# Caring for the Unborn: Antenatal Care in a Socio-Cultural Context

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**Abstract**

The paper examines some of the pertinent socio-cultural factors that influence the care of unborn babies among the Luo people of Bondo District. It explores how women navigate the 'cultural forest' from the time of conception to the time of delivery and how that path is replete with obstacles potentially harmful to the lives of both the mother and the unborn.

Data was gathered through the direct observation and longitudinal follow-up of twenty five pregnant women recruited in the fourth months of pregnancy and followed up till 6 weeks after delivery. A basic demographic questionnaire was also administered to 100 lactating mothers. Other techniques employed included key informant interviews and narratives. The results from the survey were analyzed quantitatively while qualitative data were analyzed thematically and given meaning textually.

The results indicate that culture is a great impediment to proper care of the unborn and has a bigger bearing on the pregnancy outcome. Cultural issues such as the maternal diet, avoidance relationships, maternal workload, placental handling, cultural subordination of women and the institution of polygyny, all combine in one way or the other to place a lot of burden on the pregnant woman and determines subsequent outcomes. The paper concludes that giving birth in rural Kenya is replete with danger and is a life threatening process to many women.

**Key words:** Antenatal care, Luo people, Kenya

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## Introduction

Maternal health programs are today given high priority in international public health discourse. Despite this reality, maternal mortality and morbidity still remain a burden to reckon with in Sub-Saharan Africa. Recent report of WHO, UNICEF and UNFPA indicate that Sub-Saharan African women are 175 times more likely to die from complications in pregnancy and childbirth than their sisters in richer countries (Robert, 2003). In developing countries, millions of women do not have access to good quality health services during pregnancy and child birth despite the fact that most maternal deaths take place during this period (AbouZahr, 1997).

Motherhood should be a time of expectations and joy for a woman and her family. For women in developing countries however, the reality of motherhood is often grim. For these women, motherhood is often marred by unforeseen complications of pregnancy and childbirth. Some die in the prime period of their lives from haemorrhage, convulsions, obstructed labor or severe infection following delivery or unsafe abortion.

Several socio-cultural factors contribute to unsafe motherhood. Key among them is the health seeking behavior during pregnancy and

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delivery. Some of the recent studies have concluded that culture places a greater premium on maternal courage against all odds. Praises abound in several African cultures for women who give birth unaided or in very difficult circumstances where birth represents a rare opportunity for a woman to demonstrate the proverbial virtue of courage and honour to her husband and herself (Kyomuhendo, 2003).

Since every pregnant woman needs to have a healthy reproductive life and recognising that this is not presently the case, this paper explores the antenatal care provision and utilization in Nyang'oma Division of Bondo District. Maternal Mortality in Bondo District stands at 620/100,000 (Kenya Demographic Health Survey, 1998). The district is a malaria holoendemic region and poverty is prevalent.

**Methodology**

This was an exploratory study involving several data gathering techniques as shown in Table 1.

**Table 1**: Data by method used

| Method | Interviewed | Gender |
|---|---|---|
| Longitudinal follow-up | 25 women and their spouses | Female & Male |
| Questionnaire survey | 100 | Female |
| Focus Group Discussion | 10 | Female |
| Key informant interviews | 12 | 8 female & 4 male |
| Narratives/case histories | 12 | Female |

The core of the study involved a longitudinal follow-up of twenty-five pregnant mothers and their families till 6 weeks after delivery (from July 2002-July 2003). Other techniques included a questionnaire survey of one hundred lactating mothers, Focus Group Discussions, Key informant interviews and narratives. The women in the survey were conveniently and purposively sampled and interviewed either in their homes or exit interviews from health facilities.

In the community survey, questions revolved around the women's socio-economic status, information on antenatal and postnatal care, reproductive history, characteristics of the health facilities and the socio-cultural environment during pregnancy. The longitudinal follow-up involved observations and probing the women and their spouses on general problems faced by women, health care seeking patterns, work routine, familial dialogue, food preferences and avoidances, role of the "important others" or the therapy managing group and the cultural avoidance relationships. The women were also accompanied to the facilities and the distance covered recorded. Observations were also done on the provider-client interactions.

The key informant interviews included pregnancy practices in the community, health seeking patterns, traditional maternal health care practices, relationship between tradition and modernity among others. The FGDs concentrated on the food taboos and related avoidances, cost and accessibility to maternity services, female perception of maternity health care services and the quality of care. The narratives involved further probes to the women who had shown deeper interest in the topic and those who were more knowledgeable and willing to share information.

**Results**

**Maternal profiles**

Most women in both the longitudinal follow-up and the community survey were still very young. The mean age was 29.5 years with the majority (32% in the survey and 44% in the longitudinal follow up) falling in the 15-20

years category. The youngest respondent was 16 years and the oldest was 43 years old.

**Demand and Supply constraints in maternal health care**

Most women gave different reasons for not attending antenatal clinics. Most of the reasons can be classified as either demand or supply based constraints. These constraints are categorized as social, environmental and economic in nature.

The social constraints that were demand based included maternal ignorance, shame resulting from intimidation by providers, peer influence, husband's attitude, cultural adherence and previous safe motherhood experiences, religious prohibitions, mother in laws and 'important others' influence, heavy workload and the competing alternatives to the clinic time, availability of competing health-care alternatives, laziness and the subordinate female status in the community. It was noted that women do not determine on their own when to attend clinics. This results from the dependence on their spouses for funds and decision making and an array of other people who have to be consulted.

As noted, the age of the individual also influences their capacity to use maternal health care facilities. It was noted that the young mothers and more particularly the teenagers were reluctant in going to clinics for fear of being laughed at and scolded by their peers and the providers. This was also noted among the elderly and other multigravidas.

From the supply side, women reported some shortcomings that are facility and provider-based. These included poor services provision and lack of respect for clients, rumors about the negative effects of immunization and their consequences, side effects of the injections, hospital congestion and long waiting hours, drugs and other supplies unavailability, the lack of high level of professionalism and poor communication. It was common to hear women say that clinic children often die as a result of being immunized. In some communities, it has been rumored that clinics are meant for birth control and that women who go there have their reproductive capacities curtailed. This negatively affects ANC attendance.

Most women disagreed with the hospitals' prescribed birthing positions and the level of official control and the stifling bureaucracy.

Environmental, economic and spiritual reasons included distance to the facilities and the unbearable terrain, seasonality and bad weather, prohibitive costs, fatalism and the belief that God is the ultimate provider of health and that children are part and parcel of the divine intervention.

**Table 2**: Reasons for not attending ANC clinics

| Reasons for non attendance | No (%) |
|---|---|
| Provider inefficiency | 32 (32%) |
| Distance to facility | 18 (18%) |
| Poverty (lack of money) | 11 (11%) |
| Ignorance | 10 (10%) |
| Laziness/carelessness | 7 (7%) |
| Illiteracy | 7 (7%) |
| Availability of alternatives | 6 (6%) |
| Fear of injections, lab tests etc. | 4 (4%) |
| **TOTAL** | **100 (100%)** |

From Table 2, the highest number of respondents cited provider inefficiency as the reason for their lack of attendance. Distance to the facility was second highest with poverty also featuring prominently. Availability of alternatives included all the methods outside the institutional antenatal care provisions. This ranged from spiritual therapy, traditional masseurs and all the village professionals who competed or complemented the official antenatal care providers.

97% of the 100 respondents reported that they had attended an antenatal clinic at one

point in time during their pregnancy. Only three mothers reported that they had never stepped in an antenatal clinic in their lifetime.

The study explored further whether the clinic attendance was accompanied by delivery in a facility or with the assistance of a trained attendant. The picture indicates that clinic attendance was not always followed by clinic delivery (Table 3). In total, 56% of the respondents delivered outside the facility arrangement.

**Table 3**: Place of delivery

| **Place of delivery** | **N (%)** |
|---|---|
| Personal homes | 55 (55%) |
| Clinics | 44 (44%) |
| Religious places | 1 (1%) |
| **TOTAL** | **100 (100%)** |

From the longitudinal follow-up, other than the issues noted above in the methodology, women were closely observed on how they related to the antenatal care providers, their feeding patterns, and their relationship to other people in the household and the community at large, their perception of clinical care, their routine work load and daily domestic chores among others. They were also asked about their experiences with delivery, characteristics of the health facilities closer to them including issues of cost, client friendliness of the providers or lack of it among others. The results from this process are presented below.

**Interaction with antenatal health care providers**

Most women in the cohort had differing views on their interaction with the antenatal health care providers during their pregnancy. Most of them reported that they only attend clinic for the sake of getting the clinic card which acts as a 'passport' to emergency obstetric care during delivery. The attitude of the women can be summarised by one respondent who had this to say about clinics and the subsequent hospital deliveries:

> I attend clinics simply because they insist that you must have a clinic attendance card to be attended to in-case of any emergency. For this reason, since you may not be too sure of the whole process, you go there just in case your pregnancy becomes problematic. I gave birth to my first son in Nyang'oma clinic. I went there with my own '*nyamrerwa*' who was even barred from attending to me. The nurses who were supposed to be attending to me were all asleep and whenever my '*nyamrerwa*' tried waking them up, they were very indifferent, abusive and less concerned. My '*nyamrerwa*' is the person who ended up delivering me and I vowed never to go back there. When the time came to give birth to this child (3rd born son), I decided to simply do it at home where I was comfortable under the considerate care of my '*nyamrerwa*.' (A 26 year old mother of three).

The twenty two respondents were unanimous on the poor treatment they receive in the health care facilities and the fact that their *nyamrerwa* were not welcomed at the facilities. Each of them had memories of past neglect and un-satisfactory services provision. This in essence barred them from returning to antenatal clinics beyond the first visit for purposes of getting antenatal card.

The other mothers were of the opinion that health facilities offer their services against a backdrop of arrogance and an attitude that is discouraging to the health seekers. This position was summarized by one of the respondents who had this to say:

> Whenever you go to the clinic, you find very unwelcoming staff who arrive very late at work, do much gossiping and

> empty talk at the expense of the waiting patients and when they begin offering services, they are sluggish, not professional and practice favoritism, more over, they lack basic facilities, are abusive, authoritarian and above all, the supplies are never there. (A 32 year old mother of four).

In a sample of 25 mothers only three expressed satisfaction with antenatal care and the subsequent facility delivery. All of the three had attended the clinics previously out of District and they had very unforgettable experiences in the facilities they had attended before. One of the mothers had this to say:

> During my second delivery, I did not attend clinic till the 9th month. When I went, the baby was discovered to be lying in a bad position. The nurses however advised me to just go back home. Complications developed on the day of delivery and I had to be rushed to the provincial hospital from where I got help. I promised myself that I would always be punctual with antenatal visits. (A 24 year old mother of two).

Besides the complaints about service delivery, most clinics were observed to be located far away from the two villages of Orengo and Sirongo. The average distance covered by most women in the longitudinal follow up was between 8-10 kilometres. Over 80% of the 25 respondents covered more than 8 kilometres to the clinics. The terrain was unbearable and means of transport unreliable. Mothers had to walk to clinics and at times used the *boda boda* (bicycle taxis).

**Avoidance relationship**

Among the Luo, avoidance relationship can be a hindrance to proper reproductive health. The culturally prescribed social space and avoidance relationship made Mary (all names have been changed to protect informant privacy) suffer during delivery.

> Mary was a 27 year old mother of four whose husband was in town searching for wage labour. She was in their rural home staying with her step mother-in law. Mary had been pregnant but only consulted a *'Nyamrerwa'* and did not know that she was expecting twins. On this material day, Mary managed to successfully deliver the first bouncing baby boy at dawn with the help of her *'Nyamrerwa'*. Her pain did not stop and the afterbirth did not come out. This continued with those present hoping that things will work out. By 4 p.m., nothing was forthcoming and they were now getting worried and she was getting too tired and frail. The only men in the extended kin available were related to Mary as fathers-in-law and avoidance relationship had to be observed. As her fathers-in-law, they could therefore, not get in direct bodily contact with her to take her to the dispensary on a bicycle or a wheelbarrow which were the only means of transport available. They claimed that in her condition, she was "dirty and impure" and getting in contact with her would lead to untreatable *"chira"* for breaking the avoidance taboo. The research team intervened and by the use of their bicycles, took Mary to the dispensary where she successfully delivered her second baby at around 7.30 p.m.

The TBA and other women present rationalized the behavior of the men by reporting that birth as a process among the Luo at the communal level is the concern of women and it is where women derive their power and strength. Rarely are the men involved in the process unless complications arise requiring spiritual and ancestral intervention.

Later, when it was realized that Mary had twins, the men congratulated themselves for not having been involved as the process of

cleansing themselves would have been very expensive as twins are seen as a bad omen and difficult to bring up and requiring elaborate cultural rituals.

The above examples exemplifies the degree to which cultural avoidance relationships become sites of ill health and lack of assistance to needy women in pregnancy.

**Domestic workload**

Most women in the cohort were also engaged in a variety of domestic and public domain assignments. Those in the beach areas of Sirongo were engaged in petty trade such as drying and selling of *omena*. They also did hawking of fish, tended their kitchen gardens, did domestic chores such as washing clothes, cleaning of the house, fetching water from the lake and preparing food for all the family members among others. Their daily routines were not in tandem with their pregnancy status. Those from Orengo village who were in their own homes also went gardening and tended the family livestock besides routine domestic chores. They performed tasks that rarely gave them time to rest. This tied well with the overall cultural idea of being 'hardy' to the end. One respondent commented thus:

> 'Whenever I am pregnant, I have to prove myself, I have to be strong and to provide for my husband or else you lose him permanently to your core wife' (24 year old 2nd wife).

The second respondent who underscored the essence of the proverbial virtue of being enduring and giving birth honorably commented:

> "As a woman, I have to be able to ensure that the entire family is well fed and that pregnancy alone does not interfere with that cultural responsibility. People have always given birth and will continue doing so. A child can be born anywhere whether in the garden or in the forest while fetching firewood or on your way to the market. We Luos have always been taught to give birth honourably" (26 year old mother of three).

**Prenatal Nutrition**

Most women reported that they avoided certain food items during pregnancy. Some of them craved for certain food items and culture also imposed certain prescriptions and proscriptions on maternal nutrition. Some of the foods that were frequently mentioned as worth avoiding included *mandazi*, ripe bananas, avocados, mangoes, sugar cane, milk, meat from a pregnant animal, groundnuts, and meat from animals that die alone in the bush, too much porridge and *chapati* among others.

The most frequent reason given for food avoidance was that they cause the baby to be too big and therefore cause problems during delivery. Another reason for avoiding meat from animals that die in pregnancy is that similar fate may befall the pregnant women during delivery. Sugar cane is believed to lead to the birth of a baby whose body is segmented.

Some mothers reported dislike for certain foods such as fish, *dagaa*, tea, milk and vegetable such as kales. Two key informants reported that some foods are highly recommended during pregnancy. These were flowy vegetables (*Apoth*), beans, milk, eggs and fruits such as paw paw and oranges. These foods were seen to provide additional protein and iron necessary for the proper development of the foetus. Eggs were sometimes avoided because of their association with the reproductive functions and because of the fear that the child to be born would be very greedy and a 'thief' in future. Some women reported that they craved for certain food items and soil during pregnancy.

**Gender-Power Imbalance**

The study found out that most women feel powerless and unable to make informed

choices and decisions regarding their conditions. Some in the longitudinal follow-up failed to attend clinics because they had been waiting for permission from their husbands who were away on fishing expeditions. Others believed that their fate was now tied with that of their husbands to an extent that they behaved as if attending the clinics would be in the best interest of their spouses other than themselves. One respondent had this to say:

> I cannot go to the clinic now though the days have passed. I have to wait for my husband or else he may be very cross with me, he will demand to know where I got the money and by the way, even if I were to die in pregnancy, it is upon him. He married me and he has to take good care of me. (22 year old mother of two).

Other than a woman's own husband, there are other centers of power that a woman has to confront in exercising her freedom of choice in the facility to attend. This results from the dependence on a larger network of therapy managing group. Important in this group is the mother-in-law. She is not only a reservoir of cultural knowledge on reproduction issues who must be consulted but also a powerful force whose authority is necessary and must be sought before a decision is made. This makes the pregnant woman a mere spectator in her own pregnancy. Achieng' (a 20 year old expecting her second child) had this to say:

> My mother-in-law determines where and when I go for check up. When I recently spent two days indoors, she came and quarreled me telling me to be strong and to stop being too weak. She reminded me of how in the olden days, they would work till delivery and that the clinics were never there but they were still able to deliver successfully. She instead recommended a massage and pot medicine for my pain.

About clinic attendance, men also had their misgivings. Men saw clinics as places where their spouses were taught family planning methods; others saw it as excuses to extort money from them. One of my respondent's spouse complained bitterly how his wife conned him of 500 Kenya shillings (about 6.30 dollars) lying that the money was needed in the dispensary but when he followed up, he found out that only 50 shillings was required. He also accused the wife of infidelity. This is what he said:

> Women lie to us about the cost of services just to extort money from us; they also take the opportunity to roam around in groups and even try to see other people behind our backs in the name of going to clinic. When you insist that you want to accompany them, they change the dates. (25 year old father of two).

Polygyny is a common practice in the community. This gave rise to jealous co-wives who at times made the pregnancy process heavier than necessary. Most women complained that their spouses had extra-marital affairs thus exposing them to health risks. Take the case of Anyango who was 18 years of age; she was married as a second wife to a man who was engaged in long distance cattle trade. When she visited antenatal clinic, she was diagnosed to be suffering from sexually transmitted infections and requested to come along with her husband. When she reported back this to him, she was beaten and accused of being unfaithful and a disgrace to the family. She was even told that her co-wife was not complaining and was well. The husband sent her away instead of listening to her and seeking medical care. This resulted from the patriarchal nature of our society and the subordinate status of women in the Luo community.

**Discussion**

From the foregoing, it is evident that the process of pregnancy is a key area in understanding safe motherhood at the local level. Several scholars have also previously reported barriers to proper antenatal care (Magadi *et al.*, 2000; Magadi, 2003; Suda, 1997; Owino, 2003). Some of the significant barriers include physical, financial and socio-cultural factors that prevent women from using the existing maternal health care services.

Distance and lack of transport has been reported by Family Care International (1997) in the Safe Motherhood General Fact Sheet, and their Technical Fact Sheets as contributing factors to improper clinical attendance. Nearly 80% of rural women live more than five kilometers from the nearest hospital and many have no way of getting to health facilities except by walking—even when they are in labour (World Development Report, 1994).

Although nutrition is an important aspect of good health, of all the periods in the life cycle, pregnancy is one of the most critical and unique. During this period, food is very essential to life and growth. Changes that occur during pregnancy have a great influence on nutritional needs and have a bearing on the reproductive performance. Dietary advice in pregnancy is influenced by beliefs that obvious physical properties of different foods could produce specific effects on the mother or child. The beliefs are often coloured by the emotional and mystical aura surrounding the pregnant state. The food beliefs limit the range of foods that can be used by the pregnant woman hence endangering their lives. As seen in the results, women are not getting enough food supply to aid in their good health during pregnancy. Other scholars (Castello, 1986; Allen, 2002; IOM, 1990; Anna, 1996 and Neema, 1994) have previously reported the importance of maternal nutrition in pregnancy and the subsequent childbirth. Castello, for instance, noted that maternal nutrition plays a central role in the determination of child health and survival and its influence is exerted directly during pregnancy and later indirectly during lactation.

As elaborately underscored by AbouZahr (1997) and Kyomuhendo (2003), socio-cultural factors are a great hindrance to proper antenatal care. Health services often do not respect women's cultural preferences, for example, for privacy, birthing position or treatment by women providers. Women's power to decide when to seek care is restricted in many parts of the world (Jolly and Kalpana, 1998; Ojunaga and Gilbert, 1992; Gottschang, 2000). Gottschang (2000) writing about China notes that in most situations, women are invincible as agents in themselves but as relegated to physical bodies through which the nation can reproduce and develop. In a similar view, Jaggar (1989) noted that in most cultures, pregnant women "are viewed less as individuals" than as the "raw material" from which the "product" is extracted.

As indicated in the results, women within the study area have a lot of socio-cultural restrictions that do not adequately allow them to exercise their freedom of choice. They have to seek permission from their spouses or mothers-in-law to go to clinic. They also have limited resources and see pregnancy as a normal condition requiring limited or no medical intervention.

As indicated, most women delivered in their own homes. Their going to clinics gave them the opportunity to obtain the clinic attendance cards that acted as 'passports' to professionalized care in the event of any obstetric complications during delivery. The emerging pattern clearly shows that women have developed means and methods of resisting the 'overmedicalization' of pregnancy and childbirth and the control exerted by the biomedical institutions and their agents. The

prevalence of home deliveries and the low attendance of antenatal clinics is a clear manifestation of this resistance. Home deliveries are seen to accord women greater control over their reproductive health and the entire process is in the hands of women—the parturient woman, her female kin and the midwives.

Home deliveries conform to the post delivery disposal of the placenta and other afterbirths in the most appropriate cultural ways. It gives women the opportunity to have some stakes and to prepare the newborn for the ultimate inheritance within the lineage system.

Several feminist scholars (Davis-Floyd 1992, Martin 1992, Conrad 1992) have noted that the struggle for control over reproduction has continuously been negotiated by an array of local, national and international interests. They note that the process has challenged the cultural conventional thoughts and practices thereby stretching the dominant social ideologies in which biologization, technologization and medicalization of pregnancy and childbirth has been accomplished.

One of the most recurring themes in researches on maternal health care is the question of the quality of care. Poor quality is one of the most common reasons why women do not seek care or seek it late. Quality care covers issues of chronic shortages (inadequate staff, equipment, drugs and basic supplies, poorly trained health facility staff who lack basic clinical life saving skills and finally, providers who are rude (unsympathetic, uncaring and do not attend to their duties). Women, as conscious agents of their health status, tend to resist and respond to the inefficiencies in ways appropriate to them. The most visible is avoiding the clinics and the medical system all together.

**Conclusion and Recommendation**

The results of the study clearly indicate that the process of conception, pregnancy and delivery in rural Kenya is replete with danger and can be a life threatening exercise. Now that safe motherhood has been embraced by governments all over the world including Kenya, there is a need to either introduce or strengthen the existing programs that reduce maternal deaths, improve reproductive health services and protect and promote women's health and well-being especially during pregnancy and childbirth.

Efforts to improve the quality of care must find a balance and avoid 'overmedicalization' of maternal health, which occurs when specialized interventions and technologies are used routinely. Given the importance attached to childbirth and its centrality in the continuation of the human species, the following actions can aid in addressing the plight of women during their most cherished state. For the health facilities, efforts should be made to locate them in accessible locations and to address the issue of distance, ensure that they all offer affordable, high quality services, build a functioning referral system and invest in the provision of necessary supplies and equipment.

On the quality of services and behavior of health providers, re-training is necessary to make sure that service providers are respectful of—and responsive to—women's needs, preferences and cultural beliefs. Culturally competent communication that respects the client is necessary here and all providers need to have cultural knowledge of their areas of jurisdiction.

At the policy level, the authorities must enforce standards and protocols for services delivery. There has to be proper management and supervision in a friendly environment that utilizes the feedback from clients to maintain and evaluate services quality.

At the community level, education should be provided to women and community members on the importance of maternal health, availability of safe motherhood services, and

the need for women to have decision making power over their own health and life choices. Specifically and in a very special way, target men with reproductive health education. Make them understand their roles and expectations in child birth. On the whole, efforts should be made at all levels to bring the plight of women more particularly during their periods of pregnancy to greater focus and to the national debates on health care.

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