COMMUNITY AND INSTITUTIONAL FACTORS INFLUENCING
ACCESS TO ANTENATAL HEALTH CARE SERVICES BY MAASAI
WOMEN IN ISINYA, KAJIADO COUNTY

REBECCA LEMARON
N69/71175/2014

A RESEARCH PROJECT SUBMITTED TO THE INSTITUTE OF
ANTHROPOLOGY, GENDER AND AFRICAN STUDIES IN PARTIAL
FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF
ARTS IN GENDER AND DEVELOPMENT STUDIES OF THE UNIVERSITY OF
NAIROBI

2016
DECLARATION
This project is my own original work and has not been presented for examination in any other University.

Signature……………………… Date…………………………………
Rebecca Lemaron

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

Signature……………………… Date…………………………………
Dr. Salome Bukachi
DEDICATION

I wish to dedicate this work to my Husband Abdi Malik Hussein, My dear mum Damaris Pulei, My younger sister Amy Chichi Soinatei and my grandmother who all inspired me to work hard and prayed for me. Not forgetting my brothers Manaseh Kerika, Shadrack Lasiti and my cousin, Mercy Naserian who have been encouraging me. I will forever be grateful to them.

Allah bless them all
## TABLE OF CONTENTS

DECLARATION ........................................................................................................................................ ii

LIST OF TABLES AND FIGURES .................................................................................................... iv

ABBREVIATIONS AND ACRONYMS .............................................................................................v

ACKNOWLEDGEMENT ...................................................................................................................1

ABSTRACT ..........................................................................................................................................2

CHAPTER ONE: BACKGROUND TO THE STUDY ...........................................................................1

1.1 INTRODUCTION .........................................................................................................................3

1.4 OBJECTIVES OF THE STUDY ....................................................................................................6

1.4.1 GENERAL OBJECTIVE ........................................................................................................6

1.4.2 SPECIFIC OBJECTIVES .......................................................................................................6

1.6 JUSTIFICATION OF THE STUDY ............................................................................................7

1.7 SCOPE AND LIMITATION OF THE STUDY ...........................................................................8

1.8 DEFINITION OF KEY TERMS .................................................................................................9

CHAPTER TWO: LITERATURE REVIEW ......................................................................................... 10

2.0 INTRODUCTION .....................................................................................................................10

2.1 GENERAL OVERVIEW OF ANTENATAL HEALTH CARE IN KENYA ..................................10

2.2 THE CULTURAL PRACTICE OF THE MAASAI WOMEN ......................................................11

2.3 FACTORS THAT INFLUENCE ACCESS TO ANTENATAL HEALTH CARE SERVICES OF WOMEN 13

2.3.1 CULTURAL FACTORS ..........................................................................................................13

2.3.2 SOCIO-ECONOMIC FACTORS ............................................................................................15

2.3.3 INSTITUTIONAL FACTORS ..................................................................................................16

2.4 THEORETICAL FRAMEWORK ................................................................................................17

2.4.1 RELEVANCE OF THE HEALTH BELIEF MODEL TO THE STUDY ..................................19

2.4.2 CONCEPTUAL FRAMEWORK ..............................................................................................20

CHAPTER THREE: RESEARCH METHODOLOGY ....................................................................21
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Introduction</td>
<td>21</td>
</tr>
<tr>
<td>3.2 Research Design</td>
<td>21</td>
</tr>
<tr>
<td>3.3 Description of Study Site</td>
<td>21</td>
</tr>
<tr>
<td>3.5 Sample Size and Sampling Procedure</td>
<td>23</td>
</tr>
<tr>
<td>3.6 Data Collection Methods</td>
<td>23</td>
</tr>
<tr>
<td>3.6.1 Survey</td>
<td>23</td>
</tr>
<tr>
<td>3.6.2 Focus Group Discussion</td>
<td>24</td>
</tr>
<tr>
<td>3.6.4 Key Informant Interviews</td>
<td>24</td>
</tr>
<tr>
<td>3.6.3 Secondary Data</td>
<td>24</td>
</tr>
<tr>
<td>3.7 Data Analysis and Presentation</td>
<td>24</td>
</tr>
<tr>
<td>3.8 Ethical Consideration</td>
<td>25</td>
</tr>
<tr>
<td>Chapter Four: Community and Institutional Factors Influencing Access to Antenatal Health Care Services</td>
<td>26</td>
</tr>
<tr>
<td>4.0 Introduction</td>
<td>26</td>
</tr>
<tr>
<td>4.1 Socio-demographic Characteristics of the Respondents</td>
<td>26</td>
</tr>
<tr>
<td>4.1.1 Age</td>
<td>26</td>
</tr>
<tr>
<td>4.1.2 Marital Status of the Respondents</td>
<td>27</td>
</tr>
<tr>
<td>4.1.3 Education</td>
<td>28</td>
</tr>
<tr>
<td>4.1.4 Occupation</td>
<td>29</td>
</tr>
<tr>
<td>4.1.5 Religion</td>
<td>31</td>
</tr>
<tr>
<td>4.2 Community Factors Influencing Access to Antenatal Health Care Services</td>
<td>32</td>
</tr>
<tr>
<td>4.2.1 Cultural Factors</td>
<td>32</td>
</tr>
<tr>
<td>4.2.3 Institutional Factors Influencing Access to Antenatal Health Care Services</td>
<td>38</td>
</tr>
<tr>
<td>Chapter Five: Conclusion and Recommendation</td>
<td>40</td>
</tr>
<tr>
<td>5.1 Introduction</td>
<td>40</td>
</tr>
</tbody>
</table>
5.2 SUMMARY ................................................................................................................. 40
5.3 CONCLUSION ............................................................................................................. 42
5.4 RECOMMENDATIONS ............................................................................................. 43
5.5 AREAS FOR FURTHER RESEARCH ................................................................. 41
Reference ...................................................................................................................... 42
Appendix I: Consent Form ............................................................................................. 49
Appendix II: Questionnaire .......................................................................................... 51
Appendix III: Interview Schedule .................................................................................. 58
Appendix IV: Focus Group Discussion Guide ............................................................... 60
Appendix V: Key Informant Interview Guide ................................................................. 62
APPENDIX VI: RESEARCH BUDGET ......................................................................... 63
APPENDIX VII: WORKPLAN ....................................................................................... 64
LIST OF TABLES AND FIGURES

Figure 2.1: Conceptual framework ................................................................. 20

Figure 2.2: Map of Kajiado County courtesy of Kajiado County Integrated Development Plan 2013-2017. ................................................................. 22

Table 4.1: Age of the Respondents ............................................................. 24

Figure 4.2: Marital Status of the Respondents .......................................... 25

Table 4.3: Respondent’s Level of Education .............................................. 26

Figure 4.4: The occupation of the respondents .......................................... 28

Table 4.4: Respondents’ Religious Affiliation ............................................ 29

Figure 4.2: Reasons for visiting TBAs ....................................................... 30
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIET-</td>
<td>Canadian Institute for Energy Training</td>
</tr>
<tr>
<td>FGM-</td>
<td>Female Genital Mutilation</td>
</tr>
<tr>
<td>G.O.K-</td>
<td>Government of Kenya</td>
</tr>
<tr>
<td>HIV-</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>ICSM-</td>
<td>Independent Commission on Social Mobility</td>
</tr>
<tr>
<td>KDHS-</td>
<td>Kenya Demographic Health Surveys</td>
</tr>
<tr>
<td>MDGs-</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MNCH-</td>
<td>Maternal Newborn Child Health</td>
</tr>
<tr>
<td>SPSS-</td>
<td>Statistical Package for Social Sciences</td>
</tr>
<tr>
<td>TBAs-</td>
<td>Traditional Birth Attendants</td>
</tr>
<tr>
<td>WEF-</td>
<td>Women’s Empowerment Framework</td>
</tr>
<tr>
<td>WHO-</td>
<td>World Health Organization.</td>
</tr>
<tr>
<td>HBM-</td>
<td>Health belief Model</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENT

I wish to express my sincere gratitude and appreciation to all those who in one way or another contributed to the success whether directly or indirectly in the preparation of this research project. Indeed this is a dream come true.

Special thanks go to my supervisor DR. SALOME BUKACHI who guided me through the vigorous process of writing the research project. I will forever be grateful, for the invaluable advice, direction and support.

I do also wish to acknowledge the support from my workmates at National Transport and Safety Authority (NTSA), my classmates and research assistants as I aimed at achieving higher education. Thanks to them all.
Finally, I am grateful to Allah to have achieved this dream.
Abstract
The study sought to investigate the community and socio-economic factors affecting access to antenatal healthcare services in Isinya, Kajiado County. Guided by Reasoned Action Theory, the study employed a mixed method approach where qualitative and quantitative data collection methods were used. A sample of 100 participants were selected for survey while 3 focus group discussion and key informants were used to collect qualitative data. Quantitative data analysis was done using SPSS and presented in charts and figures. Qualitative data was analyzed using thematic analysis.

The findings indicated that community (cultural), socio-economic and institutional factors affect access and uptake of antenatal care by women. Cultural beliefs on Traditional Birth Attendants, gender power balance, education, financial constraints, and religion form a set of community and socio-economic factors affecting women’s access and uptake of antenatal healthcare services. Institutional factors such as availability of health centers, clinic staffing, and provider-client relationship also influence access to antenatal care services.

The study concludes that these factors pose barriers or enhance women’s access to antenatal healthcare services depending on how they are juxtaposed. Thus, it is recommended that the factors that limit access such as poor provider-client relationship, negative cultural beliefs, low knowledge level, gender power differences, and shortage of staff need to be addressed through awareness creation, increasing clinic staffing, and community-based support systems.
CHAPTER ONE: BACKGROUND TO THE STUDY

1.1 Introduction

Antenatal health and survival depend on the care given to the newborn. Antenatal care is simply the medical services that are provided to a woman during her period of pregnancy and childbirth in order to avoid any detrimental effect to the pregnant woman and her baby (Berhan and Berhan, 2014). Despite, newborn care being a very essential element in reducing child mortality, it has often received less than optimum attention. There have been agreements to affirm the world’s commitment to improving newborn health. Current global evaluations confirm that commitment to improving newborn health makes meaningful socio-economic contributions as well (Yinger & Ransom, 2003). Although child survival programmes have helped reduce death rates among children under-the age of 5 over the past 25 years, the biggest impact has been on reduced infant mortality for those over a month old.

Furthermore, Yinger and Ransom (2003) suggest that greater proportions of infant mortality occur during the first month of life, a period when a child’s risk of death is nearly 15 times greater than at any other time before the first birthday. While Tinker and Ransom (2003) stipulate that though newborn health is closely related to that of their mothers, newborns have a unique need that must be addressed in the context of maternal and child health services. They further argued that millions of newborn deaths could be avoided if more resources were invested in proven low-cost interventions designed to address newborn needs. It is estimated that almost two-thirds of infant deaths occur in the first month of life, of whom, more than two-thirds die in their first week, and among whom, two-thirds die in their first 24 hours (Lawn et al., 2001).

The United Nations Development Programme (UNDP) MDG 2014 Report lists Kenya among the 25 countries with insufficient progress in curbing the under-five mortality rate. One of the reasons for this is that most women still give birth at home because they live too
far away from hospitals. For this reason, the county governments have invested in emergency response services, including providing ambulance services. The National Coordinating Agency for Population and Development shows that 300 Kenyan women die while giving birth. Kenya had a target of reducing maternal deaths to 100 in 100,000 births but this has not been achieved. As the situation in Kenya has not been able to reduce maternal and infant mortality which is at 52 per cent way above the country’s target of 32 per cent (KNBS, 2014).

The most distinguishing feature from the Maasai Women who are from the pastoral community, like other groups of the relatively poor, have special needs that must be specifically recognized and respected (Al-Eisa, 2011). These include access to ownership of natural resources and other forms of capital; an increase in the productivity of capital through improved infrastructure; and accessibility to health, sanitation and social services, a lack of which, for example, is severely felt and which acts as a major impediment to economic and social change as it is the absence of a safety net for the pastoralists and their families. The remedy requires the provision of social investment funds. The cost of the necessary measures is likely to be high in the region, because of a lack of effective environmental monitoring, poor resource management in the past, inefficient extension services, and inappropriate macro-economic policies. There is much to be said in favour of preparing in advance an in-depth analysis of the scale and structure of a full range of identified needs before proceeding with policy and programme interventions (Geerken et al., 2007).
1.2 Statement of the problem

Child mortality in Kenya has declined by over 20 percent since 2008 with 6 out of 10 pregnant women now receiving skilled care at childbirth and over half receiving postnatal care (KDHS, 2014). However, despite this progress, Kenya could not achieve maternal and child health Millennium Development Goals (MDGs). In Kenya today, many women, neonates, and children continue to experience morbidity or die from preventable conditions that have proven and cost effective interventions. Access to quality maternal newborn child health (MNCH) services remains a challenge across all levels of care, and inequities continue to persist among population sub-groups, and between rich and the poor.

Household and community practices during pregnancy involve demand for antenatal care services and planning for a health birth, including emergency preparedness, prevention of malaria, HIV testing and nutrition. This issue is of particular importance to Kenya because majority of its population lives in rural areas according to the Kajiado County Integrated Development Plan 2013-2017, Maternal health is a priority service area that the Kenyan government through ministry of health has invested a lot of its resources purposely to reduce the barriers faced by women in seeking access to adequate and affordable antenatal care services.

In Kajiado county, antenatal care is still more a question of ritual rather than of effective interventions. Accessible studies and reports reveal that, many women in the rural settings of Kajiado County do not attend antenatal care as recommended. According to the Kajiado County Integrated Development Plan 2013-2017, health care is a devolved function and the county government identifies that access to and utilization of antenatal health care services has been constrained by problems such as vastness of the county, the presence of few health services, the cultural beliefs and practices, inadequate financing, presence of few community health units, uncoordinated private practices, poor staff attitudes and retention rates among other factors (GOK, 2016).

This was therefore designed to evaluate the access to and utilization of available antenatal care services while paying a close attention to existing alternative antenatal care being
undertaken in by the Maasai women in Kajiado County. Harun et al, 2012 identify that in Kajiado County the overreliance on unskilled birth attendants is very high with Loitoktok sub-county having 30.7 per cent while other rural areas such as Kisoro within Isinya sub-county that are hindered by socio-economic and cultural factors among others are having 31.7 per cent reliance on unskilled birth attendance. The purpose of the study therefore was to investigate the community and institutional factors affecting Maasai women from accessing antenatal health care services in Isinya, Kajiado County.

1.3 Research Questions
   i. What cultural factors affect women access of antenatal health care services in Isinya, Kajiado County?
   ii. What socio-economic factors affect women in accessing antenatal health care services in Isinya, Kajiado County?
   iii. What institutional factors affect women from accessing antenatal health care services?

1.4 Objectives of the Study
1.4.1 General Objective
To investigate the community and institutional factors influencing access to antenatal health care services by Maasai women in Isinya, Kajiado County.

1.4.2 Specific Objectives
   i. To investigate the social cultural factors affecting Maasai women access to antenatal health care services in Isinya, Kajiado County.
   ii. To describe the socio-economic factors affecting women access to antenatal health care services in Isinya, Kajiado County.
   iii. To determine the institutional factors affecting women’s access to antenatal health care services in Isinya, Kajiado County.
1.5 Study Assumptions

i. Socio-economic factors limit women’s access to antenatal care services in Isinya, Kajiado County

ii. Financial constraints and competing needs pose a barrier to women’s access to antenatal healthcare services in Isinya, Kajiado County

iii. Structural and institutional factors do not support access and proper utilization of antenatal healthcare to women in Isinya, Kajiado County.

1.6 Justification of the Study

The study illustrates the community factors which includes socio-economic and cultural factors and medical complexities of mothers in Isinya sub-county. The findings will be based on the experiences and views of pregnant women and mothers, community members, health workers, policy makers of the County, non-governmental organizations working closely with the women in the county, community based organizations as well as traditional birth attendants and any other relevant individual to the study.

Their perspectives will provide vital information for policymakers at the County and National levels of administration that will help them reshape and model new policies that will assist in creating clearer grounds in order to meet the reduced mortality rates of the nation that lie at 32 per cent from the current 52 per cent (KNBS, 2014). It will also help health workers to learn how well to serve and handle pregnant women and newborns. For the donors and communities the study will generate new knowledge on how to combat maternal mortality and morbidity and how to support the girls and women who fall victim to obstetric complications. The study findings will in addition provide a contextual analysis of rural women’s access to antenatal care services and provide insights for policy makers and interventions on how to increase access to rural areas of Kajiado County.

The findings will also inform further research and generation of new knowledge in similar research settings. The information will then be utilized as a reference point and create a
basis for further research in the area of health improvement among the rural populations and through enhanced antenatal care among pregnant women and children.

1.7 Scope and Limitation of the Study

This was a descriptive study and it was conducted in Isinya Sub-county of Kajiado County. The geographic scope of this study was therefore, limited to Maasai households in Kisoro, Isinya sub-county of Kajiado. The study looked into the social cultural and economic factors influencing access to antenatal health care service. This informed about those women in Isinya sub-county who demand the Antenatal health care services for their newborns and themselves and told us about the services accessibility and utilization. Information was also obtained from those who interact closely with the Antenatal health care service provision at any one given point who included but not limited to County government health officials, health care workers, non-governmental agencies working with women in the area on matters of antenatal health care, community based agencies, and unskilled Antenatal health workers as well as health facility heads. They allowed for a clearer understanding of how social cultural and economic factors affect Maasai women’s access to antenatal health care services within Isinya sub-county of Kajiado.

The main limitation of this study was that the information on the social cultural and economic factors influencing access to antenatal health care services in Isinya, Kajiado County could not be generalized to all women. It was specific to Maasai women in Isinya sub-county as various women based on their ethnic affiliations wherever found differ in their access to and utilization of antenatal health care services based on ascribed differences in their way of life. However, the study provided in-depth information that could be used to understand and inform the general aspects of antenatal health care service access and utilization especially in Kenya and the global south in general.
1.8 Definition of Key Terms

**Antenatal care** is simply the medical services that are provided to a woman during her period of pregnancy and childbirth in order to avoid any detrimental effect to the pregnant woman and her baby (Berhan and Berhan, 2014).

**The Health Belief Model (HBM)** is one of the first theories of health behavior. It was developed in the 1950s by social psychologists Hochbaum, Rosenstock, and Kegels working in the U.S Public Health Services, who wanted to explain why so few people were participating in programs to prevent and detect disease. HBM is a good model for addressing problem behaviors that evoke health concerns (e.g., high-risk sexual behavior and the possibility of contracting HIV) (Croyle, 2005).

**Institutional factors:** In this study refers to those factors that relate to the health facilities which will include availability of health centers, provide patient relationships and clinic staffing.

**Community factors:** In this study will refer to the socio-economic factors such as income, employment, education and culture such as taboos, social norms, religion, attitudes, beliefs and traditional medicines.
CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction
This chapter reviews both theoretical and empirical review; specifically on the general overview of antenatal health care in Kenya, The cultural practice of the Maasai women, social-economic and cultural barriers influencing access of antenatal health care services and finally the two theories that supports the study.

2.1 General Overview of Antenatal health care in Kenya
Health, wellbeing, equality, and the rights of women are clearly recognized as a central pillar and indicator of health, development and peace of any society. Despite Kenya’s tremendous economic, developmental and health strides over the years however, inequality in health and mortality experienced by women remains unacceptably high. The bulk of this burden is as a result of pregnancy and child-birth which continue to carry high risks despite numerous national and international commitments towards addressing the factors fuelling this. In Kenya, approximately 14,700 women and girls die every year due to pregnancy-related complications with an additional 294,000 to 441,000 women and girls suffering debilitating health conditions as a result of pregnancy or childbirth. Conditions arising during the perinatal period are the second leading cause of death and disabilities in Kenya at 9% of total deaths and 10.7% of total delay respectively.

Estimates from Kenya show that more than 90% of women make at least one antenatal care visit but fewer than 50% make four or more visits. Thus they miss out on key services such as urine and blood tests, and medical advice on possible pregnancy complications. Lack of Sufficient antenatal care interrupts the continuum of maternal care (KNBS, 2010). It is encouraging, however, those levels of having at least four antenatal care visits show improvement since 1990.

Use of skilled health providers in antenatal care also has been increasing in most developing countries since the 1990s (Wang et al. 2011). While doctors are the main providers in Latin America and the Caribbean, in sub-Saharan Africa women rely primarily on nurses or midwives for antenatal care. Rarely are TBAs and health care providers other than nurses,
midwives, or doctors reported as providers of antenatal care. There appears to be a strong association between a woman receiving antenatal care from a skilled health care provider and residence in an urban area rather than a rural area, having a higher education level, and coming from a wealthier household (Ochako et al. 2011; Wanjira et al. 2011). The differentials are smaller in countries with overall high levels of antenatal care (Wang et al. 2011).

While the number of women with access to at least one antenatal care visit is easily and regularly monitored, little has been done to monitor and measure the content and quality of this care (Rani et al. 2008,). Studies suggest that full access to antenatal care often may not be enough, because many women who seek antenatal health care do not deliver in a health facility (Bloom et al. 1999). Because the quality of antenatal health care might have a significant role to play, there have been recommendations that it should be considered when assessing the relationship between use of antenatal health care and maternal health (Bloom et al. 1999; Rani et al. 2008). Quality of antenatal care can be examined from various aspects such as structure, process and outcome. It can also be assessed by looking at clinical quality or inter-personal quality (Rani et al. 2008). Tests and services by a skilled health care provider such as measuring weight and height, taking blood pressure, testing urine and blood, abdomen examination, providing iron and folic acid supplementation, and conducting tetanus toxoid examinations all constitute measurement of clinical quality. In addition, information on nutrition, danger signs of pregnancy, delivery care, newborn care, and family planning helps to measure quality of care (Rani et al. 2008; WHO, 2001).

2.2 The Cultural Practice of the Maasai Women
Edward (1994) identifies two meanings of culture. First, it refers to the many practices like the arts, communication, and representation which have relative autonomy from the economic, social, and political domains. These human expressions have an aesthetic dimension embedded in art and seek to cause pleasure and entertainment. Second, culture includes a community’s reservoir of what defines them as a people which in most cases represents the best that has been known and thought. Through culture we are able to see
society in its strengths and weaknesses and to see ourselves. Culture, viewed as such, becomes a space for engagement by various interests and forces.

The Maasai are a tribe of people who live in parts of Tanzania and Kenya and are known as tall and fierce warriors. They can be recognized by the special red cloth they wear which is called a *Shuka*. Maasai people live a nomadic life, which means they move from place to place with their animals. They rely on their animals for food (including milk, meat and animal blood) and walk for many miles with their animals to find fresh food and water. They get all the other foods they need by trading (swapping) with other Maasai people. Maasai men herd cattle and carry spears to protect their cattle from wild animals such as lions. The Maasai women are responsible for cooking, collecting firewood and building the home.

The majority of Maasai women in Kenya are destined to live a life of poverty and cultural oppression (Spencer, 1988). Just one generation ago, less than 20 percent of Maasai women in Kenya enrolled in school. Today, even with free primary school education in Kenya since January 2003, only 48 percent of Maasai girls enroll in school, and only 10 percent of girls make it to secondary school. A Maasai woman has to do more work compared to her husband. The tradition is since the history of the Maasai people. A woman does not own any property. While she refers to property as "ours", in reality every cow, every sheep, every goat, every donkey and land is owned by her husband.

Maasai girls are circumcised between the ages of 11 to 13 and soon afterwards married to a man chosen by her father in exchange for cattle and cash. A Maasai woman will never be allowed to divorce, except in the most egregious cases of physical abuse, and will never be allowed to marry again, even if the husband her father chooses is an old man who dies when she is still in her teens. Instead, she becomes the property of one of her husband’s brothers. She will be one of multiple wives, and will have many children, regardless of her health or ability to provide for them. She will rise early every day to milk cows, and spend her days walking miles to water holes to launder clothes and get water, and to gather heavy loads of firewood to carry back home. If she is lucky, she will have a donkey to share her burden.
(Spencer, 1988). She will live a life of few physical comforts, dependent on a husband and a family she did not choose. Her life expectancy is 45 years.

The economic, cultural and physical factors that combine to deny education to Maasai girls in Kenya are numerous and, taken together, almost impossible for all but the most determined girls to overcome. Even when possible, Maasai girls have the added impediment of cultural beliefs that prevent many from enrolling or completing school (Goodman, 2002). They include: Economic incentives for early marriage, such as cattle and cash dowries; The belief that the biological family does not benefit from educating a daughter, since the girl becomes a member of her husband’s family when she marries, and they will reap the benefits; Family and peer pressure for early marriage, as women are valued by the number of children they have; Fear of early pregnancy, which is a disgrace prior to marriage and lowers the bride price, which perpetuates the practice of early marriage, and finally The distances that a girl must walk to the nearest school make it unsafe, and even impossible for a nursery-school-age child.

2.3 Factors that influence access to antenatal health care services of Women

This section covers the effect of community and institutional factors such as socio-economic, infrastructure and lack of health facility hinders women from accessing antenatal health care services

2.3.1 Cultural factors

The World Health Organization (2003) defines traditional medicine as health practices, approaches, and knowledge and beliefs incorporating animal and mineral based medicines, spiritual therapies, manual techniques and exercise singularly or in combination to treat diagnose and prevent illness or maintain wellbeing. Culture and society shape traditional medical beliefs and practices. Traditional Medicine is often used when the economic, social and cultural cost of using public health services are perceived as too high. In Africa up to 80% of the populations utilize traditional medicine for health care (WHO, 2003).
According to Johnstone and Kanitsaki (2005), “Culture includes a particular people’s beliefs, value orientations and value systems, which give meaning, logic, worth and significance to their existence and experience in relation to both the universe and other human beings”. Culture determines both who you are and what you are, and critically is the determiner of gender roles and identity. Each culture has a distinctive moral code. FGM was traditionally associated with rites of passage ceremonies. Despite the increased awareness of the dangers of FGM on the girl child, particularly on her educational development and empowerment, FGM has persisted in practice by both the elites and the less educated worldwide, especially in Africa. In Narok and Isiolo, female genital mutilation (FGM) continues to affect women during childbirth as well as service provision. According to one midwife in Narok “we are yet to see a change in the numbers of FGM”. And in Isiolo a midwife explained that “the majority of Borana and Somalis even with the third baby they will get an episiotomy even sometimes the fourth. This is because when you suture an episiotomy you suture what you cut, so you leave behind again the very small hole that you met. Sometimes you give bilateral episiotomies and she will still tear however much you support that perineum, even if they are birthing a child of two kilograms.”

There are deep cultural biases that influence the uptake of maternity services. For example, “Maasai generally birth at home, we don’t often go to maternities”; “I didn’t go or even consider going to the hospital as Maasai women do not like to go to hospitals as they believe that God will help them”; “we Turkana’s just have our babies at home”; and “the Turkana like to give birth at home”. The perception of pregnancy and birthing being a very normal function and part of the cycle of life is very strong among these communities. A Maasai woman shared that “even now there are still many who birth at home. People have always been birthing at home throughout our history. People are yet to get confidence/trust in hospitals. Some people have, some people haven’t.” And a mother in Isiolo confidently said that “we don’t go to hospital because we are used to birth at home.

In 12 African countries which include; Ghana, Mali, Nigeria and Zambia, 60% of children with Malaria are treated with local herbal medicines (WHO, 2003). Traditional birth attendants are also considered a part of traditional medicine. Women are often more comfortable with traditional practice and the individual performing these services, which in
turn alleviates the stress of using unfamiliar western style medical services at health care facilities. Scientific evidence for the efficiency and safety of traditional medicine is ambiguous. Also, the lack of coordination between traditional medicine and western medicine creates problems of competition, communication and safety. Overdoses of some traditional medicines can have negative health effects. In China, the Herb Ma Huan or Ephedra is traditionally used to treat upper respiratory tract infections however; overdoses have caused heart attacks and strokes in the United States (WHO, 2003). In South Africa, the medical research council is studying the efficiency of traditional medicine for treating of pregnant women.

2.3.2 Socio-economic factors

According to One factor that is pervasive in maternal health throughout the world in different forms, not only in Narok and Isiolo is the socio-cultural constructs of pregnancy and birth. In the cultures living in these areas, “great value is given to pregnancy and childbirth”. “Having your own children is a good thing. Children are your life and the life of your husband. They are the lives of everyone.” In general, “women always look forward to giving birth. It is something good. It makes them a mother and a mother is greatly valued”. And as the women approach childbirth they are spoken to extensively by other women on what to expect. The messages that women receive differ slightly, but are commonly along the lines of: “women are told that birth is painful, but it’s a good thing as it brings you a new life to spend your life with you”; “women say that birthing is painful, but you shouldn’t worry as it passes.

The individual’s use of the health facility is also influenced by the characteristics of the community in which the person lives, indicating a need to look beyond the individual factors when examining health seeking behaviors (Stephenson, 2002) First, consumers lack of the human capital-education to promote their own and their families’ health (Ensor, 2006). Education may provide consumers with a basis for evaluating whether they or a dependent require treatment inside or outside the home. Thus, rural areas like Kisoro with high rates of illiteracy have been characterized by less antenatal care visits by pregnant women and mothers. Education provides the consumer with the basis for evaluating whether they require
treatment. While it is sometimes suggested that individuals are unable to assimilate information on treatment options, this assumption is challenged by Leonard’s recent work in Tanzania (Leonard, 2002).

These studies suggest that, far from being passive consumers, patients actively seek out not only the best-known provider but the best facility for a particular illness. Thus, Perceptions of quality do, in fact, accord quite well with technical evaluations. Studies in many countries have also shown that barriers such as distance may be surmountable, as evidenced in cases where individuals bypass local services to reach ones of higher quality or when Distance is given as a reason for non-use, despite health facilities being available. There is much evidence to suggest that distance to facilities imposes a considerable cost on individuals and that this may reduce demand. In studies reviewed for this study, transport as a proportion of total patient costs, a study carried out in Bangladesh suggested that, transport to health facilities was the second most expensive item for patients after medicines (CIET Canada, 2000).

Mead (1968:19) is of the opinion that the more men are removed from the phenomenon of human birth, the more the male imagination contributes to the “cultural superstructure of belief and practice, regarding childbearing.” In many African societies, it is women who rear children and teach them manners, respect, and social obligations. Women, when empowered could contribute significantly in reshaping gender roles and expectations. They can subvert the stereotype while fulfilling the social and cultural role of child rearing and socializing. Thus critical interventions targeted at mothers could contribute in women’s empowerment by reorganizing and restructuring gender relations. Due to the patrilineal nature of countries in the Great Lakes Region, women have found themselves denied many capabilities. They have less access to education, skills development, economic opportunities and participation in decision-making.

2.3.3 Institutional factors

Infrastructure determines the accessibility to the nearby health facility. Here, accessibility refers to the distance the patient lives from a health care facility, transportation and total travel time, wait time and available services, (Hjortsberg & Mwikisa, 2002; Perry & Gesler, 2000). In Andean, Bolivia where travel times are greater than one hour by walking, limited
physical access to care is a major obstacle in improved health (Perry & Gesler, 2000). Limited access is especially important in rural areas where there are fewer healthcare facilities and villages may be physically isolated. In Zambia, 56% of surveyed rural household perceived distance as an obstacle (Hjortsberg & Mwikisa, 2002). In the same study, only 17% of individual living more than 40 kilometers from a facility sought care when sick compared to 50% of individuals living less than five kilometers away. Another barrier in the rural areas is that travel time takes longer per kilometer than in urban areas due to poor quality of roads and the burden of having to use several modes of transportation. Climate is also a factor especially during the rainy season when heavy rains and flooding create even worse road conditions. Advanced transportation is often nonexistent in developing nations and healthcare may be unattainable if the means of transportation are in adequate or time consuming such as walking, bicycling or using the bus (Perry & Gesler 2000). These longer travel times deter individuals from travelling particularly to access advanced technology that may only be available in large health facility located in the cities. These sometimes overwhelming obstacles may also encourage women in developing countries to turn to traditional medical practices. Fournier et al (2009) found that maternity referral system in Mali, that attempts to remove geographic and financial barriers, that ensured basic and comprehensive emergency obstetric care, transportation to obstetric health services and community cost-sharing schemes, has produced a substantial reduction in maternal mortality rates.

2.4 Theoretical Framework

Health Belief Model

This research was guided by health belief model, which is appropriate for addressing problem behaviors that evoke health concerns (e.g., high-risk sexual behavior and the possibility of contracting HIV) (Croyle, 2005). The Health Belief Model (HBM) is one of the first theories of health behavior. It was developed in the 1950s by a group of U.S. Public Health Service social psychologists who wanted to explain why so few people were participating in programs to prevent and detect disease. The health belief model proposes that a person's health-related behavior depends on the person's perception of four critical areas: The severity of a potential illness, The person's susceptibility to that illness, The
benefits of taking a preventive action, and The barriers to taking that action. Health Belief Model is a popular model applied in nursing, especially in issues focusing on patient compliance and preventive health care practices. The model postulates that health-seeking behaviour is influenced by a person’s perception of a threat posed by a health problem and the value associated with actions aimed at reducing the threat. Health Belief Model addresses the relationship between a person’s beliefs and behaviors. It provides a way to understanding and predicting how clients behave in relation to their health and how they will comply with health care therapies.

There are six major concepts in Health Belief Model;

**Perceived Susceptibility**: refers to a person’s perception that a health problem is personally relevant or that a diagnosis of illness is accurate.

**Perceived severity**: even when one recognizes personal susceptibility, action will not occur unless the individual perceives the severity to be high enough to have serious organic or social complications.

**Perceived benefits**: refers to the patient’s belief that a given treatment will cure the illness or help to prevent it.

**Perceived Costs**: refers to the complexity, duration, and accessibility of the treatment.

**Motivation**: includes the desire to comply with a treatment and the belief that people should do what.

**Modifying factors**: include personality variables, patient satisfaction, and socio-demographic factors.
2.4.1 Relevance of the Health belief model to the study.

The health belief model has been used to develop effective interventions to change health-related behaviors by targeting various aspects of the model's key constructs. Interventions based on the health belief model may aim to increase perceived susceptibility to and perceived seriousness of a health condition by providing education about prevalence and incidence of disease, individualized estimates of risk, and information about the consequences of disease (e.g., medical, financial, and social consequences).

Interventions may also aim to alter the cost-benefit analysis of engaging in a health-promoting behavior (i.e., increasing perceived benefits and decreasing perceived barriers) by providing information about the efficacy of various behaviors to reduce risk of disease, identifying common perceived barriers, providing incentives to engage in health-promoting behaviors, and engaging social support or other resources to encourage health-promoting behaviors. Furthermore, interventions based on the health belief model may provide cues to action to remind and encourage individuals to engage in health-promoting behaviors.

Interventions may also aim to boost self-efficacy by providing training in specific health-promoting behaviors, particularly for complex lifestyle changes (e.g., changing diet or physical activity, adhering to a complicated medication regimen). Interventions can be aimed at the individual level (i.e., working one-on-one with individuals to increase engagement in health-related behaviors) or the societal level (e.g., through legislation, changes to the physical environment).
2.4.2 Conceptual Framework

The conceptual framework depicts the relationship between the independent variables

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Dependent Variable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community Factors</strong></td>
<td></td>
</tr>
<tr>
<td>➢ Traditional Medicine</td>
<td></td>
</tr>
<tr>
<td>➢ Traditional birth attendants</td>
<td></td>
</tr>
<tr>
<td>➢ Knowledge and beliefs</td>
<td></td>
</tr>
<tr>
<td>➢ Taboos</td>
<td></td>
</tr>
<tr>
<td>➢ Social norms</td>
<td></td>
</tr>
<tr>
<td><strong>Socio-economic factors</strong></td>
<td></td>
</tr>
<tr>
<td>➢ Personal income</td>
<td></td>
</tr>
<tr>
<td>➢ Employment</td>
<td></td>
</tr>
<tr>
<td>➢ Competing financial needs</td>
<td></td>
</tr>
<tr>
<td><strong>Institutional Factors</strong></td>
<td></td>
</tr>
<tr>
<td>➢ Availability of health centres</td>
<td></td>
</tr>
<tr>
<td>➢ Provider-patient relationship</td>
<td></td>
</tr>
<tr>
<td>➢ Clinic staffing</td>
<td></td>
</tr>
<tr>
<td><strong>Access to and utilization of antenatal health care services</strong></td>
<td></td>
</tr>
</tbody>
</table>

Figure 2.1: Conceptual framework
CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction
This chapter gives a description of the study area with specific reference to its location and size and an overview of the general framework that the study utilized in order to respond to its objectives. The chapter therefore details; the research design, target population, sampling design, data collection instruments, and data collection procedure and data analysis and presentation techniques.

3.2 Research Design
This study adopted a descriptive research design, which enabled the study to address the specific variables that it was seeking to answer through narrative-type description. With mixed method outlook, the strengths of quantitative approach offset the weaknesses of qualitative and vice versa. An exploratory descriptive research design was preferred in this study because there was an issue of access to antenatal that needed to be explored. The analysis enabled the description of the socio-cultural, economic, and institutional factors that affected how women access health care services in relation antenatal care.

3.3 Description of Study Site
Kajiado County is located in the southern part of Kenya and it is said to have a total land mass of 21,900.9 square kilometers. The county borders Nairobi City County to the north and extends to the Tanzania border further south. The county is made up of 5 administrative sub-counties of: Kajiado Central, Kajiado North, Loitoktok, Isinya, and Mashuuru. It further has a total of 17 administrative divisions. Isinya as a Sub-County within Kajiado County with an area of 1,056 square kilometers. Isinya sub-county is also made up of 2 divisions and a total of 16 locations. Isinya sub-county is classified as an urban setting but with rural settings as it has met the population requirement of having the minimum threshold of 10,000 people in line with the Cities and Urban areas Act, 2011.
Figure 2.2: Map of Kenya showing Kajiado County

3.4 Study population and Unit of Analysis
The study population was the Maasai women in Isinya, Kajiado County. They provided information into the cultural factors, socio-economic factors and institutional factors influencing Maasai women access to antenatal health care services in Isinya, Kajiado County. The unit of analysis was the individual Maasai woman accessing and utilizing or those who have accessed and utilized antenatal health care services. An inclusion-exclusion criterion was used to select the participants in the study. This was where the participants must have been women residents of Kisoro area, Isinya sub-county, be at least 18 years old (but within reproductive age), and have accessed or accessing antenatal healthcare services. The key informants were purposively selected based on their knowledge and expertise in the topic of study.

3.5 Sample size and Sampling procedure
Purposive sampling technique was used to select the study participants. This was to enable the selection of only the participants who met the criteria of inclusion and whose data was relevant to the study. The study targeted 100 women participants for survey and 3 women-only focus group discussions disaggregated by age. The study also targeted 5 key informants. In the sampling procedure, the researcher solicited participation from the population sample through household visits and if the potential participants met the criteria of inclusion, they were included in the final sample. If they agreed to participate in the study, they were recruited. This process was repeated until when sufficient participants were interviewed as per the desired sample size. The key informants were individuals knowledgeable in the area of study such as County government officials, health workers, traditional birth attendants, or community leaders from the participating pastoral groups. These were selected purposively and participation was based on volunteering or solicitation.

3.6 Data Collection Methods
3.6.1 Survey
Survey method was used to collect quantitative data for this study. A questionnaire was used as an instrument. It was used to collect data on the socio-cultural, economic, and institutional factors that influence access to antenatal care by women in Isinya sub-County.
Data from the survey augmented or triangulated the qualitative data from focus groups discussions and key informant interviews.

### 3.6.2 Focus Group Discussion

Focus group discussions were conducted for qualitative data. Three women-only FGDs were organized within Kisoro area, Isinya sub-County. The women discussants were selected for the focus groups based on reproductive age whereby we had the young mothers (18-25 years), those aged between 25-35 years, and those aged 36-49 years. Data from the FGDs was used to complement the data generated from the survey. A focus group discussion guide was used to focus on the key themes on women’s access to antenatal care. With the discussant’s consent, the FGDs were recorded using a digital recorder for transcription and further analysis.

### 3.6.4 Key Informant Interviews

Key informant interviews were carried out- with county health officials, health workers, health facility in-charges, the heads of the non-governmental agencies and community-based agencies available. The traditional birth attendants were also interviewed in order to understand the socio-economic and cultural factors influencing Maasai women access to antenatal health care in Isinya, Kajiado County. A key informant guide was used to guide the interviews by focusing on the key areas relevant to the research questions.

### 3.6.3 Secondary data

The proposal development used secondary data obtained from resource materials like published journal articles, books, government reports, internet sources, and prior research reports. These was continually used in the process of enriching this study.

### 3.7 Data Analysis and Presentation

Quantitative and qualitative data analysis techniques were used for quantitative and qualitative data respectively. For quantitative analysis, data from the questionnaires was checked for completeness and consistency and cleaning was done. Data was coded and analyzed using the Statistical Package for Social Sciences (SPSS) and presented using tables and charts.

Qualitative data from focus group discussions and key informant interviews was transcribed verbatim in English. Codes and themes were developed from the transcripts using content
and thematic analysis. This was to help reveal or extract emerging core themes. Direct quotes that illustrate key themes were extracted for presentation in the final manuscript.

### 3.8 Ethical Considerations

Relevant authorization and permits study will be gotten from the Institute of Anthropology Gender and African Studies and National Commission for Science, Technology and Innovation. The nature and the purpose of the research was explained clearly to the potential participants by the researcher before seeking their informed consent in order to administer any of the research instruments. The right of refusal to participate in the study and the right to withdraw from the study at any given point was respected. With regards to privacy and confidentiality, information that the respondents provided was not and shall not be revealed to anyone else except the researcher. For quality purposes, the findings of the study were disseminated back to the community through local administrative channels, and shared with the scientific community through publications. This manuscript of the final thesis will be availed at the University of Nairobi Library for academic purposes.
CHAPTER FOUR: COMMUNITY AND INSTITUTIONAL FACTORS INFLUENCING ACCESS TO ANTENATAL HEALTH CARE SERVICES

4.0 Introduction
The analysis and study findings are presented in this chapter. The chapter consists of two sections. The first section presents the socio-demographic characteristics of the respondents while linking these characteristics to the research questions. The second part of the chapter presents the findings on the socio-cultural factors that influence the way women access antenatal health care services. The study sought to examine the factors that influence access to antenatal healthcare services by women in Isinya, Kajiado County and was guided by three specific objectives namely:

To investigate the social cultural factors affecting Maasai women access to antenatal health care services in Isinya, Kajiado County; to describe the economic factors affecting women access to antenatal health care services in Isinya, Kajiado County; to determine the institutional factors affecting women’s access to antenatal health care services in Isinya, Kajiado County.

4.1 Socio-demographic Characteristics of the Respondents
4.1.1 Age
The study had purposively targeted women aged between 18 and 49 years. There were three categories: 18-25, 26-35, 36-49. Out of the 125 respondents, 60 (48%) belonged to 18-25 age group, 42 (34%) belonged to 26-35, and 23 (18%) were aged between 36 and 49 years. This is shown in Table 4.1.

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>60</td>
<td>48</td>
</tr>
<tr>
<td>26-35</td>
<td>42</td>
<td>34</td>
</tr>
<tr>
<td>36-49</td>
<td>23</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4.1: Age of the Respondents
The age distribution shows that most respondents in the study were young women aged between 18 and 25 years. This means that since they have longer reproductive age, they will
continue to contend with the cultural, socio-economic and institutional factors that influence their access to antenatal healthcare services. This view is brought to perspective by one Key informant.

*The danger of visiting unskilled attendants for antenatal visits is that the clients are mostly young mothers who have to live up to the norms, but will be affected for long since it is likely that they will have more visits. The implication is that they continue to face the risk associated with poor access to modern antenatal care services* (Key Informant 3, Health Provider 38 years).

4.1.2 Marital Status of the Respondents

While 86 (69%) respondents were married, 24 (19%) were single, 9 (7%) were separated and 6 (5%) were widowed. This is shown in Figure 4.2 below.

![Marital Status of the Respondents](image)

**Figure 4.2 Marital Status of the Respondents**

The importance of measuring the respondents’ marital status was informed by the relationship between marital status and access to antenatal healthcare services. Apparently, the opinion of the husband is instrumental in determining whether the woman visits antenatal clinics or not. The sentiments of the FGD discussants amplifies this statement.

*You can choose what you want to do with pregnancy when you are not married. If you are married, the pregnancy is not yours. You do what your husband wants. If he is against going to the hospital, you cannot do otherwise* (FGD 2 26-35 Category).
These sentiments were echoed by a Female Key Informant

Women here do what their husbands say. For them to go to the clinic, they must have the consent and permission of the husband. I would say that this is a great barrier when women cannot make such decisions on their own (Key Informant 1, Female, 40 years, TBA)

In a Pakistan study, Mumtaz and Salway (2007) found that decision-making powers vested on men may limit or enhance the way women access antenatal care services.

4.1.3 Education

Table 4.3 shows the education level of the respondents. While the respondents who had primary education accounted for 57 (45%), those who had secondary education accounted for 20 (16%) respondents. The respondents who reported to have attained tertiary level were 22 (18%) and only 7 (6%) had attained university education. 19 (15%) respondents reported to have no literacy and numeracy skills (not attended school) and were classified as others.

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>57</td>
<td>45%</td>
</tr>
<tr>
<td>Secondary</td>
<td>20</td>
<td>16%</td>
</tr>
<tr>
<td>Tertiary</td>
<td>22</td>
<td>18%</td>
</tr>
<tr>
<td>University</td>
<td>7</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
<td>15%</td>
</tr>
</tbody>
</table>

Table 4.3: Respondent’s Level of Education

Data on the level of education was taken because of the potential influence of one’s level of education in accessing antenatal healthcare services. This concerns the knowledge level in terms of availability of services and the importance thereof. Response from a Key Informant showed that education and knowledge can transcend other barriers to access and make women go for antenatal care even in the face of limiting cultural factors. This substantiated by the quote below.
Here [clinic] we find that most women who come for services consistently have been informed about the importance of antenatal care. This shows you that knowledge level plays an important role in influencing access of antenatal healthcare services (Key Informant 3, Health Provider 38 years).

According to Ensor (2006), education and knowledge level dictate how women attend antenatal care due to the ability to make informed decision. Further, Babalola (2014) cite women's education as significant in increasing antenatal visits and that low level of education is detrimental to the same.

4.1.4 Occupation
The occupation of the respondents was classified according to the kind of income-generating activity each respondent reported. These classifications were jobless, business, informal employment, Formal employment. The jobless category included respondents who did not report any form of income-generating activities such as being a fulltime housewife. This group accounted for 34 (27%) respondents. The business category included those respondents who reported to operate small-scale business such as selling animals and animal products. This group accounted for 54 (43%) respondents. The informal employment category included the respondents who reported to engage in non-permanent informal jobs whose status does not meet salary threshold. These were respondents who engaged in part-time activities such as cleaning and other casual jobs whose payment is daily or weekly. There were 33 (26%) respondents who belonged to this category. The employed category encompassed respondents who reported permanent employment and paid salary at the end of the month as in white-collar jobs such as teacher or nurse. Only 4 (3%) respondents belonged to this category.
The data on the occupation of the respondents was important in assessing the extent to which economic status as depicted by the income level influences access to antenatal health services. An individual’s income is influenced by the occupation or income-generating activity and access to antenatal care has embedded economic or financial tags as exemplified by the payments in clinics and other entrenched payments such as travel to the centres. Indeed, the responses from FGDs depicted income as a critical factor in influencing the access to antenatal health services by women.

*Money is important in everything. Even when you are willing to go for the baby to be checked, you may not have the money to go there and sometimes you cannot walk* (FGD 1 18-25 Category)

*There are payments in the hospital. If you do not have the money, it is not possible for you to go* (FGD 3 26-49 Category)

These sentiments were reinforced by a Key informant who attributed the costs associated with antenatal visits as barriers to access as illustrated below.
Many people here do activities that do not generate a lot of money. Many live from hand-to-mouth and may not have extra income to cater for antenatal clinics. So even if the culture and norms may not warrant the visit, economic burden adds to this (Key Informant 4, Male, Health Facility In-charge).

Ensor (2006) cites income level as a partial factor in increasing antenatal care. However, when other factors such as religion and gender differences are included, income level may be comprised.

4.1.5 Religion

Table 4.4 show the religious affiliations of the study respondents. Majority of the respondents were Catholics 43 (34%), while the Protestants accounted for 36 (29%) of all respondents. 42 (34%) respondents belonged to other (traditional religions) and only 4 (3%) were Muslims.

<table>
<thead>
<tr>
<th>Religion</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholics</td>
<td>43</td>
<td>34%</td>
</tr>
<tr>
<td>Protestants</td>
<td>36</td>
<td>29%</td>
</tr>
<tr>
<td>Other (traditional)</td>
<td>42</td>
<td>34%</td>
</tr>
<tr>
<td>Muslim</td>
<td>4</td>
<td>3%</td>
</tr>
</tbody>
</table>

Table 4.4: Respondents’ Religious Affiliation

It was deemed important to measure the religious affiliation of the respondents because of the potential influence of religious beliefs in the context of seeking antenatal health care services as identified in the literature review. The study findings confirmed that religious foundation have impact on access to antenatal care by women. Consider the quote below from FGD 3.

*In our church, the pastor is skeptical of the healthcare providers because they do things that are not traditionally allowed here in our community. He is not for the idea of men nurses checking women* (FGD 3 36-49 Category).

However, in other circumstances, religious affiliation positively influences access to antenatal health services.
We have a church welfare group and if you are pregnant, members ask you how you are going to the clinic. So you have to go in order to fit in (FGD 1 18-25 Category).

4.2 Community Factors Influencing Access to Antenatal Health Care Services

4.2.1 Cultural Factors

The study findings indicated that women are under a cultural matrix that significantly influences their access to antenatal healthcare services. Apparently, the cultural belief in the power of traditional birth attendants was found to negative influence women’s access to antenatal healthcare services. Resultantly, most women fear going against this cultural expectation and may shun going for biomedical antenatal care. The consequences for violating this expectation includes being curse and ostracized in extreme cases. In the community, visits to TBAs are considered conformity to the culture and linked with ancestral blessing for successful delivery and growth of the child. Figure 4.2 shows different reasons for getting antenatal services from the TBAs.

![Figure 4.2: Reasons for visiting TBAs: Multiple Responses](image)

The figure illustrates that the major reason for visiting TBAs for antenatal healthcare services is hinged on the desire to conform to the culture including conforming to the ancestral wishes and avoid community ostracism. In addition, women believe that the services provided by the TBAs are of high quality and fulfilling and also please their
husbands. Accessing the services from TBAs is also associated with lowered costs compared to what would be incurred in the clinics. These views are supported by the sentiments in the following quotes from FGDs.

For all my pregnancies, I have visited a TBA and even give birth under her help. You know you can’t live without culture and this is our practice here although many people are now going to the clinics also (FGD 3 36-49 Category)

TBAs do not charge as much as the clinics. In the clinics, there are a lot of payments. However, when you go to her [TBA], she can even care for you for credit or pay her with non-monetary items. You cannot do this in a hospital (FGD 2 26-35 Category)

Thus, although some women may visit clinics for antenatal care, they also visit the TBAs for cultural fulfillment. In the study’s survey, 55 (55%) women reported to have visited the TBAs for antenatal care or would visit in future. The consensus from FGDs reinforced the view that the cultural issue of TBAs may limit access of antenatal health services.

If you do not see a TBA and people here know that you are pregnant, they will question you as this is the norm. Your husband or parents may insist that you visit one in order to avoid the consequences. So, you have to go. (FGD 3 36-49 Category).

It is a tradition here that we must see a TBA. They [TBAs] are very common, respected and important people in the community (FGD 1 18-25 Category)

This is confirmed by the sentiments of a Key Informant.

Although some [TBAs] have knowledge on pregnancy issues, some acquire it through apprenticeship and people respect them here. When they [clients] come, we ask them whether they have visited a TBA in order to know how to handle them (Key Informant 4, Male, Health Facility In-charge)

A TBA Key Informant said that her role cannot be disputed in the community and she gets overwhelmed when the clients are many.
Most of the women here have passed through my hands. Some even do not go to deliver in the hospital. I have to plan my day well because sometimes they [clients] can be many (Key Informant, TBA 58 years).

These findings show that the cultural issues of TBAs can limit access to antenatal care by women. When the women have to visit the TBAs for antenatal care and at the same time go to the antenatal clinics, they may end up with double and/or conflicting treatment or advice.

Another aspect of cultural influence in accessing antenatal healthcare services is the belief in the traditional medicine and prestige associated with visiting TBAs and giving birth at home. Essentially, it was found out that women who visit the TBAs and give birth at home are more respected than the ones who go to the hospital. This is rooted in the belief that strong women do not allow strangers in their pregnancy and birth matters. Consider the quotes below.

_In our culture, especially for the first child, women give birth at home and seek the care of a TBA when pregnant. This also makes you earn respect from peers_ (FGD 2 26-35 Category).

_Culture here is rich and people do not bother going to hospital as long as they fulfill the cultural expectation. For example, being attended to by a TBA is key here and people attach a lot of importance on that. However, if the TBA is not skilled, complications and even death are apparent_ (Key Informant 1, Female, 40 years, TBA).

Thus, the (cultural) prestige associated with local administration of care during pregnancy and at birth is a barrier towards accessing and utilizing antenatal healthcare services. Mostly, cultural beliefs and practices limit access and uptake to modern antenatal healthcare services. Similar findings were reported by Agus, Horiuchi and Porter (2012) who observed that low uptake of antenatal care is a function of traditional beliefs linked with choice between traditional birth attendants and biomedical attendants.
4.2.2 Socio-economic Factors

The findings indicated that socio-economic factors are fundamental in determining whether women visit or access antenatal healthcare service. Indeed, this set of factors play an integral role in placing constraints that rather limit the access. The social factors influencing access to antenatal care include education level, gender relations (marital status), financial constraints and religion. In the level of education, knowledge about the antenatal services and the importance of going for biomedical healthcare services influences visit to antenatal clinics. Further, gender relations were found to influence how women visit the antenatal clinics. Apparently, women have to get the husband’s consent in order to go for antenatal health services. Religion was also found to play a key role since religious beliefs dictate the course of action in relation to caring for pregnancy. Women also experience financial constraints amid competing needs and prefer going to the TBAs who charge much less as hinted above (reasons for visiting TBAs). Figure 4.3 shows the distribution of the socio-economic factors in influencing access to antenatal healthcare services by women.

![Figure 4.3: Socio-economic factors influencing access to antenatal healthcare services: Multiple responses](image)

The knowledge of availability of the services and the basic understanding of the importance of seeking antenatal care services influenced significantly the access. This points to the importance of education in relation to access and utilization of antenatal healthcare services.
Indeed, respondents with at least secondary education reported to have visited the biomedical clinics compared to those who reported lower levels of education. The view of a Key Informant reinforce this statement.

*Although it is not a guarantee that educated women know where, why, and when to go for antenatal clinics, the ones with higher levels of education show consistency and commitment in the visits here* (Key Informant 3, Health Provider 38 years)

However, as indicated by the Key Informant above, education may only play part of the role in determining access to antenatal healthcare services since other socio-economic factors come into play. Such factors include the gender relations and the way women have to seek approval of the family or husband in order to access antenatal healthcare services. The FGDs brought out this issue well.

*Most things I do must bear the approval of my husband or his people. When he says that I should not go to the hospital, who am I to refuse. Sometimes he prefers I go to TBA and seek traditional medicine* (FGD 1 18-25 Category).

*In my first pregnancy, I could not go to hospital because everyone in the family was against it. My husband also warned me against going against the tradition* (FGD 2 26-35 Category).

Religion was found to act as a barrier and as a facilitator in relation to accessing antenatal healthcare services by women. A majority of the respondents (34%) belonged to other denominations (Table 4.4). These other traditional religions were found to have strong emphasis on conservatism and culture. These prevented women affiliated to such religions to shun hospital treatment and instead go for traditional ways of caring for pregnancy and birth. One respondent belonging to such religion (*rijumaria*) put this into perspective.

*My church teaches us to preserve culture and one of the ways of doing that is to observe traditional medicine even when pregnant. Although I have come to refute that since my second child died, it is true religion can prevent one from going to the hospital* (FGD 3 36-49 Category).
The impact of religion is however not negative solely. In other cases, women are encouraged by religious leaders to go for biomedical clinical checkups when expectant as shown in the following statement:

*When my church leaders come during home visits and meet a pregnant woman, they inquire whether she is going for treatment in hospital. Now you see on that point, you cannot escape* (FGD 1 18-25 Category).

Thus, depending on the religious influence, women may access antenatal healthcare services or not.

On the financial constraints, the cost of antenatal care in the clinics was cited as a major barrier. The respondents’ occupation (Figure 4.4) shows that majority either were jobless or had informal employment, with most respondents earning between Kes 3000 and kes 5000 shillings a month. This indicates low income. Amidst competing financial needs, women opt to go for other alternatives such as TBA, where services are cheaper. Further, there are embedded costs in going to the clinics apart from the clinical fee. Such costs include food and travel (fare). In the study, the findings indicated that the distance travelled is long (highest 16 km lowest 2 km) in order to access antenatal services. Financial constraints thus pose a barrier to accessing antenatal healthcare services by women. A key informant reinforced this statement:

*Sometimes when you ask some of them why they miss scheduled visits, they cite money as the problem. This is true because most are poor, not supported by husbands, and have to travel long distances* (Key Informant 4, Male, Health Facility In-charge)

Socio-economic factors are revealed by several studies as barriers to access and uptake of antenatal care services. In investigating the factors that prevent women in seeking antenatal care from skilled personnel, Johnson, Primas and Coe (1994) noted that socio-economic variables such as second position of women in the society and economic disadvantages suffered by women are key contributors. Similarly, Fatmi and Avan (2002) shows that low socio-economic status of women is a key driver to their low access to antenatal care. A study conducted by Mustafa and Mukhtar (2015) revealed that poor antenatal service delivery is
hinged on poor education and among the women. Further, Dahiru and Oche (2015) show that the level of education of women and the husband greatly determines access to antenatal care. On the same note, wealth level also influences access and uptake of antenatal care where poverty discourages seeking care. Religion is cited as one of the barriers to access and uptake of antenatal care in various studies (Bbaale, 2011; Dairo and Owoyokun, 2010).

4.2.3 Institutional Factors Influencing Access to Antenatal Health Care Services

The study findings indicated that institutional factors may discourage women from accessing antenatal healthcare services. These factors include the staffing in the clinics and the poor provider-patient relationship, where the attitudes of the providers discourage women from subsequent visits. Further, as noted above, some women have to travel for long distances since the health centres are located in far places from their homes.

In terms of staffing, low provider-client ratio makes women to wait for long hours before being attended to and this is deemed a barrier to accessing antenatal healthcare services. This is more apparent if the women have other household chores. Consider the quote below.

>You waste a lot of time in the hospital because of the long queue. You feel like going home without treatment. I have done that twice and I know many of my friends who do not go for clinics because of this. There are other duties at home to be done (FGD 2 26-35 Category)

A key informant confirmed the issue of long waiting time in the queue as shown below:

>We also get overwhelmed. Being alone in the antenatal clinic is demanding and the clients continue to stream in (Key Informant 3, Health Provider 38 years).

Further, the respondents reported poor relationship between women seeking antenatal care and the providers. Apparently, the latter have bad attitude and talk to the patients rudely. In certain instances, they insult the women and use derogatory terms to refer to women and their pregnancy. The quotes below exemplifies this:
There is one nurse I will live to hate. She told me not to complain about the pains since she is not the one who impregnated me. I felt bad and since then am reluctant to go there (FGD 3 36-49 Category)

My friends tell me that doctors there [clinics] talk badly. I fear going there because I also hear that they can insult you (FGD 1 18-25 Category)

Thus, the institutional factors discourage women from visiting clinics for antenatal care and creates a barrier to access. Similar studies reveal that transportation and travel time, waiting time and availability of services influence access to antenatal care (Hjortsberg & Mwikisa, 2002).
CHAPTER FIVE: CONCLUSION AND RECOMMENDATION

5.1 Introduction
This chapter presents a synthesis of the research findings and summary. Based on the research findings, the chapter also details the recommendations for improving access to antenatal healthcare by women. Areas of further research are also discussed in this chapter. The study sought to identify the community and institutional factors that influence access to antenatal healthcare services by women in Isinya, Kajiado County. The findings show that there is no single factor that solely influences access to antenatal healthcare services. Rather, there is an amalgam of factors, which in different combinations enhance or limit women’s access to antenatal healthcare services.

5.2 Summary
There are general and unique factors that influence women’s access to antenatal healthcare services. These factors are grouped into two major categories: community factors (cultural, socio-economic) and institutional. Each set of the factors has subsets. The study findings indicated that cultural factors are pivotal in determining whether women visit health centres for antenatal clinics or not. In the context of this study, cultural factors form a significant barrier towards access to antenatal healthcare services. Specifically, the presence and work of Traditional Birth Attendants is a cultural attribute with deeply engrained cultural ramifications and importance. Their work has cultural significance and women wish to fulfill their cultural obligations by seeking the services of TBAs. As a cultural phenomenon, the traditional administration of medicine and care to the expectant women imply that few of them go to the biomedical health centres for the same. In addition, the cultural beliefs surrounding TBAs and their services bind women to adhere to the expectation. For instance, it was found out that visiting TBAs is associated with fulfillment of ancestral wish and that adherence exempts women from social ostracism. Another cultural reason for visiting TBAs for antenatal care and delivery is the perceived quality and unwavering care provided as well as cutting the cost. This is because the TBAs are relatively cheaper and payments need not to be in monetary terms necessarily, based on social arrangement.
Another cultural aspect is the prestige associated with local caring of pregnancy. Apparently, women who shun antenatal care in biomedical centres are respected for perpetuating a cultural practice that entail seeking care within the community. Home deliveries are also considered culturally binding and enriching, especially for the first child.

The socio-economic factors entail both societal and financial issues that influence the way women access antenatal healthcare services. Social issues constitute behaviours that take place in the social world and influence decision-making and access to opportunities and resources. Social factors also transcend to affect economic status of individuals based on relational behaviours and activities. In the context of this study, the social factors include gender relations and power differences in decision-making, education, and religion as a social phenomenon. In the study it was found that the gendered power differences between men and women in the community affect the way women access antenatal healthcare services. This is hinged on decision-making where men make decisions on whether women will access the services or not. Under a patriarchal society such as Maasai, the decisions of men affect the course of action for women. It was found that men would not allow women to shun traditional care based on cultural issues and cost.

Religion was also found to influence access to antenatal care by dictating the best practice. In the study, certain religious groups did not allow women to seek antenatal care in health centres as this would be against their doctrines. However, certain other religious groups supported antenatal healthcare services among the congregation. This way, religion may be seen as both a barrier and promoter of access to antenatal healthcare by women.

The knowledge system as depicted by the level of education and exposure also affects access to antenatal care by women. The study found that women who were educated past high school had greater tendencies and will to visit health centres for antenatal care compared to those with lower level of education. However, education alone cannot account for increased or decreased access to antenatal care since other variables such as financial status, religion, and gender power imbalances come to play. Economic factors encompass the income level of the women to warrant accessing antenatal care. Most women were either unemployed or relied on low-income activities and were faced with competing needs where access to antenatal care becomes the opportunity cost. The study found that women are
financially incapacitated and may rely on their hesitant partners for financial support. This limits access to antenatal care and a driver towards tradition medicine and care for expectant mothers.

On institutional factors, the availability and proximity of health centres providing antenatal care, clinic staffing, and provider-client relationship issues manifested. This is where the clinics have few staff members providing antenatal services to many clients. Shortage of staff discourage women to visit the clinics due to long waiting times and as they save time for other domestic chores. The perceived bad attitude among the healthcare provider further discourage women from visiting the clinics. Finally, most clinics are far away from the women seeking antenatal care. This creates a barrier by imposing extra cost (travel) and most importantly making TBAs the preferred providers as they are readily available.

5.3 Conclusion
Based on the study findings, access to antenatal healthcare services is under the influence of inter-dependent factors. Enhancing access to the services thus requires identification and understanding of the drivers of seeking care. The availability of TBAs versus the healthcare centres create conflict where women may seek both services, hence conflicting care standards and outcomes. The increased access to TBAs exposes the women to multiple dangers especially when they (TBAs) are not as skilled. It is thus important to either build the capacity of TBAs to provide antenatal services or promote access in health centers through confronting the identified barriers.

Women seek alternative antenatal care because of the underlying barriers in regard to accessing health centres. Distance, cost, and limiting social factors hinder women to seek biomedical antenatal care. The consequence of such as trend is deteriorating maternal health and the danger of maternal and infant mortality resulting from poor antenatal care and delivery assisted by unskilled attendants. It is conceivable that the high rates of maternal and infant mortality are attributable to the cited barriers in accessing antenatal healthcare services.
5.4 Recommendations
The study findings reveal certain gaps in relation to accessing antenatal care among women in low-income settings. The recommendations included here would fill the gaps and enhance increased access to antenatal healthcare services.

- Creation of community support systems including resource centers to support expectant mothers. This entails providing women with enabling environment that encourage access to antenatal care through moral and financial support. This would also entail increasing the capacity of TBAs through training, where necessary.

- The health facilities providing antenatal care need to be strengthened in terms of staffing to cater for expanding clientele. On the same point, authorities need to review providers’ standard operating procedures and protocol and ensure implementation in order to facilitate good provider-client relationship.

5.5 Areas for Further Research
The study has identified a research gap that can be sealed through studies on the same area. Specifically, it is important to undertake research on the role of Traditional Birth Attendants in modern antenatal care and how they can contribute to strengthened comprehensive care. This stems from the fact that many women as exemplified by the Maasai population still prefer visiting TBAs for both antenatal medication and delivery.
REFERENCES


World Health Organization (2008). Teen Pregnant in New York, Department of Health and Mental Hygiene, New York City USA
Appendix I: Consent Form

COMMUNITY AND INSTITUTIONAL FACTORS INFLUENCING ACCESS TO ANTENATAL HEALTH CARE SERVICES BY MAASAI WOMEN IN ISINYA, KAJIADO COUNTY

Investigator: Rebecca Lemaron

Introduction
I am Rebecca Lemaron from the University of Nairobi, Institute of Anthropology, gender and African studies. I am conducting a study on community and institutional socio-economic factors influencing access to antenatal health care services by Maasai women in Isinya, Kajiado County.

Purpose
The study seeks to investigate the socio-economic and cultural factors influencing access to antenatal health care services by Maasai women in Isinya, Kajiado County. This is through establishing the cultural factors, socio-economic factors as well as institutional factors that influence Maasai women access to and utilization of antenatal health care services.

Procedure
If you agree to participate in the study you will be asked questions concerning the nature of your interaction with the Maasai women. The questions will be about the social cultural, and economic factors affecting Maasai women’s access to antenatal health care services. The questions will include the experiences, beliefs, values and attitudes as well as norms surrounding the access to and utilization of antenatal healthcare services based on social cultural and economic aspects.

Confidentiality
Your confidentiality will be maintained at all times and there will be no use of names or any possible identifiers that may connect you with the reports or publications that will be availed as a result of the study.

Voluntarism
Participation in the study is of voluntary nature and if you choose not to participate you will not be penalized in any way. You will also be free to withdraw from the study at any time.
and refuse to answer any question that you deem is too personal. However, I humbly request your full participation and cooperation in the study.

**Contact Persons**

In case of any questions you may have regarding the study, you may contact Rebecca Lemaron through telephone number: 0722476417 or email address: pool_ke@yahoo.co.uk

Your participation in the study will be highly appreciated.

I_______________________________________ hereby voluntarily consent to participate in the study. I acknowledge that I have understood the explanation given to me with regard to the nature of the study by ____________________________________. I clearly understand that my role with regard to my participation which is completely voluntary.

Signature________________________________________Date______________________

Signature of Reseacher/Assistant_____________________Date________________________
Appendix II: Questionnaire

Introduction

My name is………………………………....from the University of Nairobi. I am conducting research on: **Social cultural and economic factors influencing access to antenatal health care services by Maasai women in Isinya, Kajiado County.** I would like to ask you a few questions that will take approximately 20 minutes. Your participation and responses will be highly appreciated. Please let me know whether you have any questions. Do you allow me to continue?

Yes [ ] No [ ]

Section A. Socio-demographic characteristics of the participants

1. Age

<table>
<thead>
<tr>
<th>Age Range</th>
<th>()</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-20</td>
<td></td>
</tr>
<tr>
<td>21-26</td>
<td></td>
</tr>
<tr>
<td>27-32</td>
<td></td>
</tr>
<tr>
<td>33-38</td>
<td></td>
</tr>
<tr>
<td>Over 38</td>
<td></td>
</tr>
</tbody>
</table>

2. Marital status

<table>
<thead>
<tr>
<th>Status</th>
<th>()</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td></td>
</tr>
</tbody>
</table>

3. Highest level of Education attained

<table>
<thead>
<tr>
<th>Level</th>
<th>()</th>
</tr>
</thead>
<tbody>
<tr>
<td>University</td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td></td>
</tr>
<tr>
<td>Tertiary</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
</tr>
</tbody>
</table>

4. Religion?

<table>
<thead>
<tr>
<th>Religion</th>
<th>()</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td></td>
</tr>
<tr>
<td>Protestant</td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td></td>
</tr>
<tr>
<td>African Traditional</td>
<td></td>
</tr>
</tbody>
</table>

| Others, specify                                                                 |    |
5 Occupation

a. Salaried employee ( )

b. self-employed ( )

c. unemployed ( )

d. Herder ( )
Section B: Social Cultural Factors Influencing Maasai Women From Accessing Antenatal Health Care Services

1. In your recent (or present) pregnancy, did you attend antenatal health care?
   a) Yes ( )              b) No ( )

2. If No above, why? (probe for reasons)………………………………………………..
   ………………………………………………………………………………….

3. If YES, starting which month?
   a) 1-2 ( )              b) 3-4 ( )
   c) 5-6 ( )              d) 7-8 ( )
   e) 9 and above ( )

4. Where did you have (or plan to have) your recent or current delivery?
   a) Health facility ( )              b) Home ( )
   c) On the way to facility ( )

2. What was the outcome?
   a) Live birth – well ( )              b) Live birth- developed complications
   c) Still birth ( )

12. Did you discuss about delivering in a health facility?
   a) Yes ( )              b) NO ( )

13. What is you view on (importance of) antenatal care
   ………………………………………………………………………………….
   ………………………………………………………………………………….
   ………………………………………………………………………………….
Section C: Economic Factors Effecting Women from Accessing Antenatal Health Care Services

13. How much do you earn monthly?
   a) Less than 3,000 ( )
   b) 3,000-5,000 ( )
   c) 5,000-10,000 ( )
   d) 10,000-20,000 ( )
   e) over 20,000 ( )

14. State number of animals you have
   a) Cows……………………
   b) Shoats (goats/sheep)…………
   d) Donkeys ……………
   e) Other……………………

15. How much did you pay to access ;( transport and other costs- specify – If utilized the services
   a) Antenatal health care (Ksh)………. b) Deliver (Ksh)……………………
   c) prenatal health care (Ksh)...........

16. How far was facility from home during delivery?
   a) Less than 5km ( )
   b) 6-10km ( )
   c) 11-20km ( )
   d) 21-30km ( )
   e) 31-40km ( )
   f) Over 40km ( )

17. If attended, how did you access the health facility?
   a) Car / lorry ( )
   b) motor cycle ( )
   c) Bicycle ( )
   d) Cart ( )
   e) Donkey ( )
   f) walking ( )
18. What was your source of information about maternity services?
   a) TV  ( )  
   b) Radio  ( )  
   c) Health worker  ( )  
   d) TBA  ( )  
   e) Local administration  ( )  
   f) Neighbours  ( )  
   g) Not heard  ( )

19. What are some of Social-Economic factors do you think could prevent you from attending antenatal health care services?
   - Unplanned pregnancy  ( )  
   - Limited Knowledge about antenatal health care  ( )  
   - Financial constraints  ( )  
   - Distance to the health center  ( )  
   - Fear of disclosing pregnancy  ( )  
   - High antenatal health care fees  ( )  
   - Unfriendly health workers attitudes  ( )  
   - Unfriendly attitudes of older clients (mothers)  ( )  
   - Poor family support and social support  ( )  
   - Fear of testing for HIV status  ( )  
   - Inadequate knowledge about benefits of antenatal health care  ( )  
   - Poor economic power (poverty)  ( )  
   - Peer influence  ( )  
   - Other (specify) ……………………………………………………………………….
Section D: Institutional Factors Affecting Women from Accessing Antenatal Health Care Services

20. What was the staff attitude/ friendliness during antenatal health care services?
   a) Excellent ( )
   b) Good ( )
   c) Fair ( )
   d) Bad ( )
   e) Not attended ( )

21. Did you think the delivery was well conducted?
   a) Yes ( )
   b) No ........................................
   c) Had home delivery ( )

21. Did you find?
   i) The Staff who delivered you friendly?
      a) Excellent ( )
      b) friendly ( )
      c) Not friendly ( )
      d) rude ( )
   ii) Waiting time before being attended to prompt or long?
      a) Prompt ( )
      b) average ( )
      c) Some delay ( )
      d) very long ( )
   iii) Basic ablution facilities (i.e. toilets) good or bad
      a) Excellent ( )
      b) Good ( )
      c) Fair ( )
      d) bad ( )
   iv) Privacy good or bad?
      a) Excellent ( )
      b) Good ( )
      c) Fair ( )
      d) Bad ( )
22. What was the staff attitude/ friendliness during Antenatal care?
   a) Excellent  ( )
   b) Good  ( )
   c) Fair  ( )
   d) Bad  ( )
   e) Not attended ( )

23. Did the facility have enough supplies/ equipment?
   a) Yes..............................
   b) No.........................
Appendix III: Interview Schedule

1) How would you rate the influence of access of Antenatal Health care services – If utilized the services

..................................................................................................................................................................................
..................................................................................................................................................................................
..................................................................................................................................................................................
2) How far was facility from home during delivery?

..................................................................................................................................................................................
..................................................................................................................................................................................
..................................................................................................................................................................................
3) Of the attendance sequence, how would you rate the access of the health facility?

..................................................................................................................................................................................
..................................................................................................................................................................................
..................................................................................................................................................................................
4) What was your source of information about maternity services?

..................................................................................................................................................................................
..................................................................................................................................................................................
..................................................................................................................................................................................
5) What are the social-economic and cultural barriers that you think could prevent you from attending antenatal health care services?

..................................................................................................................................................................................
..................................................................................................................................................................................
..................................................................................................................................................................................
6) What are the cultural factors influencing Maasai women from accessing antenatal health care services

..................................................................................................................................................................................
..................................................................................................................................................................................
..................................................................................................................................................................................
7) Where and why does recent delivery happen in this area/region?

…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………

8) What strategies should be put in place to enhance the level of utilization of antenatal health care services by Maasai women in Isinya Kajiado Sub-County?

…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………
Appendix IV: Focus Group Discussion Guide

**BIO DATA:**

<table>
<thead>
<tr>
<th>No.</th>
<th>Age</th>
<th>Occupation</th>
<th>No. of children</th>
<th>Position in the household</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. What avenues do we have that we can use when it comes to child birth and who are involved in ensuring safe birth delivery takes place? Probe for: hospital use, clinics, traditional birth attendants, home use.

2. What makes us to decide on the various avenues to go and deliver our children? Probe for: reasons for either going to hospitals, home deliveries, the use of specific individuals be it traditional birth attendants or trained birth attendants.

3. What are the reasons for not taking any other avenue such as hospitals for those who do not go to hospitals or for home deliveries for those who do not do home deliveries
or any other avenue mentioned? *Probe for: reasons behind not choosing one avenue over the other.*

4. What preparation does one go through before the actual child preparation through the various delivery avenues that you use? *Probe for: what happens in various avenues from the initial months of pregnancy all the way to delivery.*

5. What advantages or disadvantages are there of choosing one avenue over the other? *Probe for: what makes the prefer one avenue such as hospital delivery over the other avenues or any other that they have.*

6. What antenatal health care services do you receive in the avenues you visit for your delivery and pregnancy care? *Probe for services offered by any venue.*

7. What antenatal health care services did you use to receive about 7 years ago compared to now when we have the county government? *Probe for whether services have changed and how have they changed.*

8. What challenges do you face as women during delivery and the pregnancy period? *Probe for: any challenges that exist whether structural or institutional that have been there before and are there currently limiting their access to antenatal health care services.*
Appendix V: Key Informant Interview Guide

**BIODATA:**

Age:

Sex:

Occupation:

Years of service:

1. In your opinion, what is the importance of seeking antenatal care during pregnancy? What are the dangers of not seeking such care?

2. What is the traditional and current perception among the people in regard to seeking antenatal care?

3. Do women here seek antenatal care? Where?

4. What informs the decision to go or not to go for antenatal care?

5. In your view, what socio-cultural barriers and challenges do women face in seeking antenatal care?

6. What economic factors influence seeking antenatal care for women here?

7. In your opinion, to what extent do institutional factors (distance to health centers, lack of information on antenatal care, clinic staffing, and healthcare provider-client relationship) affect access and utilization of antenatal care?

8. What can be done, in your view, to improve women’s access to antenatal care here in Isinya.
APPENDIX VI: RESEARCH BUDGET

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>QUANTITY</th>
<th>UNIT PRICE</th>
<th>TOTAL COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research Proposals and Thesis</td>
<td></td>
<td></td>
<td>20,000</td>
</tr>
<tr>
<td>Study Tools (guides, consent forms)</td>
<td></td>
<td></td>
<td>17,000</td>
</tr>
<tr>
<td>Publications</td>
<td></td>
<td>30,000</td>
<td>30,000</td>
</tr>
<tr>
<td>Supervision Fee (in the Field)</td>
<td>1</td>
<td>50,000</td>
<td>50,000</td>
</tr>
<tr>
<td>Research Permits (NACOSTI)</td>
<td>1</td>
<td>1,000</td>
<td>1,000</td>
</tr>
<tr>
<td>Note Books</td>
<td>3</td>
<td>500</td>
<td>1,500</td>
</tr>
<tr>
<td>Research Assistants</td>
<td>1</td>
<td>40,000</td>
<td>40,000</td>
</tr>
<tr>
<td>Refreshments for FGDs</td>
<td>50 pax.</td>
<td>500</td>
<td>25,000</td>
</tr>
<tr>
<td>Translators</td>
<td>1</td>
<td>10,000</td>
<td>10,000</td>
</tr>
<tr>
<td>Accommodation</td>
<td>60 days</td>
<td>10,000</td>
<td>60,000</td>
</tr>
<tr>
<td>Pretest</td>
<td></td>
<td>50,000</td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>403,500</strong></td>
<td></td>
</tr>
<tr>
<td>Contingency</td>
<td></td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td></td>
<td><strong>503,500</strong></td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX VII: WORKPLAN

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposal writing and literature review</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proposal Defense</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Collection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Processing and Analysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Publication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>