are you currently pregnant

b) Yes ☐ b) No ☐ c) No response ☐

3) Have you seen anyone for antenatal care for this pregnancy

Yes ☐ b) No ☐ c) No response ☐

4) Whom did you see?

Nurse / midwife ☐ TBA ☐ other ☐

No response ☐

5) Did you have children born through assistance of a Traditional Birth Attendant

a) Yes ☐ b) No ☐ c) Don't remember ☐

Section 3: Maternal Awareness

These next questions are about your knowledge and understanding on the available services and how you have/should have utilized.

1) Do you want to have a baby in the future

a) Yes ☐ b) No ☐ c) Don't know ☐

2) Are you aware of any services offered during pregnancy

a) Yes ☐ b) No ☐ No response ☐

3) What services are you aware offered during pregnancy are you aware of

a) Scanning ☐ b) Physiotherapy ☐ c) None ☐

4) Which media of information do you get this awareness from

a) Radio/TV ☐ b) Friends ☐ c) Written ☐

d) No response ☐

5) Do you think the information you have on maternal health can help in your subsequent pregnancies

a) Yes ☐ b) No ☐ c) No Response ☐

Section 4. Cultural Beliefs

The following questions are about the perceptions, feelings, attitudes you have on the use of antenatal services.

1) Do people in your locality discourage women from attending clinics during pregnancy

a) Yes ☐ b) No ☐ c) Not sure ☐

2) Ever witnessed anybody attend antenatal care

a) Yes ☐ b) No ☐ c) No response ☐

3) If yes in 3 above where?

a) Clinic ☐ b) TBA ☐ c) No response ☐

4) Do you think there is any problem attending antenatal care and your religion

b) Yes ☐ b) No ☐ c) No response ☐

5) Do you know of any health, psychological or social problems associated with antenatal care services?

a) Yes ☐ b) No ☐ c) No response ☐

Section 5.Economic status

Now I would like to ask you some questions about gender issues including how you raise money for your basic needs and how much control you have on your resources. These are private topics. Some people may feel uncomfortable with these questions. Please remember that we will

continue to make sure that your answers are absolutely confidential. We also want you to know that we can refer you to someone or organisations who can help, if you wish.

1) Are you currently involved in any income generating activity

a) Yes ☐ b) No ☐ c) No response ☐

2) Approximately how much do you earn on monthly basis (Kshs)

a) Below 15,000 ☐ b) 15,001-25,000 ☐ c) 25,001-35,000 ☐

d) Above 35,000 ☐

3) Do you think antenatal care is expensive in Kenyan Clinics?

a) Yes ☐ b) No ☐ c) Don't know ☐

4) Do you know of anyone who failed to attend antenatal care?

a) Yes ☐ b) No ☐ c) No response ☐

5) What reasons did they give for not attending

a) Could not afford ☐ b) No facilities ☐ c) No response ☐

6) If (a) in 5 above, where they involved in any income generating activity

a) Yes ☐ b) No ☐ c) Don't know ☐

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: +254-20-2213471,
2241349, 310571, 2219420
Fax: +254-20-318245, 318249
Email: secretary@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No.

Date:

10th July, 2015

NACOSTI/P/15/9792/6926

Bernard Mwendwa King`oo
University of Nairobi
P.O. Box 30197-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Factors influencing women`s attendance to prenatal care services in Kenya, the case of Somali in Eastleigh Nairobi County, Kenya,"*** I am pleased to inform you that you have been authorized to undertake research in **Nairobi County** for a period ending **31st August, 2015.**

You are advised to report to **the County Commissioner, the County Director of Education and the County Coordinator of Health, Nairobi County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

DR. S. K. LANGAT, OGW
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Nairobi County.

The County Director of Education
Nairobi County.