DETERMINANTS OF MATERNAL HEALTH AMONG THE KALENJIN WOMEN OF AINAMOI CONSTITUENCY, KERICHO COUNTY, KENYA

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C50/21686/2012

A THESIS SUBMITTED TO THE SCHOOL OF HUMANITIES AND SOCIAL SCIENCES IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF ARTS IN GENDER AND DEVELOPMENT STUDIES OF KENYATTA UNIVERSITY

JUNE, 2016
DECLARATION

This thesis is my original work and has not been presented for a degree in any other university. The thesis has been complemented by referenced works duly acknowledged.

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Kenyatta University.
DEDICATION

To my loving parents Mr. and Mrs. Julius Bii, my brothers and sisters who have been my source of inspiration, support and courage.
ACKNOWLEDGEMENTS

First, I remain eternally grateful to God for his guidance throughout my studies. I would like to express my sincere appreciation to my supervisors Dr. Mildred Lodiaga and Dr. Pacificah Okemwa for their great ideas, thoughts and full support since the inception of this work. To my other lecturers at the Department of Gender and Development Studies, thank you for all that you taught me.

I thank my parents for believing in me and supporting me in all my endeavors. I’m also grateful to all my friends for their moral support since the inception of this work.

I would like to thank the women and men from Ainamoi constituency who participated in the study. My thanks also go to the local leaders of Ainamoi constituency for the permission they granted me to conduct the research in the area and the guidance they offered during the study. Finally, to all those who helped in one way or another, I will always remain grateful.
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DEFINITIONS OF TERMS

**Gender relations:** This is hierarchical relation of power between men and women in which women are disadvantaged.

**Maternal health:** Refers to the health of women during pregnancy and childbirth and the postnatal period which begins immediately after the birth of a child and extends for about six weeks.

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

**Maternal morbidity:** This is prolonged and persistent ill-health which occurs as a result of complications of pregnancy and childbirth.

**Skilled birth attendant:** Refers to a recognized health professional who has been educated and trained to proficiency in the skills needed to manage pregnancies, childbirth and the immediate postnatal period.

**Traditional birth attendants:** These are non-formally trained and community-based care providers during pregnancy, childbirth and the postnatal period.
<table>
<thead>
<tr>
<th>Term</th>
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<tr>
<td>Asis or Cheptalil:</td>
<td>God of the Kipsigis people.</td>
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<tr>
<td>Chebiosetab sigisiet:</td>
<td>Traditional Birth Attendant.</td>
</tr>
<tr>
<td>Ipinda:</td>
<td>An age set.</td>
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<tr>
<td>Imbaret ab soi:</td>
<td>A big farm owned by men.</td>
</tr>
<tr>
<td>Kokwet:</td>
<td>A social group.</td>
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<tr>
<td>Kabungut:</td>
<td>A small vegetable garden cultivated exclusively by the mother and her daughters.</td>
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<tr>
<td>Kapande:</td>
<td>Field of maize.</td>
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<tr>
<td>Oret:</td>
<td>Clan.</td>
</tr>
<tr>
<td>Sigroina:</td>
<td>A house where unmarried male family members sleep.</td>
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<td>Tundo:</td>
<td>Initiation ceremony.</td>
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## ABBREVIATIONS AND ACRONYMS

<table>
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<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<tr>
<td>DHS</td>
<td>Demographic Health Survey</td>
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<td>FGM</td>
<td>Female Genital Mutilation</td>
</tr>
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<td>IMR</td>
<td>Infant Mortality Ratio</td>
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<td>KDHS</td>
<td>Kenya Demographic Health Survey</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>MHCS</td>
<td>Maternal Healthcare Services</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>NDHS</td>
<td>National Demographic Health Survey</td>
</tr>
<tr>
<td>OI</td>
<td>Oral Interview</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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ABSTRACT

High maternal mortality rate is one of the major maternal health concerns in developing countries including Kenya. The purpose of this study was to investigate determinants of maternal health as well as suggesting the strategies for improving it. To achieve the study objectives, this study adopted ethnography, a qualitative research design. Data was collected using interview guide, focus group discussion guide and key informant interview guide. The study targeted sixty married women of reproductive age (15 – 49 years) from three sub-locations of Ainamoi Constituency which were selected using simple random sampling. Sixty married men were also included in the research so that they could give their views on determinants of maternal health in the area. A pretest was undertaken to check and enhance validity and reliability of the research instruments before the commencement of the actual study. Data were analyzed using both qualitative and quantitative approaches. To achieve the first objective, descriptive analysis was utilized to describe determinants of maternal health among the women of Ainamoi Constituency. In the second objective, descriptive statistics were used to determine the frequencies in order to interrogate economic factors that determine maternal health. Quantitative data were analyzed using the Statistical Package for Social Sciences whereas qualitative data were analyzed thematically. The study found out that twenty eight percent of women are married off early, 85% of women do not make decisions on their sexual health, 76.7% of women bear more than four children, 18% of women prefer to deliver at home and 46% of women earn below KES 5,000. Cultural dietary precautions and gender roles also determine maternal health in the area. The study further established that 91.7% of men prefer a son and 55% suppose that pregnancy issues are absolutely women’s responsibility. Women lack access and control over family resources and are often excluded from family financial decision-making. The analysis above indicates that both cultural and socio-economic factors result into negative maternal health outcomes since pregnant mothers are not able to seek maternal health services on time. Based on these findings, it was recommended that strategies be put in place to improve maternal health which include: provision of maternal health education to men and women, encouragement of joint decision-making in the family, economic empowerment of men and women, encouragement of cultural practices that improve maternal health and discouraging those that impact on maternal health in a negative way. The main conclusion drawn from this study is that women do not make independent decisions concerning their maternal healthcare because of negative influence from the family members and the community. Further, women lack power to make decisions that concern their sexual and reproductive health. Patriarchal system of the society also denies women economic independence which in turn acts as a barrier to seeking maternal health services. The study recommends that, there should be involvement of men in matters that concern maternal healthcare, health practitioners should provide ANC services that are culturally sensitive and women should be economically empowered as well as given an opportunity to make independent decisions on their sexual and reproductive health which in turn will result into positive maternal health outcomes.
CHAPTER ONE
INTRODUCTION

1.1 Background to the study

Maternal health has become a global agenda as it is clearly stipulated as the fifth target of the Millennium Development Goals (MDGs). In this regard, Gill et al. (2007) note that the maternal mortality ratio in developing countries declined by just 6% from 430 per 100,000 live births in 1990 to 400 per 100,000 live births in 2005, whilst the under-five mortality rate fell by 28% during 1990-2007.

According to WHO (2010), worldwide, approximately 1000 women die each day from pregnancy and childbirth-related causes. In addition, 99% of these maternal deaths occur in the developing world, with Sub-Saharan Africa accounting for over half of these deaths. The international community has committed itself to improving maternal health by 2015 with MDG number five, which aims to reduce maternal mortality by three quarters and reach universal access to reproductive healthcare. Thus, efforts to reduce maternal mortality are ongoing in many parts of the world.

Bangladesh Bureau of Statistics (2007) has noted that although Bangladesh is on track to achieve MDG 5, maternal mortality is still very high. Women in rural areas of Bangladesh have lower social status which is impacted upon by oppressive social customs, lower literacy rates, poorer economic conditions, and poor quality healthcare services and all these factors hinder them from utilizing maternal healthcare facilities.

Jat and Sebastia (2011) argue that despite various efforts to reduce maternal deaths in India, mortality rates remain relatively high. India is a male-dominated society and males are often the final decision-makers in the family. They make all the
decisions including those of their maternal healthcare. The status of women and gender norms in a society determine, to a great extent, the dynamics of women’s relationships with their spouses or male partners and their place in the household. Societal factors also affect the opportunities woman have regarding education, income, occupation, expected age at first marriage, her control over earnings, and participation in decision making which in turn influence the utilization of maternal health care services.

Ujah et al. (2005) conclude that in most areas of Sub-Saharan Africa, social restructuring has promoted dangerous inequality. The most effects of these inequalities are on education, maternal and child health; while families are suffering the negative consequences of these many factors and conditions, women are in a particularly vulnerable position because by both definition and default, they suffer the most of all these ill effects.

Liberia Institute of Statistics and Geo-Information Services (LISGIS) (2008) indicate that maternal mortality rate in Liberia is ranked the fifth highest in the world. Gender inequalities worsen the situation since women do not have the social status to make their own decisions in regard to their maternal care which is often in the control of a spouse or more senior member of the family. Liberian women also lack control over resources such as access to money for transportation or care.

The World Bank (2011) asserts that Mali has one of the world’s highest fertility rates (TFR 6.6), yet the use of modern maternal health services is low. As a result of inadequate levels of preventive care, coupled with limited access to treatment for complications, the most recent Demographic Health Survey (DHS) reported that
maternal mortality ratio (MMR) is still high. Women usually have only limited, if any, independence over their reproductive and sexual health. They are disadvantaged from a young age since they are married off at an early age hence their educational opportunities become limited. Their low employment status does not enable them to utilize maternal healthcare services since they are not economically independent.

National Population Commission (Nigeria) and ICF Macro (2009) indicate that Nigeria accounts for about 10% of all maternal deaths, globally, and has the second highest mortality rate in the world, after India. Islamic injunctions which hearten male domination constrain women's supremacy and autonomy which could limit the ability to make significant decisions and also restrict movement. This could prevent women from attending antenatal clinics. Yahaya (2004) argues that Nigeria is by tradition a patriarchal society in which women are discriminated against from infancy. In the rural setting, gender disparity has been observed with women generally receiving less attention than men. Poor access to medical services is compounded by socio-cultural, economic and demographic factors including the behaviour of families and communities, social status, health decision-making power, culture, income, education and access to maternal health facilities play a vital role in causing maternal mortality.

According to WHO (2007), Ethiopia has one of the highest maternal mortality figures in the world. In a 2010 study, WHO and UNICEF reported that there are diverse underlying socio-economic determinants affecting maternal health; including poverty, gender discrimination, inequity and lack of women empowerment. Most of
the women are also not educated hence lack knowledge on the importance of utilizing maternal healthcare services.

KHDS 2008-2009 demonstrate that Kenya maternal mortality remains high at 488 maternal deaths per 100,000 live births. While this is below the Sub-Saharan average of 640 deaths per 100,000, Kenya experiences a very slow progression in maternal health. While approximately 92% of women giving birth received some antenatal in 2010, only 47% had the recommended four or more antenatal visits. Furthermore, 56% of Kenyan women deliver at home, with home births being more common in rural areas and only 44% of births were assisted by a healthcare professional (doctors, nurses and midwives). Women’s level of income and education plays a major role in determining maternal health outcomes. Sharon (2013) notes that a complex set of economic, social and cultural factors influence maternal health in Kenya. Women continue to occupy the lowest class of the society because of their illiteracy and unemployment. They have to depend on their spouses’ financial support in order for them to utilize maternal healthcare services. Barriers to access to these services play a significant role in mortality trends.

The Kenya government has made efforts to increase the number of health facilities as well as the number of health practitioners in Ainamoi constituency. Currently, the constituency has thirty-seven dispensaries, a district hospital and several private hospitals where women can seek maternal healthcare services. Despite these efforts, women in the area still die due to pregnancy related complications and this implies that there may be low utilization of the facilities hence the need for the study.
1.2 Statement of the Problem

Women have the right to enjoyment of the highest attainable standard maternal health. The enjoyment of this right is vital to women’s lives and wellbeing and influences their ability to participate in all areas of public and private life. The government has made efforts both locally as well as signing international treaties in order to reduce the rate of maternal mortality. Ainamoi Constituency is well-endowed with health facilities where women can seek maternal health services. They can seek these services from the various public health facilities as well as the private hospitals in the area. The government has also committed some finances to improve maternal health as well as increasing the number of nurses per constituency. In spite of the government efforts 91.2 per 100,000 maternal deaths have been recorded in Kericho County. Specifically in Ainamoi Constituency, in the year 2011, twelve maternal deaths were recorded, 2012, seven maternal deaths were recorded, 2013, four were recorded and 2015-2016, five have been recorded (MoH 2013). This implies that other factors may determine maternal health in the area. Socio-economic and socio-cultural factors around maternal health heighten the difficulty women face in their endeavors to access maternal health care. These hindrances contribute to delays in seeking health care, resulting in maternal morbidity, complications and mortality. To date, few research studies in Ainamoi constituency have focused on determinants of maternal health from women’s own perspectives. In order to increase the understanding of barriers that confront women in their effort to seek maternal health care, and to provide quality care for them, there was need for research that provides in-depth understanding of women’s experiences maternal health care from their own perspective.
1.3 Research Questions

i. What socio-cultural factors determine maternal health among the *Kalenjin* women in Ainamoi Constituency?

ii. What economic factors determine maternal health among the *Kalenjin* women in Ainamoi Constituency?

iii. Which strategies can be put in place in order to improve maternal health in Ainamoi Constituency?

1.4 Objectives of the Study

The objectives were:

i. To describe the socio-cultural factors that determine maternal health among the *Kalenjin* women in Ainamoi Constituency.

ii. To evaluate the economic factors that determine maternal health among the *Kalenjin* women in Ainamoi Constituency.

iii. To establish strategies to improve the maternal health in Ainamoi Constituency.

1.5 Significance of the Study

Maternal mortality is of great concern in Kenya, since it hopes to achieve Millennium Development Goal 5. Many countries hope to reduce maternal mortality by 75% by the year 2015. Even though analyses of current trends indicate that the country is making advancement in reducing maternal deaths, the rate of reduction is still slow. This research, therefore, generated information which can help in gaining more insight into socio-cultural and economic determinants of maternal health as
well as strategies that can be put in place in order to reduce maternal deaths. This research also generated data that can inform the Kenya government on future design and implementation of programmes that can deliver more sensitive, culturally relevant needs. Finally, academic fraternity will benefit from the outcomes of the study as it adds to the existing knowledge in the area of maternal health.

1.6 Scope and Limitations of the study

The study was confined to maternal health among the Kalenjin married women of Ainamoi Constituency in Kericho County. The study focused on Ainamoi constituency alone because of limited time. Only Kalenjin married women between the ages of 15-49 were studied since various studies in Kenya indicate that maternal deaths are high among the women within this age bracket. One of the limitations of the study was that some of the respondents were not willing to elicit much information on family matters especially those that concerned their sexuality and family resources. The second limitation was that the women had little time to participate in the study due to their societal gender roles. To overcome the first limitation the respondents signed the consent form. The researcher overcame the second limitation by taking respondents’ little time to allow them continue with their normal daily routines.
CHAPTER TWO
LITERATURE REVIEW

2.1 Socio-Cultural Factors that Determine Maternal health

2.1.1 Women’s Decision-Making Power Within the Family

Ashraf (2009), in a Philippine study using an exploratory design posits that women in most developing countries have restricted decision-making abilities that are as a result of differences in gender roles and family social hierarchy. Women’s inability to control their own sexual and reproductive health can lead to high fertility rates, frequent unwanted pregnancies and may increase the risk of complications during childbirth. This places women at an increased risk of maternal mortality. Power dynamics within the household can mean that women are unable to take control over their reproductive health, putting them at an increased risk of maternal death.

Yalem (2010) discusses the determinants of antenatal care and skilled birth attendant utilization among the women of Samre Saharti District in Ethiopia. He observes that there is low utilization of maternal healthcare services since husbands and mothers-in-law usually decide for the women on the utilization of antenatal care. Pregnant women always have to get permission from their husbands to seek care during pregnancy.

Klingberg-Allvin et al. (2012), in their qualitative analysis to identify and synthesize of the non-financial access barriers to maternal health services in Vietnam, conclude that the first and most important duty of a wife is to bear a son to continue with the family lineage and provide spiritual assertion. On the contrary, some other studies also found that women’s decision-making power within the family has only a
weak or no effect on women’s maternal health. For instance, Simkhada, Vanteijlingen and Porter (2008), looked at factors affecting the utilization of antenatal care in developing countries. They note that women’s decision-making power within the family does not determine maternal health. They conclude that the uptake of antenatal care is affected by maternal education, husband's education, marital status, availability, cost, women's employment, household income, media exposure and having a history of obstetric complications. Cultural beliefs and ideas about pregnancy also influenced antenatal care use.

Fotso et al. (2009), while looking at the influence of women’s decision-making on maternal health among Nairobi women in Kenya concluded that, education, household wealth, demographic and health covariates had strong relationships with place of delivery but women’s decision making was rather a weak determinant. Even though researches on the influence of women’s decision-making on maternal health have been conducted in various countries, for instance, Mali, Philippines and Ethiopia, there was need for a study interrogating determinants of maternal health in Ainamoi Constituency due to variation in cultures hence the study employed ethnographic research design to establish the relationship between women’s decision-making power within the family among the Kipsigis and their utilization of maternal healthcare services.

2.1.2 Beliefs and Practices About Food

Liamputtong et al. (2005), in a study among Thai women argue that pregnancy and the postpartum period are very special situations in the life of women as well as their babies. Traditional beliefs about food are passed by word of mouth from one
generation to the other and adherence to them also depends on the amount of health information given to women and their education. Advice on diet during pregnancy is obtained by word of mouth from the older people especially mothers or mothers-in-law to the younger women. Pregnant women are advised to avoid eating some kinds of food such as spicy foods, pickled foods and also avoid alcoholic drinks. This is believed to improve the health of pregnant women and their unborn baby.

Vida (2008) conducted a study in Ghana whose general objective was to examine Ghanaian women’s experiences when seeking maternal health. He states that lactating mothers are advised by elderly women to eat guinea fowls in order to improve their health and breast milk production which leads to positive maternal outcomes.

2.1.3 Early Marriage

Amrita et al. (2012) explored the role of gender inequalities on women access to maternal healthcare services in Namibia, Kenya, Nepal and India using a cross sectional survey design. They found that early marriage limits young women from furthering their education and this renders them not to make independent decisions concerning their health in general and particularly those that concern their maternal health. Moreover, most young women do not fully utilize the maternal health facilities since they lack knowledge on their significance.

Grown et al. (2005), in a Caribbean study whose aim was to find out the effect of gender inequalities on maternal health state that gender interrelates with age to make young women exposed to the ill effects of gender-inequality norms on maternal healthcare. These norms usually dictate early marriage for girls. Santhya (2009), in a
study on Indian women aged 20-24 argues that women who marry early are likely to have a still birth since their bodies have not fully developed. Additionally, the author notes that early marriages curtail young women’s educational opportunities which in turn lead to financial insecurity among them.

2.2 Socio-economic Factors Determining Maternal Health.

2.2.1 Women’s Education

Evidence from past researches indicates that a mother’s education has a positive effect on maternal health. For instance, Muchabaiwa et al. (2012) in a Zimbabwe study to determine maternal healthcare among women, note that education augments women’s autonomy resulting in women developing greater confidence and capabilities to make decisions regarding their own health.

Sari (2009), in an Indonesian study, posits that educated mothers have a greater awareness of the existence of maternal healthcare services and benefit in using such services. They are also likely to have better knowledge and information on modern medical treatment and have greater capacity to recognize specific illnesses. Some researchers, however, question the strong independent effects of formal education on maternal healthcare utilization. For example, Gage and Calixte (2006) argue that other factors such as childhood place of residence and socio-economic environment interact to dilute this strong association. Ugal et al. (2008) in their study conducted in Nigerian to establish the socio-cultural factors that determine maternal health argue that there is no significant relationship between educational qualification and maternal health status. Although formal education influences individual’s perceptions and dispositions towards different activities including health activities
and behaviour, education is not one of the socio-cultural determinants of maternal health.

### 2.2.2 Employment

Yar’zever and Said (2013) looked at knowledge and barriers in the use of maternal healthcare services among the women of Kano State, Nigeria. He utilized a cross sectional descriptive survey to study 1000 Hausa married women aged 18 to 49 years who were randomly selected both in urban and rural areas. From the study, they established that women employment has a positive impact on their maternal health and is usually linked to reduced maternal deaths and morbidity. Unemployed women are more likely to die from pregnancy-related causes than those who are employed.

Gwamaka (2012), in a Tanzanian study to explore factors that affect utilization of maternal health facility among 59,987 women of reproductive age, concluded that women who are employed may be able to save and so will have money to spend on a health facility. Those with more income are able to deliver in a health facility compared to women with low income. On the other hand, Sharma et al (2007), in a Nepal study, notes that employment may not necessarily be associated with greater use of maternal healthcare since non-working women may be better off than working women.

### 2.2.3 Women’s Access and Control Over Family Material Resources

Gebremariam (2007) looked at the influence of women’s autonomy and maternal health in Ethiopia and Eritrea by conducting a survey in the two countries. They
argue that since men control most of the resources in the family, women need to economically depend on their husbands in order to utilize maternal healthcare services.

Nyakato and Charles (2013) examined how couples’ relations and decision-making hierarchy determine maternal health in Uganda. They posit that in the context of maternal healthcare access, family relations play a key role since women after marriage depend on their marital families for their wellbeing and access to resources. Women healthcare decisions depend on their husbands mainly because of the hierarchical control of family social and economic resources. Women reproductive health decisions are limited by their reliance on their husbands’ control of household assets. Nyakato and Charles study was similar to the researcher’s study in examining maternal health and women’s control and access over family resources. However, the above study focused on respondents aged 20-49 but the researcher’s current study focused on married women and men aged 15-49.

Shaikh and Hatcher (2005), in a Pakistan study, posit that women’s financial dependence on their husbands affects their decision-making because healthcare options must be supported by husbands. Women lack the power to spend money on health care without their husbands’ permission.

Literature review has presented scholars’ different views and opinions concerning the economic and socio-cultural factors that determine maternal health which have resulted into either positive or negative maternal health outcomes. Researchers have found that, early marriages lead to early pregnancies and childbirth which contributes to maternal mortality since women’s body may not be physiologically
ready to bear children. Beliefs and practices about food have also acted as barriers to improvement of maternal health.

Since women lack access to family resources and are economically dependent, they are unable to seek maternal care at the required time and this result into maternal deaths. The researchers also concluded that mothers who are educated are likely to utilize maternal healthcare services than the uneducated ones since they have knowledge on maternal health and are economically independent. However, some researchers have pointed out that there is no relationship between women’s education and maternal health. Cross-sectional survey has been employed in most of the studies but what differs is the target population which varies from one research to the other.

Various gaps were identified during the literature review. The researcher observed that, limited studies have investigated beliefs and practices about food in relation to maternal health in Ainamoi Constituency hence there was need for the study in order to fill this gap. Furthermore, different societies have diverse cultural beliefs and practices around food consumption which in turn influence their knowledge in regard to food to be eaten and those to be avoided during and after pregnancy. It was therefore, in the interest of the study to explore cultural beliefs and practices about food and its relation to maternal health in Ainamoi Constituency since culture differs from society to society.

Even though researches on the relationship between early marriages and maternal health have been done in various countries including Kenya, research on the same had not been conducted in Ainamoi Constituency. In addition, cross sectional survey
designs have been employed in most of the studies but the study employed ethnographic research design to research on determinants of maternal health in Ainamoi Constituency. One of the studies in the literature has focused on women aged 20-24 while the current study focused on married women and men aged 15-49. Although previous studies have examined factors that contribute to poor maternal health outcomes and access to care, gap still persisted in understanding education as one of the determinant of maternal health since contradictory results were obtained from the literature. The researcher therefore intended to find out the relationship between women’s education and maternal health in Ainamoi Constituency by employing ethnographic research design which has not been employed in the above studies. In the opinion of the researcher, education of women is significant since it empowers them to have greater confidence and capability to make independent decisions to utilize maternal healthcare services.

From the researcher’s viewpoint, relatively limited studies have exclusively investigated the relationship between women’s access and control over family material resources and maternal health. This was crucial in understanding the socio-cultural context of pregnancy and childbirth that could allow future design and enactment of programmes that can deliver more sensitive, culturally relevant needs. The research therefore, intended to fill this gap since it is important to note that challenges facing women access and utilization of maternal healthcare services are unique because of diverse socio-cultural and socio-economic backgrounds.

Furthermore various researchers did not study on influence of the family members on women’s maternal healthcare. The researcher therefore intended to fill this gap by looking at how spouse and mother-in-law influence decisions that surround
maternal health issues. The study found out that women are not supported by their spouses during pregnancy and pregnancy issues have been entirely left to women. In addition, previous studies did not research on how regular births determine maternal health. The researcher filled this gap by asking women to state the number of children they have and who influence them to have many children. The research indicates that many children are valued in the community and boy child is much preferred which forces women to have many pregnancies if they haven’t born one which in turn negatively impact on maternal health.

Studies from the reviewed literature did not scrutinize on how gender roles determine maternal health. The researcher filled this gap by critically analyzing the daily activities men and women engage in. The study found that women are preoccupied with gender roles and are not able to seek maternal health care on time which leads to negative maternal health outcomes.
2.3 Theoretical and Conceptual Framework

2.3.1 Theoretical Framework

The study employed the theory of gender stratification as expounded by Shen and Williamson (1999). This theory focuses on gender-related differences between men and women and their social status in the society in order to explain maternal deaths. With poor socio-economic conditions, women are vulnerable to the health risks caused by childbearing, yielding high mortality. This theory further argues that societies in which women have higher status and more autonomy will generally be societies in which maternal mortality is lower. The theory addresses the perspective of inequality between genders as the main factor to high maternal mortality, and argues that women’s low social status can have a negative impact on maternal mortality. This was of interest for the study since the theory established the indirect causes of maternal health. (Shen & William 1999: pg 197-200)

The theory asserts that with expanded power and privileges, women are normally more independent and have greater influence on questions of early marriage, the number of children they want to have and access to healthcare. They are also more likely to have better access to nutrition since in societies where women and girls have lower status than men, they are often food-discriminated meaning that, they receive less amounts of food than men and boys. In addition, in such societies girls tend to be married at an early age thus not being physically prepared for childbearing. This leads to complications such as obstructed labour and even death. Further, this contributes to woman’s low status and dependence since it impedes her chances of getting education or a job since because she is bound to the home, resulting in a generation-passing never ending cycle of disadvantages. This theory
was relevant since it gave the researcher a basis to investigate the relationship between early marriages and cultural beliefs and practices about food in relation to maternal health in Ainamoi Constituency.

The theory asserts that maternal mortality is lower in countries where women have higher social status and independence. This is based on the assumption that the women’s status will contribute to female empowerment by having better access to education, job opportunities, family planning, and healthcare. This will in turn result in women having less pregnancies and deliveries, resulting in less physical strain on her body and less risk of dying from pregnancy and childbirth-related causes. This theory, therefore, gave the researcher impetus to explore women’s education and employment in relation to maternal health in Ainamoi Constituency so that timely interventions could be instituted for improvement.

2.3.2 Conceptual framework
A conceptual framework is a network of associations between variables. It demonstrates the relationship between the independent and the dependent variables. The study employed a framework for analyzing the determinants of maternal mortality and morbidity (McCarthy & Maine, 1992). Socio-cultural factors which include: beliefs and practices about food, early marriages and women’s decision-making power within the family interacts together with the socio-economic factors which include; women’s education, employment, women’s access and control over family material resources determine maternal health outcomes. The maternal health outcomes can either be positive or negative.
Figure 1.1: Determinants of maternal health

Source: Adapted from McCarthy & Maine (1992)
CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research design, area of study, study population, sampling procedure and sample size, research instruments, validity and reliability of research instruments, data analysis and ethical considerations.

3.2 Research Design

This study adopted critical ethnography to provide an understanding of determinants of maternal health in Ainamoi Constituency. Ethnography is a qualitative approach to social research that aims at understanding the behaviour of human beings in the context of a culture (Orodho, 2009). This design was employed as a method of collecting information since it was suitable in eliciting information about people’s cultural beliefs, values and practices in relation to determinants of maternal health in Ainamoi Constituency. Cultural beliefs, behaviours, values and practices are learned and passed on within a group and this world view is transmitted and shared among the people (Richards & Morse, 2012).

3.3 Study Area

The study was conducted in Ainamoi Constituency, Kericho County, Kenya. It covers approximately 258.50 km² and is located on Latitude 0.5° and Longitude 35.25°. Ainamoi Constituency is a densely populated area and its main economic activity is agriculture with tea and sugarcane as the main cash crops. Majority of the people in the area are farmers who also rear livestock and the women grow
subsistence crops for instance vegetables, beans and potatoes for consumption. The constituency has 37 dispensaries, one district hospital and several private hospitals. The study was conducted in Ainamoi Constituency since it is rich in health facilities where women can seek maternal healthcare services yet maternal deaths are still recorded in the area.

In addition, the culture of the Kipsigis people needed to be critically analyzed in order to get a clear understanding of the determinants of maternal health in the area. Kipsigis socio-cultural and economic setup is discussed below.

(i) The Clan

Peristiany (1964) noted that Kipsigis tribe is divided into clans. Clan members are more nearly related to each other than they are to people in other clans. Different clans form a social group and a wife must be sourced from a different clan from that of the husband. The chief function of the clan is to ensure that exogamy is strictly adhered to in marriage. This means, marriage between members of the same clan often closely related by blood was/is forbidden. This practice contributes to positive maternal health outcomes since it reduces the risk of couples conceiving children with genetic disorders and birth defects.

Kumar (2012) argues that a significant association has been demonstrated between exogamy and early mortality with disorders involving the expression of detrimental recessive genes especially involved. Babies born of consanguineous couples are smaller, lighter and are therefore, less likely to survive. These babies are likely to suffer from congenital heart disorders which include ventricular septal defect and atrial septal defect. When the study participants were asked if members of the same
clan could get married, they responded that it was a taboo. These beliefs result in birth of healthy babies which in turn leads to positive maternal health outcome.

(ii) Social Unit

According to Orchardson (1961), a group of people of different families, clans and *puriosiek*, living in a defined area form a social unit. Social unit (*kokwet*) was important in all works needing co-operative effort. Within the *kokwet* women irrespective of family relationship, helped one another in such matters as the carriage of wood and water, preparation of beer and the cooking of foods in times of illness, especially during childbirth and in the period of ceremonial abstention from work during childbirth.

Communal support given to pregnant women result in positive maternal health outcomes since an expectant mother requires rest before and after delivery since hard labour may cause pregnancy complications during this period. Lyall and Belfort (2007) posit that working throughout pregnancy especially during the last three months makes it more likely that babies will be born prematurely with a lower birth weight. Women who engage in hard labour during pregnancy are more likely to develop a condition that threatens the lives of both the mother and the baby. Stress caused by a lot of work increases hormone levels that put women at greater risk of pre-eclampsia, a common and dangerous complication of late pregnancy.

(iii) The Family

Orchardson (1961) argues that the family among the *Kipsigis* is of great social importance since family duty is the basis of much of everyday life. Duty is owed first to the father and mother and next to the older relatives of both parents. Children
care for their parents in old age, cultivate their fields, build their houses and care for them in sickness; anyone who failed to do so would be considered the worst of criminals.

Bangura (1994) asserts that traditionally, like in most African societies, the family is central in the daily life of the Kipsigis and more so extended families are much valued. The extended family is the basis of the social structure which includes relatives on both sides of the family as well as close friends. Kipsigis residence patterns were, and still are, mostly patrilocal. That is, typically after marriage a man brings his wife to live with him in his house or very near to his father’s homestead. Quite often, the husband’s parents will live with the nuclear family when they get older and can no longer care for themselves and it is women’s responsibility to take good care of the old parents. When people marry, they join their families thus ensuring that there will always be a group to turn to in times of need.

Close family ties among the Kipsigis community was and is still of great importance to the expectant mother since she has people to turn to when need arises. According to Shields and Candib (2010), during pregnancy, women turn to women support figures or confidantes for advice, support and reassurance. For most women, their mothers, sisters or other women family members play this central role. Occasionally, women in her husband’s family provide this support. The study participants noted that during pregnancy, they seek advice from their aunts, mothers and mothers-in-law on dietary precautions during and after pregnancy as well as antenatal care services. Both nuclear and extended family members provide support to the expectant mother by providing care to the baby.
(iii) Role of Kipsigis Men and Women Before, During and After Childbirth

According to Peristiany (1964), when a woman has noticed that her menstrual flow has stopped, she tells her husband. Sexual relations usually cease at this moment but the wife continues performing domestic chores as usual until labour begins. Sexual relations are discouraged at this stage since it is believed that sexual intercourse might harm the baby and might even cause abortion. The birth of the child is expected in the ninth month and the woman’s friends as well as the midwife are informed of the coming of the baby. The midwife is called chebiosset ab sigissiet (old woman of birth) and enjoys a very exalted position in the social group. When a child is born, he or she is given two names, one of which refers to his or her Kurenet. Naming ceremony is performed by chebiosset ab sigissiet with the help of the female relatives and friends present.

Orchardson (1961) argues that a young wife is very happy when she gives birth since it is the worst of all misfortunes for women to be childless. The Kipsigis believe this is mainly because of their ‘natural’ fondness for children and partly because childless people have nobody to look after them in their old age. Children are very important because the spirits of members of the family are reincarnated in the children. Children also ensure that property (cattle) is handed on from generation to generation in the family. Boys were valued because they could inherit family property. Girls were also valued since they offered great help at home and in the fields and the bridewealth given by her husband helped to marry the boys and give them a good start in life.

Although children are important in the Kipsigis community, regular childbirths place the health of both the mother and the baby at risk. According to Lundy and Janes
(2009), regular childbirths place women at a great risk of developing hemorrhage, a pregnancy related condition that can lead to death. It can also lead to premature births since scar tissue from past pregnancies within the uterus can cause problems with the placenta. Peristiany (1964) posits that when the expectant mother feels the labour pains, the husband leaves the hut and goes to sleep in the singroina. From this day until a month after the birth, no man can enter her hut. When the child is born, the father’s child is advised to bleed a cow or a bull according to the sex of the infant. The mother will drink the blood and include it in her meals as it is believed that it will quickly restore her strength.

Orchardson (1961) notes that when a wife has given birth, the husband is informed and if he does not have sufficient milk from his own cows, beer must be prepared in advance so that people may be invited to a beer party. In return, every guest present is expected to present two large gourds of milk at stated times, from the eight month of pregnancy till three months after the birth. According to Horlford (2004), protein serves a number of important functions during pregnancy, including the buildup of the uterus, breasts, blood supply and the baby's tissues. Insufficient protein intake during pregnancy is associated with decreased birth weight and health problems in babies.

Two or three months before the birth, the husband leaves home and sleeps in a neighbouring sigroinet. Even though the husband returns to his hut a month after the baby is born, sexual intercourse cannot take place before a year has elapsed. This was important as it is one of the natural family methods significant to women’s maternal health. Mabilia (2013) argues that prolonged sexual abstinence after childbirth is a socio-cultural practice with positive health implications and is
practised in several African countries. The practice of postpartum abstinence is closely linked to child spacing hence reduces maternal mortality.

**(iv) Religious Beliefs of the Kipsigis**

According to Orchardson (1961), the *Kipsigis* believe in a supreme being called *Cheptalil* or *Asis* who is believed to be the creator of the world and controller of everything in it. He is accessible through prayers and cares for the welfare of human beings, who are sometimes described as being his children. Prayers are made to God for relief from calamities and sickness, both in the case of communities and individuals. Though some of the ceremonies, prayers and rites have lost their original significance, others are deeply felt and form an essential part in their method of thinking and their way of life. Special prayers were also offered for both the mother and the baby to protect them from any illnesses. The midwife blesses both the mother and the baby by spitting on their faces as she utters words such as “*ingoberurin Chebongolo ak koribok ak arwengung, kogerin bunyon koi men iger kolapa*”. This means, may God bless and protect you and the baby from any harm. The other elderly women present will in turn respond “*iman, iman, iman*” meaning let it be so. This prayer is of great significance as it is believed to keep the mother safe and strong so that she can offer special care to the child. In addition, proverbs were used to make the society conscious enough on how a pregnant mother should be treated. For example, “*yome mileet ne loe*” this means a pregnant mother is already burdened with pregnancy therefore she should not carry a heavy luggage anymore. This proverb reminds individuals that they should always help a pregnant mother to carry her luggage.
(v) Economic Way of Life of the Kipsigis

It was crucial to study the economic activities the Kipsigis community engaged in and its relation to maternal health in order to establish how nutritional needs of expectant mothers were met during and after pregnancy. According to Orchardson (1961), the only field crop cultivated by the Kipsigis was millet. It is still the most important crop and is likely to remain so for some time, despite it being so demanding in terms of labor provision. Maize was introduced by the government about 1912 but took a long time to be cultivated among the Kipsigis community. Fieldwork was divided between men and women. Men were expected to clear the fields that were to be used for planting. Women would in turn take over the bulk of the farmwork from there on which include planting, weeding and processing crops.

According to Orchardson (2008), Kipsigis engage both in farming and animal husbandry. They grow crops such as millet, maize, tea and sorghum. Other subsistence crops included beans, sweet and Irish potatoes, pumpkins, and traditional vegetables. They also rear cows, sheep and goats. The Kipsigis adore their cows and milk was/is still their staple food. Varieties of crops were cultivated in order to ensure that pregnant women took a balanced diet.

Cultivation of various crops and rearing of animals was important for economic purposes as well as the health of the society and especially the expectant mother. Edelstein (2011) asserts that it is important that the diet of a pregnant woman is nutritionally sound so that she produces a healthy baby at the same time maintains her own health. The nutritional status of the mother before she conceives establishes the quality of the environment in which the fetus will develop and is a key
determinant in the life of a newborn. Even before pregnancy, it is important for a woman of childbearing age to have balanced diet so that she will be able to cope with the demands of pregnancy. The mother’s nutritional status also affects her ability to breastfeed the infant and provides postnatal nurturing.

![Map of Ainamoi Constituency](image)

**Figure 3.1: Map of Ainamoi Constituency**

### 3.4 Target Population

The study population comprised all married women aged 15-49 years. This is also considered to be the age range when a woman could become pregnant. This population was knowledgeable enough about the topic hence could elicit information on determinants of maternal health. Married men were also included in the study so that they could give their views on determinants of maternal health in the area.
3.5 Sample Size

3.5.1 Sampling Procedure

Ainamoi Constituency has fifteen Sub-locations which include; Kapsoit, Kenegut, Ainamoi, Kipngetuny, Koita-burot, Motobo, Soliat, Kipsitet, Poiywek, Township, Kipchimchim, Kaitui, Kapsorok, Tendwet and Kapsuser (part). The study sampled 20\% out of the fifteen sub-locations in the constituency that is three locations were selected using simple random sampling and this provided equal opportunity of selection of each element of the population (Kothari, 2003).

According to Kothari (2004), 20\% of an accessible population is adequate for a study in a social research. The study therefore, sampled 20\% of the total number of administrative units in Ainamoi Constituency. The sub-locations selected included Kaitui, Koita-Burot and Boiywek.

3.5.2 Sample size

The sample size for the study comprised 120 married men and women all purposely selected. Avoke (2005) also asserts that purposive sampling enables a researcher to hand pick the cases to be included in the sample on the basis of his judgment and typicality to build up a sample size that is satisfactory.

Table 3.1 Population and study Sample Size

<table>
<thead>
<tr>
<th>Study units</th>
<th>Target population</th>
<th>Accessible population</th>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaitui</td>
<td>2698</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Koita-burot</td>
<td>3192</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Boiywek</td>
<td>2572</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8462</strong></td>
<td><strong>120</strong></td>
<td><strong>120</strong></td>
</tr>
</tbody>
</table>
Further, two healthcare givers, two traditional birth attendants and two local leaders who were purposively selected acted as the key informants making a total one hundred and twenty six participants.

3.6 Research Instruments

3.6.1 Interview Guide

Women were interviewed in their various homes during the afternoons. Oral Interview method was employed since this method facilitated understanding of women’s perceptions, beliefs and accounts in relation to their maternal health. It also allowed the informants to share their experiences when accessing maternal healthcare services. Open-ended questions were used to elicit women’s experiences during pregnancy and childbirth. Men were also interviewed in their various homes and social places who in turn aired their views on determinants of maternal health in the area. Depending on the amount of information, the interview time ranged from fifteen to thirty minutes. The researcher served as the facilitator and notes were taken during the interview session. This method of data collection was preferred since it enabled the informants to give in-depth information necessary for qualitative data. Interviews are also flexible hence the required information can be easily obtained (Kothari, 2004).

3.6.2 Focus Group Discussion Guide

To facilitate discussions with women, focus group discussions were considered the most appropriate methodology. Focus group is usually composed of 6-10 individuals who share certain characteristics which are relevant for the study (Kombo & Tromp, 2006). Focused group discussion comprised of 6-10 married women within the age
bracket of 15-49 years. The participants who volunteered to participate were nominated. Three focused group discussions were conducted and each session took one to one and half hours. The researcher moderated the questions as research assistants took notes. Focus group discussion guide was appropriate for this study because it is an established instrument for qualitative research (Kothari, 2004). It is also suitable since new information can be produced quickly and it can be used to identify and explore ideas, beliefs and opinions in a community (Mugenda & Mugenda, 2003).

3.6.3 Key Informant Interviews Guide

The key informants included two local leaders, two traditional birth attendants and two skilled birth attendants in the maternal health facility. This method was chosen because a lot of information could be gathered and it allowed the researcher to obtain personal information, attitudes, perceptions and beliefs of the participants in regard to determinants of maternal health in Ainamoi Constituency. Its limitation is that they can be time-consuming since open-ended questions are used (Tromp & Delno, 2006)

3.7 Pre-test

Before data collection, the research instruments were pretested on ten respondents from one location of Ainamoi Constituency which was not used in the study. Pretesting provided an opportunity for the researcher to test her confidence in identifying difficulties and obstacles that could affect collection of useful data. It also helped in checking validity and reliability of the research instruments (Orodho, 2009). The researcher further employed the test-retest method to test the reliability
of the research instruments. Research assistants were also trained and briefed on the conduct of the research to improve reliability.

3.7.1 Validity

The validity of a test is a measure of how well a test measures what is supposed to measure (Kombo & Tromp, 2006). This study checked the content validity of research instruments to be used. To ascertain validity of the instruments, the researcher sought expert judgment from University supervisors. One focus group discussion was also conducted in Ainamoi Constituency to test the validity of the preset the focus group discussion guide. These participants and informants were not included in the final study.

3.8 Data Analysis and Presentation

Data were analyzed using both qualitative and quantitative approaches. To achieve the first objective, descriptive analysis was utilized to describe determinants of maternal health among the women of Ainamoi constituency. In the second objective, descriptive statistics were used to determine the frequencies in order to interrogate economic factors that determine maternal health. Data generated was classified into different categories through coding and tabulation. Quantitative data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 17 whereas qualitative data were analyzed thematically. Findings were then collated and are presented in form of tables, graphs and narratives.
3.9 ETHICAL CONSIDERATIONS

First, permission to conduct the research was sought from the Board of Post Graduate Studies of Kenyatta University and the National Council for Science and Technology. Further clearance for research was sought from Kericho County health offices. Informed consent from the respondents was sought by adequately outlining to them the objectives of the study. They were also made to understand their rights regarding their research responsibility, privacy and anonymity. Those who were not willing to participate in the study were left out as participation was voluntary. Further the identity of the respondents was not revealed as names that are used in the study are not their real names.
CHAPTER FOUR
RESULTS AND DISCUSSION

4.1 Introduction
In chapter three, the research methodology was presented. This chapter comprises of the findings of the study based on both primary and secondary sources. The chapter is divided into two. The first section comprises of demographic characteristics of the respondents while the second presents the findings organized in accordance with the objectives of the study as documented in chapter (1.3).

4.2 Demographic Characteristics of the Respondents
This section provides the background information of the respondents including their general information, age and education level.

4.2.1 Age
The age of both men and women was thought to be a crucial component of the study. The researcher therefore, asked the respondents to indicate their age bracket and the results are presented in Table 4.1 below.

Table 4.1: Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Women Number</th>
<th>Women Percentage</th>
<th>Men Number</th>
<th>Men Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>7</td>
<td>11.7</td>
<td>1</td>
<td>1.7</td>
</tr>
<tr>
<td>20-24</td>
<td>8</td>
<td>13.3</td>
<td>5</td>
<td>8.3</td>
</tr>
<tr>
<td>25-29</td>
<td>13</td>
<td>21.7</td>
<td>9</td>
<td>15.0</td>
</tr>
<tr>
<td>30-34</td>
<td>12</td>
<td>20.0</td>
<td>15</td>
<td>25.0</td>
</tr>
<tr>
<td>35-39</td>
<td>9</td>
<td>15.0</td>
<td>14</td>
<td>23.3</td>
</tr>
<tr>
<td>40-44</td>
<td>6</td>
<td>10.0</td>
<td>10</td>
<td>16.7</td>
</tr>
<tr>
<td>45-49</td>
<td>5</td>
<td>8.3</td>
<td>6</td>
<td>10.0</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100</td>
<td>60</td>
<td>100</td>
</tr>
</tbody>
</table>
From Table 4.1, 7(11.7%) women were between the ages of 15 and 19, 8(13.3%) were between 20 and 24 years, 13(21.7%) were 25 and 29 years and 12(20%) were 30 and 34 years, 9(15%) were 35 and 39 years, 6(10%) were 40 and 44 years and 5(8.3%) were 45 and 49 years. Among the respondents 1 (1.7%) was a man between 15 and 19 years, 5 (8.3%) were 20 and 24 years, 9 (15%) were 25 and 29 years, 15(25%) were 30-34 years, 14(23.3%) were 35 and 39 years, 10(16.7%) were 40-44 years and 6(10%) were 45-49 years. The findings above indicate that women are more likely to get married before men of their teenage years since 11.7% of women within the age of 15-19 years were married whilst only 1.7% of men within the same age bracket were married. This implies that the women may be denied opportunities, for instance education, employment and ability to make independent decisions especially in those areas that concern their maternal health. As Field, Erica, and Attila (2008) argue, early marriage is associated with a number of poor social and physical outcomes for young women and their offspring. They attain lower schooling, lower social status in their husbands’ families, have less reproductive control, and suffer higher rates of maternal mortality and domestic violence. They are often forced out of school without an education and their health is affected because their bodies are too immature to give birth.

4.2.2 Education Level

The study sought to find out the education level of the respondents. This was necessary in order to establish whether women’s education level determined maternal health in the area. The outcomes are summarized in Table 4.2 below.
Table 4.2: Education level of the respondents

<table>
<thead>
<tr>
<th>Level of education</th>
<th>Female</th>
<th></th>
<th>Male</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>No education</td>
<td>6</td>
<td>10.0</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>Primary</td>
<td>24</td>
<td>40.0</td>
<td>17</td>
<td>28.3</td>
</tr>
<tr>
<td>Secondary</td>
<td>19</td>
<td>31.7</td>
<td>25</td>
<td>41.7</td>
</tr>
<tr>
<td>Post-secondary</td>
<td>11</td>
<td>18.3</td>
<td>16</td>
<td>26.7</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100</td>
<td>60</td>
<td>100</td>
</tr>
</tbody>
</table>

The findings revealed that women with no education were 6 (10.0%), those with primary education were 24 (40.0%), those with secondary education were 19 (31.7%) and those with post-secondary education were 11 (18.3%). Among the men 17 (28.3%) had primary education, 25 (41.7%) had secondary education, 16 (26.7%) had post-secondary education and 2 (3.3%) were not educated. The findings above show that men are more educated than women.

As indicated in the above findings, most women 24 (40%) have primary education, a factor likely to affect their ability to make informed choices on proper maternal healthcare. In this regard, Grown et al. (2005) in a USA study among the women indicated that education is one of the crucial determinants of maternal health since it enhances women’s confidence in making independent choices. It is also associated with other important precursors of safe motherhood, such as more equitable marital relationships and greater economic independence.
4.3 Cultural Determinants of Maternal Health

The first objective of the study was to explore the socio-cultural factors that determine maternal health in Ainamoi Constituency. To achieve this objective the respondents were asked to state the age when they were first married, if they have a say on their sexual and reproductive health and the number of children they have. They were further asked to state the cultural factors that determine the number of ANC visits they made during pregnancy and their reasons for home deliveries.

4.3.1 Influence of Early Marriages on Maternal Health.

To document the findings on early marriages, the women were asked to indicate the age when they were first married. They were presented with age categories 15-19, 20-24, 25-29, 30-34, 35-39, 40-44 and 45-49 to select from. This was important in finding out whether early marriages are prevalent in the area and how it determines maternal health.

Table 4.3 below shows the respondents’ age at first marriage.

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>15</td>
<td>25.0</td>
</tr>
<tr>
<td>20-24</td>
<td>28</td>
<td>46.7</td>
</tr>
<tr>
<td>25-29</td>
<td>12</td>
<td>20.0</td>
</tr>
<tr>
<td>30-34</td>
<td>3</td>
<td>5.0</td>
</tr>
<tr>
<td>35-39</td>
<td>1</td>
<td>1.7</td>
</tr>
<tr>
<td>40-44</td>
<td>1</td>
<td>1.7</td>
</tr>
<tr>
<td>45-49</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100</td>
</tr>
</tbody>
</table>
Table 4.3 above shows less than half of the respondents 28(46.7%) were first married when they were 20-24 years, 15(25%) were first married when they were aged 15-19 years, 12(20%) were first married when they were 25-29 years, 3(5.0%) were first married when they were 30-34 years, 1(1.7%) were first married when they were 35-39 years and 1(1.7%) were first married when they were 40-44 years.

Although the above analysis indicates that most women (46.7%) were first married when they were between 20 and 24 years, a quarter (25%) was first married when they were 15-19 years. This indicates that there are still underage girls who are married off in the area. According to the Constitution of Kenya 2010 and Kenya’s New Marriage Act of 2014, marriage below the age of 18 is outlawed and it imposes stiff penalties to anyone who gets engaged or betrothed to a person under the age of 18 years. The research findings indicate that most married women aged 15-19 were economically dependent since they earned little income. Most of them had dropped out of school and had a difficult livelihood.

For instance, Lily Cheboi* asserts that:

“I was first married when I was 15 years old. I had to drop out of school and life has been so difficult since I have to work for other people in order to feed my family. Most of my children were born at home because I didn’t have enough money to visit the maternal health facility” (O.I, 5th November, 2014).

The above findings concur with those of Ram et al. (2012), noted that girls who marry early often discontinue their education. This will in turn result in joblessness and economic dependence. Early marriage is also associated with risk of violence, abuse, exploitation and inability to make independent decisions.
Field and Erica (2004) in a Bangladesh study conclude that early marriage is associated with a number of poor social and physical outcomes for young women and their children. They attain lower schooling, lower social status in their spouse’s families, have less reproductive control, and suffer higher rates of maternal mortality and domestic violence. They are often forced out of school without an education and their health is affected because their bodies are too immature to give birth.

According to WHO (2007), early marriages lead to early pregnancy and childbirth, both of which are harmful to very young women as their bodies may not be physiologically prepared to bear children. Early marriages often lead to early childbearing and high total fertility, both of which are linked to higher risk of maternal mortality and morbidity. The above findings indicate that early marriage is one of the determinants of maternal health in Ainamoi Constituency.

4.3.2 Women’s Decision-Making on their Sexual and Reproductive Health and its Impact on Maternal Health

(i) Women’s decisions on their sexual health

To determine women’s control over their sexuality, the respondents were asked whether they were involved on decisions that concern their sexual health. If not, then why were they not involved? The table below presents data on women’s say on their reproductive and sexual health and the findings are discussed in subsequent sections.
Table 4.4: Women’s say on their sexual health

<table>
<thead>
<tr>
<th>Decisions on sexual matters</th>
<th>Number</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>7</td>
<td>11.7</td>
</tr>
<tr>
<td>No</td>
<td>51</td>
<td>85.0</td>
</tr>
<tr>
<td>Declined</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100</td>
</tr>
</tbody>
</table>

The findings in table 4.4 reveal that most of the respondents 51(85%) do not have a say concerning their own sexual and reproductive health. Only 7(11.7%) mentioned that they could discuss matters of sexual and reproductive health with their husbands and the 2(3.3%) did not answer the question.

Members of focus group discussion expressed the view that women cannot determine when to have sex for fear of social consequences for instance being beaten, neglected or abandoned. It was also established that they are not allowed to negotiate for sex and those who do so are perceived to disobey their husbands. Thus, women have no control over their own bodies as most of the time it is their husbands who make decisions on when to have sex. For instance, the FGD noted:

“It is a taboo in the Kipsigis community to discuss sex issues with your husband and denying your husband conjugal rights is regarded as disobedience. When a woman does so, the husband can either marry a second wife or engage in outside sexual relationships.” (10th November, 2014 at Kaptalamwa in Kaitui).

Women’s inability to make decisions regarding their sexual and reproductive health poses a risk of having more pregnancies which is detrimental to their maternal health. These findings are in line with those of Rao and Gupta, (2002) who noted
that the way gender is constructed for men and the cultural understandings of masculinity shape how men are expected to behave. Social norms often restrict female sexuality and encourage girls and women to remain passive, sexually naive and unable to control their sexual and reproductive health. Men are encouraged to take risks, be sexually experienced with many partners, and to prioritize their pleasure over concerns for their health.

Ashraf (2009) in a study in the Philippines argues that women’s inability to control their own sexual and reproductive health can lead to high fertility rates, frequent unwanted pregnancies and may increase the risk of complications during childbirth. This places them at an increased risk of maternal mortality. Women’s inability to make decisions that concern their sexual and reproductive health was thus found as one of the factors that determine maternal health in Ainamoi Constituency.

(ii) Women’s decision on the number of children to have

The women were further asked to state the number of children they have. They were required to state if they had no children, 1-3 children, 4-6 children or more than six. Further, it was important to establish if the women had a say on the number of children they had. Table 4.5 below presents the number of children the women had.

<table>
<thead>
<tr>
<th>Number of children</th>
<th>Number</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>1-3</td>
<td>12</td>
<td>20.0</td>
</tr>
<tr>
<td>4-6</td>
<td>27</td>
<td>45.0</td>
</tr>
<tr>
<td>More</td>
<td>19</td>
<td>31.7</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100</td>
</tr>
</tbody>
</table>
The results in Table 4.5 show that majority of the respondents 27(45%) have 4-6 children, 19(31.7%) have more than six children, 12(20.0%) have between 1-3 children and 2(3.3%) have no children. The results indicate that women prefer giving birth to more than four children. WHO (2005), notes that the risk of a woman dying in pregnancy and childbirth depends on the general reproductive health of the mother and the number of pregnancies she has had in her lifetime. The higher the number of pregnancies, the greater the lifetime risk of pregnancy-related deaths. When a woman bears more children, she is more likely to expose herself to more dangers during birth as well as pregnancy complications. The study further established that husbands as well as the parents (father-in-law and mother-in-law) influence women’s choice on the number of children they should give birth to. In this regard, Irene Chebaibai* affirmed that:

“Kipsigis community encourages giving birth to many children because children are seen as blessings from God. Our parents especially mothers-in-law encourage us to have more children in order to keep the house “warm”.” (O.I, 5th November, 2014).

The findings from this study are in congruent with those of Gipson and Hindin (2007) who adduce that in Bangladesh marriage customs, the societal value of having many children and strong extended family ties influences maternal health. United Nations Millennium Project (UN 2006) also observes that child bearing is used to measure a woman’s worth and her mother-in-law’s desire to have grandchildren as it improves their status and accord them much respect.

The study further established that childbearing is an important role of a Kipsigis woman. A woman who has never born children is not respected both in the family
and the community. The community believes that the chief function of a woman is to bear children. For instance, Nelly Kering* noted that:

“Immediately after marriage a woman is expected to bear children. If a woman fails to do so, her husband marries a second wife. Women who have never born children are looked down upon. Some men also pressurize women to have many children and even discourage them from using family planning methods.” (O.I, 5th November, 2014).

The sentiments expressed above are in line with the findings of Peristiany (1964) who asserts that however important the value of a wife for her economic activities may be, she is first and foremost the mother of a man’s children and it is mainly this function that makes her, in the eyes of a Kipsigis more than a chattel and an instrument of pleasure. Orchardson (1961) posits that in the Kipsigis community, a young wife is very happy when she finds herself with a child as it is the worst misfortune for women to be childless. From the findings, it is quite evident that women’s pressure to bear many children determines maternal health in Ainamoi Constituency.

(iii) Son preference by the community

The study further established that son preference in the community is one of the chief reasons that women are forced to bear many children. Both men and women were asked to state the sex of the child Kipsigis community prefer and why. The results are presented in Table 4.6 below.
Table 4.6: Son preference by the community

<table>
<thead>
<tr>
<th>Child preference</th>
<th>Women</th>
<th>Men</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>Boy</td>
<td>52</td>
<td>86.7%</td>
<td>55</td>
<td>91.7%</td>
</tr>
<tr>
<td>Girl</td>
<td>8</td>
<td>13.3%</td>
<td>5</td>
<td>8.3%</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100%</td>
<td>60</td>
<td>100%</td>
</tr>
</tbody>
</table>

As it can be seen in the Table 4.6, 52(86.7%) of women stated that the community preferred the boy child and 8(13.3%) noted that the girl child was preferred in the community. Furthermore, 55(91.7%) of men mentioned that the community preferred a boy child and 5(8.3%) noted that the girl child was preferred in the community.

The study established that, women in the area are encouraged to have more pregnancies in order to give birth to a baby boy whenever they have girls only. Women may therefore, become pregnant earlier than they would like in order to prove their fertility, or have multiple and closely-spaced pregnancies until they produce a son. Son preference is a practice enshrined in the value system of the Kipsigis society. Although girls are valued for their economic value, boys are much preferred since the family lineage is carried on by male children and the preservation of the family name is guaranteed through sons. In this regard, Jennifer Chebii* remarked that:

“Much value is placed on a baby boy and incase a mother has never born one, she is encouraged to try her “luck” by having more pregnancies. Culturally, a man is encouraged to marry a second wife if the first one has never had a son.” (O.I, 5th November, 2014).
These findings concur with those of Gipson and Hindin (2007) who note that in Sub-Saharan Africa baby boys are much preferred since they are believed to take care of their parents when they are old and inherit the family property as well as the family name. Frequent births which entail repeated life-threatening processes are, therefore, encouraged so as to give birth to a baby boy. Isiugo and Uche (1985) assert that in Sub-Saharan Africa, anthropological and demographic evidence emphasizes the dominant role of males in traditional patrilineal societies in which descent and inheritance are transmitted through the male lineage. Furthermore, male children strengthen the relationship between the wife and her husband’s kin, that is, by guaranteeing the continuation of his lineage and securing the mother’s access to residence and inheritance upon the husband’s death.

Further, Klingberg-Allvin et al. (2012) in their study in Vietnam concluded that culturally, women are encouraged to bear more children and those who have never born a baby boy are encouraged to have more pregnancies in order to give birth to one. A woman is likely to blame herself and be blamed by her husband and family if she did not bear a son.

Men’s views were also sought on child sex preference. They were asked to state the sex of the child most preferred in the Kipsigis community. In response, 91.7% of the men stated that the community prefers a baby boy. Boys are much preferred since they inherit family property, protect the family and continue with the family name. Women are therefore, forced to have more pregnancies in order to satisfy their husbands’ wish. For instance, Sigei* pointed out that:

“In our culture you are not considered “man enough” if you don’t have a son to inherit your name as well as the family property. Man without a son will
never be remembered in the family since his branch of the family will come to an end. A son is also very important since he will take good care of me and my wife during old age.” (O.I, 8th November, 2014).

From the above discussion, it is evident that the boy child is much preferred in the Kipsigis community. After the initiation process, boys are allowed to inherit the family property as well as the father’s name. For instance, a boy who has undergone the initiation ceremony is no longer referred by his first name (Kip) but rather inherits the father’s name (Arap Rotich) meaning Mr. Rotich. On the other hand, girls do not inherit the family name since they are expected to be married off and take the husband’s name and clan. This implies that preference of the boy child is woven into the naming system of the Kipsigis. This makes it more mandatory for a man to have a son and the women to desire sons to fulfill the demands of the cultural naming system. Boy child preference was, therefore, found to be one of the factors that determine maternal health in the area.

4.3.3 Cultural Influence on the Number of Antenatal Visits Made by Women

This sub-section is mostly based on qualitative research.

(i) Pressure from family members

The study sought to establish the influence of culture on the number of ANC visits made by women during pregnancy. To this end, the respondents were asked: how many ANC visits did you make during pregnancy? Why did you not attend the required four ANC visits? Table 4.7 summarizes the number of ANC visits made by women.
Table 4.7: Number of antenatal visits made by women during first, second and third trimester.

<table>
<thead>
<tr>
<th>No of ANC visits during pregnancy</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>6</td>
<td>10.0</td>
</tr>
<tr>
<td>Two</td>
<td>26</td>
<td>43.3</td>
</tr>
<tr>
<td>Three</td>
<td>19</td>
<td>31.7</td>
</tr>
<tr>
<td>Four+</td>
<td>9</td>
<td>15.0</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100</td>
</tr>
</tbody>
</table>

The findings from Table 4.7 show that 6(10%) of the women made one antenatal visit, 26(43.3%) of the women made two, 19(31.7%) made three and 9(15%) made the required more than four ANC visits. Further, the study findings indicate that 75% of women make two and three antenatal visits during pregnancy. According to Kenya Ministry of Health (2004), the first ANC visit should occur within the 1st trimester of pregnancy and continue on a monthly basis through to the 28th week up to the 36th week or until birth. This implies that an expectant mother should make a minimum of four antenatal care visits.

The above ANC visits are inadequate since pregnant women require regular medical checkups to ensure the health of the mother and that of the baby in order to reduce maternal mortality and morbidity. The findings show that pregnant women miss out on important information and advice that would ensure a healthy pregnancy, safe childbirth and postnatal recovery. According to WHO (2005), pregnant mothers should attain at least four antenatal visits. Antenatal care services are very important to pregnant women since it allows early detection and treatment of complications. Where necessary, the mother is also advised on proper management of anticipated
complications. For instance, if a mother is expecting quadruplets or the fetus is too big for normal delivery, the caesarean section is anticipated and proper advice is given.

Leppert and Peipert (2004) note that, the first ANC visit mainly focuses on assessment and examination of a pregnant woman for chronic conditions and infectious diseases. ANC visits also provide a pregnant woman with a plan about place of delivery, transportation, companionship and blood donor, items for clean and safe delivery. In addition, the woman is imparted with knowledge about danger signs, and actions to take if they arise. It includes dietary and nutrition education, for example, how to get essential nutrients.

The study established that extended family members for instance, the mothers-in-law influence the number of ANC visits made by their daughters-in-law. Mothers-in-law advise them not to make all the required four ANC visits since they regard them as a waste of time. As discussed earlier in section 4.3.2, Kipsigis community value extended families and advice given by the elderly are respected. The FGD noted that:

“Mothers-in-law encourage us to make only one or two ANC visits during pregnancy since the rest are regarded as not necessary. They advise us that when we feel okay it is not a must to attend all the required ANC visits.” (10th November, 2014 at Kptalamwa in Kaitui).

From the above discussion, it is apparent that expectant mothers are misadvised by their mothers-in-law since there may be pregnancy-related complications that may not manifest in ill-health yet may result in death of the mother and the baby if not
treated. According to UNFPA (2004), antenatal care presents an opportunity to evaluate the mother’s overall condition, diagnose and treat infections, screen for anemia, HIV and AIDS to prevent low birth weight. The findings above are in line with those of Simkhada (2010) who asserts that in Nepal, mothers-in-law negatively influence utilization of ANC services by their daughters-in-law since they tend to persuade them to fulfill household duties instead of making ANC visits. Lee et al. (2009) in a study conducted in Taiwan also found that mothers-in-law and spouses, heavily influence decision about where and whether to go for antenatal care. The foregoing discussion above indicates that extended family members determine the number of ANC visits made by the women in the area.

(ii) Spousal support

The study also sought to find out if men were concerned about their spouses ANC visits. The men were then asked why pregnant women fail to make the four required ANC visits. Table 4.8 below summarizes reasons presented by men on why pregnant women fail to make the required four ANC visits.

**Table 4.8: Men’s responses on why women fail to make the four required ANC visits**

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t know</td>
<td>22</td>
<td>36.7</td>
</tr>
<tr>
<td>It is women’s responsibility</td>
<td>33</td>
<td>55.0</td>
</tr>
<tr>
<td>Influence from other women</td>
<td>5</td>
<td>8.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Table 4.8 shows that most men 33(55%) believe it is the responsibility of the women to know when to make the ANC visits, 22(36.7%) said they do not know why pregnant women fail to make the required ANC visits and 5(8.3%) noted that influence from other women make them not to make the required ANC visits.

The research established that most men (91.7%) are not concerned with why their wives fail to make the required four ANC visits. The men emphasized that it was the role of the women to know the importance of the visits and when to attend them. They noted that issues to do with pregnancy and childbirth were entirely women’s responsibility. The study further established that most of the men were not aware of how many ANC visits a pregnant woman should make. In the researcher’s view therefore, women in the community get little or no support from their husbands during pregnancy because men believe women do not need any support because pregnancy is a normal condition for women. For instance, Sang* commented that:

“It is the responsibility of the pregnant mother to know the number of ANC visits to make and adhere to the instructions from the nurse.” (O.I, 10\textsuperscript{th} November, 2014).

The above findings concur with those of Byamugisha et al. (2011) who conducted a study in Uganda. They concluded that involvement of men in ANC has been very low and maternal healthcare issues have solely been left for women. Consequently, there is low male participation in maternal healthcare. The study underlines that expectant women have accepted decisions on antenatal visits as entirely their responsibility hence they seek advice from fellow women instead of their husbands. The findings therefore, demonstrate that lack of spousal support may be one of the factors that explain negative maternal health outcomes in Ainamoi Constituency.
(iii) Other reasons why women fail to make the required ANC visits

In the previous sub-section (sub-section ii) it is noted that decisions around antenatal visits are entirely left to women. In this sub-section, reasons why women themselves failed to achieve the four compulsory visits are underlined. Thus, it was necessary to establish if there were other barriers to ANC visits that the women faced. To understand the reasons behind pregnant women not making the four required antenatal visits, the respondents were asked to present the obstacles to these visits. Table 4.9 presents the reasons why women fail to make the four required ANC visits.

### Table 4.9: Reasons for not making the required ANC visits

<table>
<thead>
<tr>
<th>Reasons for not making the required ANC visits</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of financial support from husband</td>
<td>7</td>
<td>11.7</td>
</tr>
<tr>
<td>Lack of permission from husband</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>The four visits are not necessary</td>
<td>29</td>
<td>48.3</td>
</tr>
<tr>
<td>Influence from other women</td>
<td>22</td>
<td>36.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 4.9 indicates that slightly less than half of the women 29(48.3%) believe that the more than four ANC visits are not necessary, 22(36.7%) mentioned that they were influenced by other women, 7(11.7%) mentioned that they lacked financial support from their husbands and 2(3.3%) mentioned that they were not given permission by their husbands. The foregoing above analysis indicates that majority of women lacked knowledge on the importance of making the required four ANC visits. Hence, the majority perceived the four visits as a waste of time as advised by other women. Most of the women (48.3%) reported that the recommended four
visits are not necessary since they do not have information on the importance of antenatal visits. This implies that most of the women make ANC visits when it is too late which makes it hard to treat pregnancy complications that might have developed during the early stages of pregnancy. This is because they depend on other people (other women, husbands, mothers in-law) for information who in turn advise them wrongly.

For instance, Risper Chepkemei* affirmed that:

“I attended only one ANC visit because my friend advised me to make ANC visit during the seventh month of pregnancy to pick the maternity card and so I felt the other visits were not necessary.” (O.I, 11th November, 2014).

The above statement was confirmed by sentiments by a key informant (a nurse aged 35) who said:

“Most of the women believe that making one antenatal visit during the seventh month of pregnancy is enough and so they only come to the maternal health facility during that period to pick the maternity health card. This has resulted to expectant mothers having obstetric complications, such as haemorrhage, sepsis, pre-eclampsia and eclampsia and prolonged or obstructed labour. Some pregnancy complications have even resulted into the death of the mother or/and the baby since they fail to come for regular medical checkups.” (O.I, 11th November, 2014).

According to United Nations (2008), poor health outcomes among women of reproductive age result from women not utilizing modern maternal healthcare services, for instance antenatal, delivery and postnatal care. Antenatal care provides the opportunity for complications to be detected and women are advised on the management of complications. Antenatal care is a crucial safety net for healthy motherhood and childbirth, where the well being of both the prospective mother and
her offspring can be monitored. Although antenatal care alone cannot prevent all obstetric emergencies, the information provided by antenatal service provider is important for the successful management of pregnancies and the subsequent wellbeing of the child. Antenatal care also provides an entry point for women to the healthcare system.

With regard to ANC visits, Converston et al. (2003) indicate that Argentine women often rely on the knowledge they obtain from their own past pregnancy experiences or from the experiences of women within their social network to help determine whether or not they need to seek prenatal care. Some respondents mentioned that since they gave birth to their firstborns safely after attending two or three ANC visits then, they could do the same for the rest of the pregnancies. For instance, Caroline Chemusar* pointed out that:

“I attended two ANC visits since I had done the same with previous pregnancies and I delivered my children safely so I could comfortably do the same with the other pregnancies.”  (O.I, 11th November, 2014).

The results of this study concur with the findings of Simkhada and Teijlingen (2008) in a Nepal study. The researchers assert that knowledge on ANC is critical in determining pregnant women’s use of antenatal services. The present study further established that, Kipsigis community considers pregnancy as natural phenomenon thus regular checkups are seen as unnecessary unless there are some complications. In addition, pregnancy is considered “shameful” in the community therefore, young women especially during their first pregnancy feel shy to attend the four ANC visits. For instance, Chebila* asserted that:

“I felt shy during my first pregnancy so it was hard for me to even go out of the compound. I felt comfortable attending only one ANC visits since I did
not want anyone to recognize that I was pregnant.” (O.I, 12th November, 2014).

The findings are in line with a study conducted in South-West Zone of Nigeria by Amosu et al. (2011) who remarked that ignorance among the pregnant women was one of the factors affecting utilization of ANC services. In the researcher’s view therefore, Kipsigis women do not make the number of required ANC visits since they lack knowledge on their importance hence impacting negatively on maternal health outcomes in the area.

### 4.3.4 Reasons for home deliveries

This sub-section discusses reasons why women choose to deliver home. The findings are presented in two sub-sections which include: Influence of family members and religious influence on place of delivery.

To establish the reasons for home deliveries, the women were asked to identify the place they prefer to deliver their babies and why they prefer that place. They were presented with places of delivery and asked to tick their preferences. Their responses are summarized in Table 4.10.

#### Table 4.10: Women’s choice of place of delivery

<table>
<thead>
<tr>
<th>Place of delivery</th>
<th>Number</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>18</td>
<td>30.0</td>
</tr>
<tr>
<td>Hospital</td>
<td>37</td>
<td>61.7</td>
</tr>
<tr>
<td>Traditional Birth Attendant</td>
<td>5</td>
<td>8.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Table 4.10 indicates that 18(30.0%) of the respondents prefer to deliver at home, 37(61.7%) prefer to deliver in the hospital and 5(8.3%) are assisted by the traditional birth attendants. Those who selected hospital as their preference place of delivery were further asked to explain if all their babies were born in the medical facilities and the majority of the respondents noted that this was not always the case. This implies that women are not always able to get immediate access to maternal health facilities in case of pregnancy-related emergencies and this poses great danger to both their health and that of the baby.

Some women preferred home deliveries because of the support they get at home. Betty Chepketer* commented that:

“I prefer home deliveries since home environment is a relaxed one and I can get help from the nuclear as well as extended family members unlike in the hospital whereby I have to be alone.”(O.I, 12th November, 2014).

The study established that childbirth among the Kipsigis is a communal event that elicits support from friends and the neighbours. Among other advantages of home deliveries is that it enabled the women to perform childbirth rituals and adhere to cultural practices such as naming ceremony which should be performed by an old woman. In addition, they maintained that the placenta should be disposed properly and accompanied by some rituals, a procedure that delivering in the hospital will not allow. Home deliveries are still common in the area because of cultural beliefs and practices related to childbirth. This places expectant mothers at risk since they are not able to get immediate medical support in case of an emergency.
(i) **The Influences of the family members**

To obtain this objective, the family and community setup of the *Kipsigis* was first looked into. As discussed earlier in section 4.3.1, the family set-up of *Kipsigis* is structured in a way that the extended family members play a major role in family issues. Women’s place of delivery is influenced by external factors since many people are involved in the decision-making process.

The study established that the role of family was very significant in women’s lives and was one of the most important and legitimized ways that women could negotiate access to maternal healthcare. FGD noted:

> “Decisions on place of delivery take long since many members of the family are involved which include the husband, aunts and other relatives. Expectant mothers in labour do not make independent decisions and have to wait for the final decision from the older members of the family whenever the husband is not around.” (14th November 2014, at Koita-Burot).

Delays in making decisions that concern place of delivery may result in prolonged labour among pregnant women and may lead to pregnancy complications or even death of the mother and the baby. The study further established that, mothers in-laws hold a very unique position in the *Kipsigis* family structure and influence the healthcare of their daughters-in-law which could result in negative maternal health outcomes. Pauline Chesigei* affirmed that:

> “I gave birth to my second born child at home because my mother in-law and other family members alleged that I was experienced in child birth. Furthermore, they suggested that it was not necessary to deliver in the health facility since I had been healthy and so I could have a safe home delivery.” (O.I, 15th November, 2014).
Duong and Truong (2004) argued that in Vietnam, husbands as well as the mothers-in-law are considered as particularly dominant in determining maternal health. The collective society results in the experiences of parents greatly influence the care-seeking choices of young people. Eunice* pointed out that:

“My labour started in the afternoon and I informed my mother-in-law since she was the only one around. She then told me to be patient enough and wait for my husband’s say. She finally convinced my husband that I could safely deliver at home since I was never sick during pregnancy so, that is how I ended up delivering at home.” (O.I, 15th November, 2014).

The study found that pregnant women had to inform their husbands first before utilizing the maternal health facility. Men are regarded as the final decision-makers hence their permission must be sought. These findings are supported by Gabrysch and Campbell, (2009) in a United Kingdom study, who argue that family members greatly influence pregnant women’s choices because women might need to seek husband’s/partner’s permission or approval before taking decisions related to maternal healthcare. A nurse in the health facility had this to say:

“Lack of decision making power does not allow pregnant women to make independent decisions when they are in labour. Their husbands and other older members of the family must be involved in the decision-making process which in most cases takes a lot of time hence pregnant women either give birth at home or come to the hospital when it is too late.” (O.I, 17th November, 2014).

From the research findings, women believe that once they have had a safe home delivery with their first born child then all the other children can also be safely delivered at home. There was also great influence from elderly women and those who had prior experiences on pregnancy and delivery. They believed that, it was
okay for a pregnant woman to deliver at home especially if they had never felt sick during pregnancy. Some women saw it as normal to give birth at home and giving birth in a health facility is considered only when there is an emergency of during the first delivery. In view of this, Ann* noted that:

“If the delivery looks normal, then there is no need to go to the hospital.” (O.I, 12\textsuperscript{th} November, 2014).

During an interview with the health worker, she reported that:

“Pregnant women prefer to give birth at home till they confirm that the delivery is going to be complicated. They come to the hospital when the complications have already developed hence they end up losing their lives and that of their babies.” (O.I, 17\textsuperscript{th} November, 2014).

The research further established that in the community women are expected to endure labour and those who do so are seen to be brave and are accorded much respect if they deliver alone at home. Women greatly value secrecy during labour and they can only inform the elder members of the society who in turn encourage them to deliver at home. Shouting out or ‘causing disruption’ is perceived as a ‘childish behaviour’ so labouring women are expected to remain silent and ‘endure the pain’. This has an adverse effect on women’s health since prolonged labor can result into death. For instance, Chepchilat* affirmed that:

“My labour started in the afternoon and when I informed my mother-in-law she told me to wait. It got worse during the night and she persisted that I should remain silent and patient enough so that I could have a safe delivery at home. She only informed a neighbour who assisted me deliver at home.” (O.I, 14\textsuperscript{th} November, 2014).

The above analysis indicates that various members of the family as well as the members of the community are involved in pregnant woman’s decision on place of
delivery which may result in delay. Further, enduring labour pains in silence is considered a mark of an adult woman whose behaviour is no longer childish. Therefore, this may result into death of the mother or/and the baby. It is, however, worth noting that there is need to monitor both the fetus and the mother during labour. The influence of family members on place of delivery is thus one of the factors that determine maternal health among the *Kipsigis* women.

(ii) Religious influence on women’s choice of place of delivery

To document the findings on influence of religious beliefs on maternal health, the respondents were asked to state their religion. Christianity, Islam and African Traditional Religion were the choices provided. Findings are presented on figure 4.1.

![Religion of the respondents](chart.png)

**Fig 4.1: Religion of the respondents**

Figure 4.1 indicates that 98% of women were Christians and 2% believed in African traditional religion. The research established that the *Kipsigis* women believe in
existence of a supernatural being that helps and protects them from any danger. As stated earlier in section 4.3.5, the Kipsigis are a very religious people who believe that God listens to their petitions.

The study noted that women believe they can have safe deliveries at home once they have prayed. The presence of elderly women who make petitions during delivery further assure them of safe home deliveries.

According to the Kipsigis culture, prayers were important before and after delivery. The elderly women present during delivery were required to pray to Asis (God) to protect the expectant mother and grant her a safe delivery. The mother-in-law was required to spit on the face of the baby after delivery as well as the breast of the mother. This was done to ensure that both the mother and the baby were protected from any illness or misfortune. This practice was also done as a sign of blessings to them. In case of birth of twins, a charm (a special Kipsigis plant called sinendet) was tied around their necks and this was believed to protect them from any harm such as witchcrafts or bad eyes. The research established that although most of the contemporary Kipsigis women are Christians, they still practise African traditional religion. This is evident from the presence of elderly women during the delivery who encourage the expectant mother as well as asking Asis for a safe delivery.

According to Mbiti (2012), Africans exercise their spirituality in all of their daily activities. The author therefore underlines that Africans are religiously notorious and whenever the African is, there is religion. He carries it to the fields where he is sowing seeds or harvesting a new crop, he takes it with him to the beer party, or to attend a funeral ceremony; and if he is educated, he takes religion with him to the
examination room at school or in the university; if he is a politician he takes it to the house of parliament. The author further notes that in African societies, there are celebrations and rituals to welcome the baby and to protect it. There are naming ceremonies and names are taken seriously. A baby can be named for the day of the week on which it was born, to show gratitude of its parents or metempsychotically after grandfather, grandmother or a departed relative, after an animal or even a demeaning word so as to avert harm. Similarly, Abia (2012) who conducted research in Nigeria notes that Africans believe that living things including humans are linked in harmonious relationship with the gods and the spirits and as such, relationship is ascribed to vital forces which each entity generates. Therefore, a state of health exists only when there is perfect harmony between human beings and their environment.

4.3.5 Beliefs and Practices About Food

The study sought to document the cultural beliefs and practices concerning food to be taken and those to be avoided during pregnancy. To this end, women were asked to identify such foods, who advises them and why they are advised to consume the mentioned foods. The data was absolutely based on qualitative research. The findings are presented in table 4.11 below.
Table 4.11: Dietary precautions and women’s explanations

<table>
<thead>
<tr>
<th>Food</th>
<th>Advice</th>
<th>Cultural explanation</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bananas and avocados</td>
<td>Avoided</td>
<td>They have a lot of “energy” and may cause the fetus to grow too big resulting in complications while giving birth forcing one to undergo caesarean section during delivery. In addition, this kind of foodstuff also prolongs labour.</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>Pineapples</td>
<td>Avoided</td>
<td>Causes a baby to have thrush.</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>Eggs</td>
<td>Avoided</td>
<td>Makes the baby grow bigger in the womb and this may cause difficulties during delivery.</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>Three glasses of milk daily</td>
<td>Consumed</td>
<td>Helps deliver more easily and improve both the health of mother and that of the baby.</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>Traditional vegetables e.g. pumpkin leaves and “Isoik”</td>
<td>Consumed</td>
<td>Increase the amount of blood and makes both the mother and the baby healthy.</td>
<td>Pregnancy and after</td>
</tr>
<tr>
<td>A lot of millet porridge</td>
<td>Consumed</td>
<td>Stimulates breast milk production and makes the mother strong.</td>
<td>After pregnancy</td>
</tr>
<tr>
<td>Meat and soup made from cow’s bones</td>
<td>Consumed</td>
<td>Makes the mother strong and regain energy after birth. Makes the bones strong.</td>
<td>After pregnancy</td>
</tr>
</tbody>
</table>

The research established that when a woman becomes pregnant, she is advised to be conscious enough on her daily diet. Pregnant women are advised to avoid certain food during pregnancy period because they are believed to cause complications during birth. Further, the respondents noted they get such advice from elderly women, friends and women who had experience in pregnancy.

The study notes that some advice resulted in positive maternal health outcomes. For instance, pregnant women were advised to take a lot of milk, traditional vegetables
and millet porridge. According to Edelstein (2011), green leafy vegetables supply Carotene, Vitamin C, Folic acid, Iron and Calcium. Vitamin C is important for many metabolic processes that take place in the body such as, tissue repair and bone growth. Folic acid is also important for expectant mothers since those who are deficient in folic acid are likely to develop megaloblastic anaemia and are at an increased risk of having babies with neural tube defects. This kind of food is also healthy for both the mother and the baby since it is excellent in boosting body’s immunity from illness. Edelstein (2011) further notes that milk is important to a pregnant mother since it is a source of protein which is important for growth and development of the fetus. Furthermore, it helps in tissue development which is required to support pregnancy. Milk is also a source of calcium which helps build baby’s bones and teeth.

The research also established that mothers are advised to take millet porridge and meat after delivery which is essential for their health. According to Tessmer (2010), meat is an important source of protein which keeps the mother’s energy high and gives the baby the amino acids for it to grow. Proteins are also body building blocks used for building and repairing cells, muscles, organs, enzymes and tissues. Millet porridge contains vitamin B minerals and fiber which keep the body healthy and keeps digestive system functioning.

Pregnant women were advised to avoid some fruits like bananas, avocados and pineapples which in turn negatively affect their health and that of their baby. Skinner and Hunter (2013) argue that fruits such as bananas, oranges and pineapples are important for an expectant mother since they contain vitamins which provide extra energy required for the growth of the fetus as well as the production of extra blood,
growth of the placenta, and extra requirements for the mother, especially in the second half of pregnancy. It also improves iron absorption from the woman’s stomach and increases her resistance to infection. Folic acid which is found in fresh fruits is necessary for red blood cells formation and prevents development of neural tube defects in the fetus.

From the above discussion, it is evident that expectant mothers seek advice from other women on food to be taken and avoided during pregnancy which result to either positive or negative maternal health outcomes. Pregnant women should, therefore, seek information on nutrition during pregnancy from the health practitioners in order to be given the correct information.

The findings of this research are consistent with those of Shaikh and Hatcher (2005) who conducted an ethnographic research among the women of Ghana. They concluded that the advice of elderly women concerning foods to be avoided and those to be taken during and after pregnancy is honoured and the adherence of younger women to this advice is expected. Traditional beliefs about food are passed by word of mouth from one generation to the other and adherences to them also depend on the amount of health information given to women and their education. The results of this study also concur with the findings of Liamputtong (2003) who conducted a study among pregnant women in Thailand. The researcher asserts that women are advised to eat only half of the banana during pregnancy since eating a whole banana may result in a birth obstruction. Based on these findings, the study concludes that cultural beliefs and practices about food is a factor that influences maternal health outcomes among the Kipsigis women. This is because the advice
given to expectant mothers by other women may result in either positive or negative maternal health outcomes.

4.3.6 Influence of Gender Roles on Access to Antenatal Care

To enable the documentation of the actual roles performed by women and men, the study applied a twenty four hour activity framework. This was important in order to understand the time available for women to attend maternal healthcare services. The results are summarized in table 4.12 below.

Table 4.12: Daily activity profile of women and men in Ainamoi Constituency

<table>
<thead>
<tr>
<th>Time</th>
<th>Women’s activities</th>
<th>Men’s activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>5am-6:30 am</td>
<td>Milking, deliver milk, prepare breakfast, serve breakfast to the children, prepare children and escort them to school.</td>
<td>Sleep.</td>
</tr>
<tr>
<td>6:30am-8.30 am</td>
<td>Wash the utensils, clean the house and fetch water.</td>
<td>Wake up, take breakfast and take the cows to the grazing field.</td>
</tr>
<tr>
<td>8.30am-11am</td>
<td>Work on the farm e.g., planting or weeding. Pick tea leaves in tea zones.</td>
<td>Inspecting the farm, may help the wife in farm work.</td>
</tr>
<tr>
<td>11am-12pm</td>
<td>Deliver tea leaves to the collection centre.</td>
<td>May help the wife deliver tea leaves to the collection centre and leave for the shopping centres.</td>
</tr>
<tr>
<td>12-2pm</td>
<td>Prepare lunch, serve lunch to the family, wash utensils, bathe the young children, give water to the animals, wash clothes and rest.</td>
<td>Come for lunch and rest.</td>
</tr>
<tr>
<td>2pm-5pm</td>
<td>Fetch firewood, may go back to the farm, milk the cows and prepare tea for the family and go to the shopping centre.</td>
<td>Go back to the shopping centres and meet friends.</td>
</tr>
<tr>
<td>5pm-7pm</td>
<td>Feed the animals and ensure that they are locked in, prepare supper for the family.</td>
<td>At social centre.</td>
</tr>
<tr>
<td>7pm-9pm</td>
<td>Help children with homework, wash utensils and prepare a place for children to sleep.</td>
<td>Come back home and sometimes ensure that the cattle have been locked in, listening to the radio or watching the television.</td>
</tr>
<tr>
<td>9pm-10pm</td>
<td>Rest and wait for their husband in case they have not arrived, serve supper for their husbands and then sleep.</td>
<td>Take supper and sleep.</td>
</tr>
</tbody>
</table>

The above analysis indicates that women are heavily burdened with reproductive activities. They are therefore, left with little or no time at all to seek maternal healthcare services. Larsen et al. (2004) posits that the status of women and their perceived or expected roles within a culture influence a woman’s decision to utilize prenatal and delivery health services. In New Guinea, women are the caretakers of children and they find it more difficult to take their other children with them to receive antenatal care or to find someone else to look after them. On the same note, Camacho et al. (2006) argue that in Latin America, women have been assigned roles of women as mothers, caretakers and dependants who have limited their autonomy and utilization of maternal health services. Women are often expected to occupy a number of roles at the same time: wife, mother, homemaker, employee, or caregiver to an elderly parent. Meeting the demands of so many roles simultaneously leads to
stressful situations and lack of time to attend to maternal healthcare services. This is also evident from the information given by Elizabeth Rono* who said:

“When I’m pregnant, I still have to perform my daily chores so I’m left with little time to visit the maternal health facility. Women cannot avoid activities such as working in the tea plantations because if they do not work, there will be no food on the table.” (O.I, 13th November, 2014).

The study established that women are engaged in a lot of work throughout the day. The Kipsigis women have been assigned gender roles which they must fulfill first and their maternal health comes second. This concurs with the findings of Idowu et al. (2011) in a research conducted in Badagry Local Government, Lagos State. The researchers assert that because of their heavy household duties, women cannot afford to be sick themselves. Many ailments exist among pregnant women but they never receive attention from the medical profession. Their limited time reduces the promptness with which medical assistance is obtained anytime an illness is suspected during pregnancy. Even if a woman notices symptoms of illness, she may completely ignore these signs because of other competing demands. Rael Maritim* remarked that:

“When I’m pregnant I have to perform all the duties by myself without help from anyone. Although sometimes I feel sick and tired, I just have to persevere and continue with my daily chores because sometimes I do not have enough time to visit the maternal health facility.” (O.I, 13th November, 2014).

According to Peristiany (1964), before marriage a Kipsigis girl has to look after her mother’s children and after marriage her work begins with the rising sun and is never finished before sunset. Orchardson (1961) notes that there is no prohibition on working during pregnancy and every Kipsigis woman does as much as she feels able
to. Gender roles was, therefore, found to be one of the determinants of maternal health in Ainamoi Constituency.

4.4 Economic Factors that Determine Maternal Health

In this section, the economic determinants of maternal health are discussed based on the second objective of the study. To achieve this objective, women’s occupation was looked into, their monthly income, expenses and their access to and control over family resources. Economic status of a pregnant woman greatly determines her decisions on whether to seek maternal healthcare services or not. According to WHO (2005), general socio-economic status of mothers, ability of women to manage resources and make independent decisions about their health has an impact on reduction of maternal mortality. Poor mothers are at high risk of developing pregnancy-related complications. This section is, therefore, divided into three sub-themes which include: women’s occupation and its impact on maternal health, women’s income level and its impact on maternal health and lack of women’s access to and control over family resources.

4.4.1: Women’s Occupation and its Impact on Maternal Health

The study sought to find out the occupation of the respondents that would enable them to earn an income. This was important as understanding the occupation of the respondents was deemed to have implications in relation to maternal health. The respondents were asked to state the kind of productive activities they engaged in. The findings are summarized in Table 4.13 below.
Responses indicate that 42(70%) of the respondents depend on farming for their daily sustenance, 10(16.7%) were business women, while 8(13.3%) were civil servants. Based on these findings, the study established that most of the women engage in subsistence farming for family sustenance and sell some food crops which earn them some income. The crops grown by the women include; Irish potatoes, beans, cabbages, kales, traditional vegetables, sweet potatoes, tomatoes, sorghum and millet. The land in the Kipsigis community is owned by men and they decide on the size of land the women should cultivate. Women are usually allocated a small portion of land to cultivate and this is done after seeking permission from their spouses. This negatively impact on maternal health since women do not get enough finance to seek maternal health services. This is also evident from the information given by Nancy Rotich * Who said:

“The crops we cultivate in our gardens are only meant for family consumption. We sometimes sell the surplus but still the money we get is used to by family needs. Women therefore, do not have enough money to safe for their future maternal healthcare needs.” O.I 15th Nov 2015.

Peristiany (1964) in his study on the Kipsigis asserts that women owned Kabungut (a small vegetable garden) which was/is cultivated exclusively by the mother and

Table 4.13: Occupation of the women

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business</td>
<td>10</td>
<td>16.7</td>
</tr>
<tr>
<td>Farmers</td>
<td>42</td>
<td>70.0</td>
</tr>
<tr>
<td>Civil servants</td>
<td>8</td>
<td>13.3</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100</td>
</tr>
</tbody>
</table>
her daughters. No man ever has anything to do with it. In this garden are grown vegetables. The produce from this small farm was used exclusively to feed the household. The husband had complete authority over the big farm that is imbaret ab soi and Kapande (field of maize). The produce of the big farm was used for trading. Furthermore, 16.7% of women engage in small businesses which include selling groceries and owning small shops. They also noted that, the money they get is used for household purposes and at times it is their husbands who decide on how the money is spent. This indicates that the patriarchal system in the Kipsigis community limits women from making independent financial decisions which in turn leave them at the vicious circle of poverty impacting negatively on their maternal health.

According to Lubbock and Stephenson (2008) in their study in Nicaragua, women who are not employed in a gainful occupation are always economically dependent on their husbands. This dependence grants men the authority to dictate women’s access and utilization of maternal health services. On the other hand, Gill et al. (2007), note that if women are employed, they can control the income they earn and are able to accumulate assets. They are also less dependent on spouses and other members of their households and are better able to make their own healthcare decisions. From the above findings, occupation of women determined maternal health in the area.

4.4.2: Women’s Income Level and its Impact on Maternal Health

To cover the scope of the second objective on economic determinants of maternal health in Ainamoi Constituency, women were further asked to state the level of income they earned per month. Understanding women’s level of income was vital in
order to establish whether they had enough money to spend in the maternal health facility. The outcomes are presented in Figure 4.2 below.

![Bar chart: Women's income level](image-url)

**Fig 4.2: Women’s level of income**

As shown in figure 4.2, 46% of women earn income below KES 5,000, 26% earn an income of KES 5,000-10,000, 15% earn income of KES 10,000-15,000 and 13% earn income above KES 15,000 per month.

The above analysis shows that nearly half of the women (46%) earn income below KES 5,000 and they are required to spend the same on family upkeep as indicated in Figure 4.3. This implies that women do not have enough money to attend to pre-natal health care services or for hospital deliveries.

It was also important to establish the women’s expenditure in order to find out whether they have enough money left to cater for expenses related to access to a maternal health facility.
Figure 4.3: Household expenditure per month

The above analysis indicates that women spend approximately KES 2,500 on food, Medical expenses KES 1,500, Education KES 1,000 and Clothing KES 1,000.

From the above findings, total monthly expenses (KES 6,000) exceed the total monthly income (KES 5,000). This implies that most women were not financially independent hence could not fully utilize the available maternal health facilities. The findings therefore, imply that lack of adequate finances among women may be one of the reasons explaining why women delivered at home or through the assistance of TBAs. Since they occupied low economic status, they were not able to seek further medical attention unless it was perceived as urgent by spouses and mothers-in-law. These findings concur with those of a research conducted in a rural community in Kerara, India by Mohindra (2006). He concluded that the low socio-economic status of women puts them at greater jeopardy of morbidity and mortality, and leads to women resorting to other options such as self-care or treatment that may jeopardize
their reproductive health status. Ikamari (2004) in a study on maternal healthcare utilization in Teso District, Kenya, notes that the majority of women delivered at home. Among other factors, lack of money to meet user charges and travel cost was some of the factors that led to home deliveries.

The study further established that most women were not involved in making decisions on how family income is spent and usually such decisions are made by men. The Kipsigis community is primarily male-dominated and this limits the independent decision-making of women when it comes to seeking maternal healthcare services. Helen Chebile* opined that:

“Most of the times, it is my husband who decides on how family income is spent and at times he spends without informing me. I then have to ask for his financial support whenever I need to visit maternal health facility.” (O.I, 15th November, 2014).

The above findings corroborated with the findings of a research conducted in Bangladesh. Rahman (2003) argues that the patriarchal structure places women in a low status in the family and in the society and this is evidenced through limitations of women’s poor community support structure and lack of access to financial and other resources. This study also found that some men opted to have their wives to deliver at home since there are no costs incurred in home deliveries. In view of this, Rachel* mentioned that:

“My husband usually suggests that I have home deliveries since he considers it to be cheap and convenient. I don’t have any power to say no because I depend on him financially.” (O.I, 15th November, 2014).
This was confirmed by Elijah Yegon* who said:

“I prefer my wife to deliver at home since no cost will be incurred but in case of any complication I will take her to the hospital.” (O.I, 21st November, 2014).

Lack of finances among the women to spend in the maternal health facility was confirmed by the TBA aged 52 who reported that:

“Some pregnant women come for my assistance during delivery because they do not have money to go and deliver in the hospital. They also lack money for transport since it is quite expensive to hire a car if the labour starts at night.” (O.I, 21st November, 2014).

The findings are in line with those of Ensor and Ronoh (2005) in a review of the literature on health policy who assert that cost is a key factor accounting for the low rates of utilization of maternal healthcare services among poor women. For women seeking maternal healthcare, costs include those for facilities and services, and involve both formal and informal fees, the cost of drugs and equipment, transport to a hospital or clinic. The research further found that most women do not save for their maternal healthcare use since the money they earned was not enough. Consequently, during labour many people have to be involved concerning their place of delivery since they are economically dependent. Nancy Kirui* pointed out that:

“Although we women wake up early every morning to go and work in our gardens or small businesses, we still do not save any money for our own use. We use the money we earn to feed our families and sometimes pay school fees for our children.” (O.I, 21st November, 2014).

The above findings agree with those of Su et al. (2007), who conducted a study among the women of China. They noted that the income of the family itself affects
maternal health outcomes. A family with low income may be constrained in being able to pay for health services fees, transport to facilities, or health-related resources that incur additional expenses. From the above discussion, it is evident that women’s income level determines maternal health in Ainamoi constituency.

4.4.3: Lack of Women’s Access to and Control Over Family Resources

To attain positive maternal health outcomes, women should get access to and control of family resources. This will enable them to be financially independent and will not have to depend on their spouses whenever they want to seek maternal healthcare services. This study first sought to find out the types of property people generally had in the household and who decides on the purchase and sale of such property. These included land, real estate, machinery, houses, vehicles, household goods, bank account, livestock and tea plantations.

The respondents were then asked to state who own the above property. The findings are presented in Table 4.14.

**Table 4.14 Ownership of family property**

<table>
<thead>
<tr>
<th>Type of property</th>
<th>Number</th>
<th>Percentage</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>-</td>
<td>-</td>
<td>60</td>
<td>100%</td>
</tr>
<tr>
<td>Real estate</td>
<td>-</td>
<td>-</td>
<td>60</td>
<td>100%</td>
</tr>
<tr>
<td>Machinery</td>
<td>3</td>
<td>5%</td>
<td>58</td>
<td>96.7%</td>
</tr>
<tr>
<td>Houses</td>
<td>2</td>
<td>3.3%</td>
<td>57</td>
<td>95.0%</td>
</tr>
<tr>
<td>Vehicles</td>
<td>4</td>
<td>6.7%</td>
<td>19</td>
<td>31.7%</td>
</tr>
<tr>
<td>Household goods</td>
<td>58</td>
<td>96.7%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Livestock</td>
<td>2</td>
<td>3.3%</td>
<td>59</td>
<td>98.3%</td>
</tr>
<tr>
<td>Tea plantations</td>
<td>-</td>
<td>-</td>
<td>60</td>
<td>100%</td>
</tr>
</tbody>
</table>
Table 4.14 indicates that only men 60(100%) own land, men 60(100%) own real estate, 3(5%) women and 58(96.7%) own machinery, 2(3.3%) women and 57(95.0%) men own houses, 4(6.7%) women and 19(31.7%) own vehicles, 58(96.7%) own household equipments and no man mentioned he owns the same, 2(3.3%) women and 59(98.3%) men own livestock, 8(13.3%) women and 60(100%) men own tea plantations.

The above analysis shows that men own most of the valuable family properties for instance land, real estate, machinery, livestock and tea plantations. Women have to financially depend on men in order to seek maternal healthcare services.

The respondents were further asked to state who decides on the purchase and sale of the above property. The findings are presented in Table 4.15.

Table 4.15: Decisions on the purchase and sale of family property

<table>
<thead>
<tr>
<th>Type of property</th>
<th>Women</th>
<th>Men</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>Land</td>
<td>7</td>
<td>11.7%</td>
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<tr>
<td>Real estate</td>
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<td>28.3%</td>
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<tr>
<td>Machinery</td>
<td>12</td>
<td>20.0%</td>
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<tr>
<td>Houses</td>
<td>37</td>
<td>61.7%</td>
</tr>
<tr>
<td>Vehicles</td>
<td>10</td>
<td>16.7%</td>
</tr>
<tr>
<td>Household goods</td>
<td>58</td>
<td>96.7%</td>
</tr>
<tr>
<td>Livestock</td>
<td>21</td>
<td>35.0%</td>
</tr>
<tr>
<td>Tea plantations</td>
<td>8</td>
<td>13.3%</td>
</tr>
</tbody>
</table>
Table 4.1 indicates that 7(11.7%) women and 56(93.3%) men decide on the purchase and sale of land, 17(28.3%) women and 52(86.7%) men decide on the purchase and sale of real estate, 12(20.0%) women and 53(83.3%) men decide on the purchase and sale of machinery, 37(61.7%) women and 41(68.3%) men decide on the purchase and sale of houses, 31(61.7%) women and 54(90.0%) men decide on the purchase and sale of vehicles, 58(96.7%) women decide on the purchase and sell of household equipments and no man mentioned that they decide on the purchase and sale of the same, 21(35.0%) women and 50(83.3%) men decide on the purchase and sale of livestock, 8(13.3%) women and 57(95%) men decide on the purchase and sale of tea plantations.

The above analysis shows that men often decide on the purchase and sale of family property that are productive. The study established that Kipsigis culture is predominantly patrilineal in nature and authority, decision-making and control of family resources is in the hands of men as heads of households and families. Most women are not financially stable since they own household goods which do not generate any income. The study further found that husbands were pivotal to wives gaining permission to seek maternal healthcare services because they were the custodians of financial resources. Since husbands control and manage family finances, women have limited control over money and property. These findings are in line with those of Doss and Truong (2012) who conducted a study in Uganda. They concluded that women’s healthcare decisions depend on their husbands mainly because of the hierarchical control of family social and economic resources. Family relations play a key role since women after marriage depend on their marital families for their wellbeing and access to resources. Sally Cheriro* had this to say:
“Almost all the property in the family belongs to my husband since they are under his name. As women, we do not usually decide on the sale and purchase of these property but we are expected to take good care of them. We therefore have to financially depend on our husbands when we want to seek maternal health services.” (O.I, 24th November, 2014).

The above statement was confirmed by one of the local leaders who said:

“The women in this area are not allowed to own property. Kipsigis culture dictates that since the man is the head of the family, he is the one to decide on how the resources should be utilized. Some men do not even let their wives know of some of the property they own.” (O.I, 24th November, 2014).

The findings of this study also concur with the findings of Jansen (2006) who notes that in Pakistan dominant patriarchal cultures, men play a very significant role in defining what counts as healthcare prerequisite for women and almost all the resources in the family are owned by men. A woman may be allowed by her husband to seek healthcare only when her illness is considered severe.

Culturally, women are expected to be submissive to their husbands and men are expected to be heads and leaders of the family. When a woman does not submit, she may miss out on the opportunities of being part of the family and benefiting from her husband’s decisions. In view of this Grace Cherorot* noted that:

“My husband always decides on purchase and sell of valuable family property and at times he sells them secretly and informs me later.” (O.I, 25th November, 2014).

When the men were asked why they do not involve their spouses on decisions that concern purchase and sale of family property, Bor* noted that:

“Men know how to plan on how family resources should be utilized and therefore there is no need to involve our wives.” (O.I, 25th November, 2014).
These findings concur with those of Rani, (2003) in an Indian study. He argues that men play a paramount role in determining healthcare needs of women. Since men are decision-makers and in control of all the resources, they decide when and where women should seek healthcare. The foregoing findings indicate that women’s access to and control over family finances is limited. Consequently, they lack money to cater for expenses related to maternal health such as transport expenses and cost of services at the health facility. This is largely because almost all the resources in the family are owned by men. Thus, access and control of family resources was found to be one of the determinants of maternal health in the area.

### 4.5 Strategies for Improving Maternal Health in Ainamoi Constituency

The third objective was to find out the strategies to improve maternal health in Ainamoi Constituency. The participants were asked to state the strategies that can be put in place in order to improve maternal health in the area. Figure 4.5 presents the responses.
Fig. 4.5: Strategies for improving maternal health

Figure 4.5 indicates that 72% of men and 91% of women agreed that both men and women should be provided with maternal health education. 86% of men and 95% of women mentioned that men and women should be economically empowered. 67% of men and 92% of women agreed that there should be joint decision-making process in the family. 78% of men and 90% of women agreed that cultural practices that improve maternal health should be encouraged. These findings are discussed in subsequent sections which include: provision of maternal health education to both men and women, economic empowerment of men and women, encouraging joint decision-making process in the family and encouraging cultural practices that improve maternal health.
(i) Provision of Maternal Health Education to Both Men and Women

Both men (72%) and women (91%) pointed out that maternal health education is an important strategy to reduce maternal deaths in the area. The participants felt that there was need for both men and women to be provided with maternal health education. From the study findings, 6(10%) of women made one ANC visit, 25(41.7%) of the women made two ANC visits, 20(33.3%) made three ANC visits and 9(15%) made the required more than four ANC visits. When women were asked to state the reasons for not making the four required ANC visits, 25(41.7%) mentioned that the four visits were not necessary and 18(30%) mentioned that they were influenced by other women. This implies that, most women lack maternal health education on importance of making the required ANC visits. Furthermore, 22(36.7%) of men mentioned that they did not know why women did not attend the required ANC visits and 33(55%) stated that issues to do with pregnancy and childbirth were women’s responsibility. This implies both men and women lack maternal health education. Kabakyenge (2012) argues that women are more likely to have better maternal health outcomes when their husbands get involved in maternal healthcare by attending ANC visits and supporting their wives during pregnancy. Rahman (2011) notes that when men know the danger signs of pregnancy and delivery, they may act as life-saving agency, ensuring that their wives get appropriate attention in obstetric emergencies.

Some women mentioned that there was no need to make the required four ANC visits and one visit was enough as long they were not sick. Pregnant women therefore, need to gain knowledge on importance of pregnancy and delivery care and awareness of where to receive them and uptake of such services. Improving
knowledge about the benefits of ANC visits for pregnant women is an important element in enabling them to enrich their experiences as well as supporting their effort to better appreciate ways to protect their health and that of their children.

From the study findings 18(30%) of women still deliver at home and 5(8.3%) deliver with the assistance of a TBA. Women mentioned that lack of finance to meet maternal health expenses was the major reason for home deliveries. The study findings further revealed that, men opted to have their wives deliver at home since there are no costs incurred. This implies that, men do not understand the dangers of home deliveries. Therefore, men should be provided with maternal health education so that they can have their spouses deliver in hospital since they own and control the family resources. Mullany et al. (2007), opined that men’s role can contribute to better outcomes for their pregnant wives. In most families, the men are empowered financially and are the main decision-makers in all issues including reproductive and maternal health. They may use this opportunity to ensure that their pregnant wives seek maternal healthcare services or arrange for skilled care during delivery if delivery takes place at home. For men to make the right decision for their wives regarding place of delivery, as well as professional attention, they need to understand the importance of maternal care.

(ii) Economic Empowerment of Men and Women

Both men and women viewed economic empowerment as an important strategy to improve maternal health in Ainamoi constituency. Ninety five percent of women and 86% of men agreed that maternal deaths can be reduced when both men and women are economically empowered. From the study findings, 46% of women earn income below Ksh 5000 and their monthly expenses amount to Ksh 6,000. This
indicates that women do not have enough money to spend on family daily needs as well as their maternal healthcare services. Moreover, 42(70%) of women depend on farming for their daily sustenance, 10(16.7%) were business women, while 8(13.3%) were civil servants. The majority of the women are farmers who practise subsistence farming hence they are not economically independent. Furthermore, men own the land and decide on the size of the land their wives should cultivate. This limits them from practising large scale farming for economic purposes. Gill et al. (2007) argue that if women are employed, they can earn income and are better able to purchase healthcare services. They are less dependent on their spouses and other members of the household and better able to make decisions on their maternal health. Women’s employment has a positive effect on maternal health and is associated with reduced maternal mortality and morbidity.

The study further established that most women do not decide on the purchase and sale of family property. Most of the women (96.7%) decide on the purchase of household goods which are not productive. Men make decisions on the purchase and sale of productive properties like land, real estate, tea plantations, vehicles and machinery. According to Parkhurst (2006), the factors that undermine women’s decision to access maternal healthcare include; lack of control over assets, overall lack of autonomy and low social position at both household and community levels. Women’s maternal and reproductive health decisions are limited by their reliance on their husband’s control of household assets. Eswaran (2002) argues that women who have no stake in family assets are at a disadvantage and cannot make independent maternal healthcare decisions. A small increase in women’s assets has potential effect on decision-making to utilize maternal healthcare.
The participants agreed that women should have access and control of family property so that they can be financially independent. They should be given an opportunity to access and control productive resources especially land so that they can practise large-scale farming. This will in turn make them to be economically independent hence they will be able to seek maternal healthcare services.

(iii) Encourage Joint Decision-Making Process in the Family

From the study findings, 92% of women and 67% of men agreed that there should be joint decision-making process in all family matters and especially those that concern maternal as well as sexual and reproductive health. From the study findings, 90% of women reported that they are not allowed to participate in decisions that concern their sexual and reproductive health. There should be a discussion between husband and wife on sexuality matters and the number of children to have. This will help reduce the number of pregnancies a woman will have which will reduce pregnancy risks. Riyami et al. (2007) in a study among Oman women conclude that, women who are more highly empowered in decision-making are more likely to have their first child at an older age and have longer intervals between births.

The study further established that, it is usually the men who decide on how family income is spent. In a FGD, it was noted that men at times spend family income without informing their spouses. For positive maternal health outcomes to be achieved there should be a discussion between husband and wife on how family income should be spent so that women can have some amount to save for their maternal healthcare services. Mullany et al. (2005) in a Nepal study posit that couples joint decision-making may yield better maternal health outcomes compared to men making decisions alone or women making decisions without input or
agreement from their partners. Furthermore, husband’s domination of household decision-making has been associated with less male involvement during pregnancy and childbirth, while joint decision-making leads to male involvement in maternal healthcare issues.

(iv) Encouraging Cultural Practices that Improve Maternal Health

Ninety three percent of women and 85% of men agreed that cultural practices that ensure maternal health outcomes in the area should be encouraged. Childbirth in the community is considered a blessing thus, nuclear and extended family members as well as the community at large give support to the mother after delivery. Women from the neighbourhood are expected to visit the mother with water, firewood and food. Mothers after delivery are expected to have a bed rest for a week in order to regain energy. She is under the care of either the mother-in-law or the sister-in-law and they make sure that the mother is well fed. Orchardson (1961) noted that after a Kipsigis woman delivers the people of the kokwet (social unit) are always willing to help unless she has made herself unpopular.

According to the customs of Kipsigis community, it is important for women who have just delivered to be placed on a special diet. This is believed to help the woman regain lost nutrients during delivery. From the study findings, pregnant women are encouraged to eat traditional vegetables, drink milk and take millet porridge. The husband is expected to ensure that there is regular food supply in the house and at no one time the woman should feel hungry.

Orchardson (1961) noted that when a wife informs her husband of the date of delivery, he arranges for a beer party if the milk from his own cows is not sufficient. Beer must be prepared in advance so that people may be invited for the party. In
return, every guest presents two large gourds of milk at stated times from the eight month of pregnancy till three months after birth.

Furthermore, the culture holds it that any sexual act during pregnancy is thought to be dangerous to the baby as it could cause high contractions of the uterus and miscarriage. In addition, sexual intercourse could injure the baby and cause congenital malformation as well as preterm labour. Sexual abstinence during lactation is also encouraged since it is believed that a woman is not fully pure at this time. This practice helps in child-spacing and family planning. Peristiany (1964) in a study among the Kipsigis posits that although a husband returns to his hut a month after his wife has delivered, sexual intercourse cannot take place before a year has elapsed, that is, after the child has been weaned.

The participants also agreed that cultural practices that lead to negative maternal health outcomes should be discouraged. Early marriages should be discouraged by encouraging girl child education and educating both men and women on negative impacts of early marriages.

According to Idehen (2007), some of the cultural practices which have endured centuries of practice work for the people. Not all cultural practices are bad however, some have stood the test of time and have positive values, and others are uncertain and negatively harmful. Therefore, it is important to have an idea about cultural practices of some communities because the practices a community adopts fulfill certain purpose for the culture bearers.
CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of the research findings, conclusions, recommendations for decision-makers and suggestion for further research. The main aim of the study was to find out the determinants of maternal health in Ainamoi Constituency, Kericho County.

5.2 Summary of the Findings

The first objective of this study was to investigate the cultural determinants of maternal health in Ainamoi Constituency. The study established that there are some cultural practices that hinder improvement of maternal health in the area. Women are not involved in decision-making process in most of the areas especially those that concern their maternal and reproductive health. Women’s maternal health is at risk since they are not given a chance to negotiate for sex and to decide on the number of children to have. These findings affirm those of Shen et al (1999), who argued that inequality between men and women is the main factor to high maternal mortality since women’s low social status has a negative impact on maternal mortality.

The study also found that, women do not have power to make independent decisions concerning ANC visits and place of delivery since various individuals for instance husbands and mothers-in-law are involved in the decision-making process and are regarded as the final decision-makers. These findings agree with those of Shen et al.
(1999), who posit that with expanded power and privileges, women are normally more independent and have a greater influence in questions of early marriage, the number of children she is having and access to healthcare. Women lack of decision-making power on matters that concern their sexual reproductive, health and maternal health issues have a retrogressive effect on their maternal health. Women should, therefore, be given power to decide on their own sexual and reproductive health, the number of children to have and matters that concern their maternal healthcare in general.

The second objective was to find out the economic determinants of maternal health in Ainamoi Constituency. The study established that Kipsigis community has a very strong patriarchal structure which places women in a low status both in the family as well as in the society and this is evidenced through women not being fully involved in family decisions and lack of access to financial and other resources. The research established that, most women do not have enough income and so they have to depend on financial support from their husbands whenever they want to seek maternal health services. These findings concur with those of Shen et al (1999) who assert that women economic status reflects gender inequality by the possibilities a woman has of controlling economical resources and possibilities to self-sufficiency. Her economic status further affects her health by not having access to healthcare such as maternal or obstetric care.

The study found that women engage in small businesses that do not earn them enough income hence they remain financially dependent whenever they want to seek maternal healthcare services. Women in the area also lack enough education which in turn limits them from joining careers that pay well. These findings are affirmed by
Shen et al (1999) who posit that women’s educational status can impact women’s ill-health and maternal mortality in that with low education, the woman is often given a lower role within the family and does not have much to say in decisions taken. Women in the area should therefore, get access and control of family resources so that they can less depend on their spouses for financial support. They should also be given enough education since if they, are educated, they can control the income they earn and be able to accumulate assets.

The third objective was to find out the strategies to improve maternal health in Ainamoi Constituency. The respondents noted that both men and women should be provided with maternal health education which will enable them to gain knowledge on importance of pregnancy and delivery care. Second, both men and women in the area should be economically empowered. Third, joint decision-making process in the family should be encouraged in order to attain positive maternal health outcomes. Finally, cultural practices that improve maternal health in the area should be encouraged and those that result in negative maternal health outcomes should be discouraged. Cultural practices such as communal support and proper feeding of the mother after delivery should be encouraged while negative ones such as the practice of FGM and early marriages should be discouraged.

5.3 Conclusion

It is evident from the research that socio-cultural and socio-economic factors determine maternal health in Ainamoi Constituency. Unequal power relations between men and women run across the study for instance, women are unable to make independent decisions especially those that concern their sexual and reproductive health. Furthermore, women cannot make decisions on the number of
children to bear. Early marriages have also led to negative maternal health outcomes. The research findings show that poor maternal health outcomes have resulted from women’s inability to access antenatal and delivery services due to negative influence from the extended family members and lack of spousal support. From the second objective, it be concluded that patriarchal nature of the Kipsigis society does not allow women to get access to and control family resources. Almost all the resources in the family are owned by men therefore, women depend on their spouses for financial support whenever they need to access maternal health facilities. This has negatively impacted on maternal health since expectant mothers do not seek medical attention on time due to financial instability. The study further established that women engage in economic activities in order to meet family daily needs therefore they cannot save for future maternal healthcare.

5.4 Recommendations

1. Public health practitioners and policy makers should develop maternal health policies that are sensitive to incorporate elements of culture that contribute to positive maternal health outcomes with full involvement of key people from the community. Effective programmes which provide information, education and communication on safe motherhood programmes should reach men, women and their relatives.

2. The research findings indicate that men are in control of most of family resources needed by women to access maternal healthcare. It is, therefore, pertinent that men are educated on importance of women’s access to and control of family resources since they maintain the financial power to control women’s access to services. Furthermore, women should be empowered
through the development of microfinance programmes which will enable them to be financially independent and trained on how they can save for their future maternal health needs.

3. Public health officers and other stakeholders should discourage preconceived ideas about pregnancy by the use of health promotion and education. Trained male community health practitioners could facilitate dialogue among men in the community which in turn may ignite household level discussions between the husband and wife about the importance of prenatal care and delivery preparation.

5.5 Suggestons for Further Research

1. A study can be conducted on men’s involvement in maternal health since men are regarded as the final decision-makers in the family who own family resources.

2. This research has focused mainly on family and community influence on maternal health. Further research could be conducted on perception of pregnant women towards health facilities and health workers.

3. A study can be conducted on the place of family planning in the community.
REFERENCES


Kenya Demographic and Health Survey (KHDS) 2008-2009


APPENDICES

Appendix I

Respondent Consent

My name is Jackline Chelangat Bii a M.A student from Kenyatta University. I am conducting a study on “Determinants of Maternal health among the Kalenjin women of Ainamoi Constituency”. The information will be used to improve maternal health in the area.

**Procedures to be followed**
Participation in this study will require that I ask you some questions and record the responses from you. I may also audio tape your responses to help me transcribe later for data analysis. Please remember that participation in this study is voluntary. You have the right to refuse to participate in this study.
Appendix II

INTERVIEW GUIDE FOR MARRIED WOMEN BETWEEN (15-49 YRS)

This research is purely for academic purpose and any information collected will be treated with high confidentiality.

Interview guide No…………………
Location……………………
Date of the interview……………

Section A- Socio-Demographic Background

1. Age: 15-19 [ ] 20-24 [ ] 25-29 [ ] 30-34 [ ]
   35-39 [ ] 40-44 [ ] 45-49 [ ]

2. Educational background
   No education [ ] Primary education [ ]
   Secondary education [ ] Post-secondary education [ ]

3. What is your religion?
   Christianity [ ] Islam [ ]
   African traditional religion [ ]

Section B-General Information

4.(a) At what age were you first married?
   15-19 [ ] 20-24 [ ] 25-29 [ ] 30-34 [ ] 35-39 [ ]
   40-44 [ ] 45-49 [ ]

   (b) Which challenges did you encounter when accessing maternal health services after marriage?
5. (a) How many antenatal visits do you attend during pregnancy period?

One [ ] Two [ ] Three [ ] Four + [ ]

(b) Why don’t you make four or more than four ANC visits?

Probing if they don’t make more than four ANC visits:

- Lack of financial support from the husband
- Lack of permission from the husband
- The four visits are not necessary
- Influence from women who have experience in pregnancy and childbirth.

6. (a) Do you have a say on your sexual and reproductive health?

Yes [ ]
No [ ]

(b) Why?

7. (a) How many children do you have?

None [ ]
1-3 [ ]
4-6 [ ]
More [ ]

(b) Why did you give birth to the number of children stated above?

8(a) Which child sex does the Kipsigis community prefer?

Girl [ ]
Boy [ ]

(b) Why does the community prefer the above stated child?
9. (a) Where do you prefer to deliver?
   - Home [  ]
   - Hospital [  ]
   - Traditional birth attendants [  ]

   (b) Why?

   Probing if it is home and TBA:
   - Lack of financial support from the husband
   - Advice from elderly women
   - It is common practice in the community.

10. (a) What kind of food were you advised to eat during pregnancy?

    (b) Who advised you?

    (c) Why were you advised to eat such kind of food?

11. (a) What kind of food were you advised to avoid during pregnancy?

    (b) Who advised you?

    (c) Why were you advised not to eat such kind of food?

12 (a) What roles do you perform in a typical day in the household? (For male and female respondents)
Gender activity profile (24 hour clock)

<table>
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<tr>
<th>Men</th>
<th>Activity</th>
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<td>24.00</td>
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</tbody>
</table>

(b) Do the daily roles you perform prevent you from seeking maternal health care services?

(c) If yes, then how do they act as barriers?

13. (a) What is your occupation?

<table>
<thead>
<tr>
<th>Business [ ]</th>
<th>Farmer [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil servant [ ]</td>
<td>Any other specify [ ]</td>
</tr>
</tbody>
</table>

(b) Which type of farming or businesses do you engage in?
(c) In your estimate, how much do you get as income per month?

Above 15000 [ ] 10001-15000 [ ] 5001-10000 [ ] Below 5000 [ ]

(d) In your estimate, how much do you spend per month?

- Food
- Medical expenses
- Education
- Clothing

(e) Does the money you get enough to save for future maternal healthcare use?

14. (a) Do your husband involve you on how family income is spent?

(b) If No, Why don’t they involve you?

15. (a) When you are pregnant, do you save any money for maternal healthcare services?

(b) If No, Why?

16. (a) Please indicate who owns the family property below.

<table>
<thead>
<tr>
<th>Type of property</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Real estate</td>
<td></td>
<td></td>
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<tr>
<td>machinery</td>
<td></td>
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<tr>
<td>Houses</td>
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<tr>
<td>Vehicles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household equipments</td>
<td></td>
<td></td>
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<tr>
<td>Back accounts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Livestock</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tea plantations</td>
<td></td>
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</tr>
</tbody>
</table>
b) Indicate who decides on the purchase and sale of family property below.

<table>
<thead>
<tr>
<th>Type of property</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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<tr>
<td>Real estate</td>
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<tr>
<td>Machinery</td>
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<tr>
<td>Vehicles</td>
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<td>Back accounts</td>
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<td>Livestock</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tea plantations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17. In your own opinion, which strategies can be put in place to improve maternal health in this area?

Thank you!!
Appendix III

QUESTION GUIDE FOR WOMEN FGD

1. Why do most women fail to make the required more than four Antenatal visits?

2. Why are women denied to decide on their own sexual and reproductive health?

3. Why do women prefer to have many children?

4. Which child sex do the Kipsigis community prefer and why?

5. Why do women opt to deliver at home or through the assistance of tradition birth attendant instead of going to the hospital?

6. (a) Which foods are pregnant women advised to eat during pregnancy?
   (b) Who advised them and why?

7. (a) Which foods are pregnant women advised to avoid during pregnancy?
   (b) Who advised them and why?

8. (a) Do your husband involve you on how family income should be spent?
    (b) If No, why?

9. (a) Do you save some money for maternal health care services?
    (b) If No, Why don’t you save?

10. (a) Do you decide on the purchase and sell of family property?
    (b) If No, Why?

11. Which strategies can be put in place to improve maternal health in this area?

Thank you for your participation!!
Appendix IV

INTERVIEW GUIDE FOR MARRIED MEN

This research is purely for academic purpose and any information collected will be treated with high confidentiality.

Interview guide No……………………………………………………………
Location………………………………………………………………………..
Date of interview………………………………………………………………

1. Age…………………………

2. Education background

   No education   [  ]   Primary education   [  ]
   Secondary education   [  ]   Post-secondary education   [  ]

3. Why do pregnant women fail to attend the four required ANC visits?
   - I don’t know why
   - It’s their responsibility to know when to make such visits
   - Influence from their friends

4. How do men deal and participate in maternal health care issues?

5. (a) Where do you prefer your wife/partner to deliver?
   - Home
   - Traditional birth Attendant
   - Health facility

   b) Why do you prefer your wife to deliver in the chosen place above?

      Probing if it is home and TBA
6. (a) Which child sex does Kipsigis community prefer?
   
   Boy
   
   Girl

   (b) Why does the community prefer the above stated child?

7. (a) Do you give support to your wife when she is pregnant?

   (b) If yes which kind of support do you give them?

8. (a) Do you involve your wives on how family income should be spent?

   (b) If No, Why?

9. (a) Please indicate who owns family property below

<table>
<thead>
<tr>
<th>Type of property</th>
<th>Women</th>
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</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Tea plantations</td>
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</tbody>
</table>
(b) Who decide on the purchase and sale of family property.

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</table>

(c) Why don’t you involve your wives on decisions on purchase and sale of family property?

10. Which strategies can be put in place to reduce maternal health in this area?

Thank you!!
Appendix V

INTERVIEW GUIDE FOR THE HEALTH WORKERS AND LOCAL LEADERS

Respondent No…………………….

Location……………………………

1. Background information

(a) Gender

Male ( ) Female ( )

(b) Age ……………………

(c) Level of education…………………

2. Why is maternal mortality still being recorded in this area?

3. Why do some women still deliver at home or through the assistance of Traditional Birth Attendant?

4. Why do pregnant women fail to attend all the required 4+ ANC visits?

5. Which cultural factors contribute to the maternal deaths in this area?

6. Which social-economic factors contribute to the maternal deaths in this area?

7. (a) Do Kipsigis culture allow women to own property? (Local leaders only)

   (b) If No, why?

8. What do you think is the way to reduce maternal mortality in this area?
Appendix VI

INTERVIEW GUIDE FOR TBAs

Date of interview:………………………

Location:…………………………….

1. Background information

   • Age
   • Education status
   • Marital status

2. (a) Do you help some women deliver their babies?
    
       (b) If yes, would you please tell me why pregnant woman come for you assistance instead of going to deliver in the hospital?

3. (a) Do women come to you for ANC visits?
    
       (b) If yes why don’t they go to the hospital?

4. Do women get any support from their husbands during pregnancy and childbirth?

5. What do you think about giving birth at a health facility?

Thank you!!
Appendix VII

RESEARCH PERMIT

THIS IS TO CERTIFY THAT:

MS. CHELANGAT JACKLINE BII
of KENYATTA UNIVERSITY, 0-20210
LITEIN, has been permitted to conduct research in Kericho County on the topic: DETERMINANTS OF MATERNAL HEALTH IN AINAMOI CONSTITUENCY for the period ending:
31st March, 2015

Applicant’s Signature

National Commission for Science, Technology and Innovation

CONCLUSIONS

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do so may lead to the cancellation of your permit.

2. Government Officers will not be interviewed without prior appointment.

3. No questionnaire will be used unless it has been approved by Technology and Innovation Commission for Science, Technology and Innovation.

4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.

5. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice.

RESEARCH CLEARANCE PERMIT

Serial No. 3953

CONDITIONS: see back page