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Traditional maternal health care practices and antenatal and postnatal care in Mwingi central sub-county, Kitui county

Authors: [1]Mary Syokoli Mutisya, [2]Johnson Nzau Mavole and [3]Urbanus Mwinzi Ndolo
[123]The Catholic University Of Eastern Africa. P.O BOX 62157-00200 Nairobi, Kenya
Corresponding author's Email: mmutisya34@gmail.com

Abstract

The purpose of the study was to establish the role of traditional maternal health care practices and antenatal and postnatal care in Mwingi Central Sub-County, Kitui County. The following objectives guided the study; to examine the effects of traditional medical practices on antenatal and postnatal care and to investigate the influence of traditional beliefs on food and nutrition on antenatal and postnatal care in Mwingi Central Sub-County. The study used descriptive survey research design. The target population comprised of expectant, lactating mothers and those with children below five years of age, fathers caring for their children below five years of age, traditional and conventional health care givers. Mixed method was used for data collection where questionnaires and interview guides were used as the research instruments. From the five wards, the researcher used 30% of these wards and randomly selected two wards to carry out the study (Mwingi Central and Kivou) wards. Through Census method, all the public health care institutions in the two wards were selected for the study due to their uniqueness. Conveniently, twenty conventional health care workers, 258 traditional medical practitioners and 78 members of the general public. They responded to questionnaires through face to face techniques done by the trained researchers. Interviews were also done with the traditional health care givers and the parents until saturated information was collected. The study found out that, 142(39.4%) of the respondents agreed that there are antenatal clinic visit barriers in their community. Further, 239 (66.4%) agreed that expectant women visit conventional health centers for their general treatment while 129 (35.8%) of the respondents agreed that expectant women visit traditional medical practitioners for their general health treatment. Majority of the respondents 298 (82.8%) agreed that there are prohibited foods for pregnant women in their community. The study concluded that there are antenatal clinic visit barriers in their community. Expectant women visit both conventional health centers and traditional medical practitioners for their general treatment. There are also prohibited foods for pregnant and lactating women in their community The study recommends that the government's health policy should clearly stipulate the roles played by the various health practitioners in the Sub-County. It also recommended that the government should organize for continuous trainings for the health care practitioners both traditional and conventional especially in the rural areas. The study recommends further that, traditional birth attendants be provided with delivery kits to help women who deliver in the rural areas.

Key terms: *Traditional maternal health care practices, antenatal care and postnatal care*

Introduction

1.1. Background of the Study

According to Marks et al in WHO (2005), health is a complete state of economic, physical, psychosocial, cultural and spiritual well-being and not merely the absence of disease or infirmity. Traditional and alternative health care (2010) defines African traditional medicine as the sum total of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental, or societal imbalance, and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing. Silwal (2011) on maternal health care practices among indigenous people in Nepal, India accounts that, local people are marginalized in the conventional health care service delivery systems. In such cases, women tend to get help from the traditional health care workers. In 2014, Ferdinard, Geoffrey and Christoper on traditional birth attendants and women health practices in Patani, Southern Nigeria, found out that despite existence of modern health care facilities in Nigeria, over 58% of deliveries took place at home where as 37% took place in Hospitals. The responsibility of care is therefore left to the traditional birth attendants in rural communities. In Tanzania, a study was done to ascertain the influence of customs and practices during pregnancy. It was concluded that, traditional and modern perceptions compromised maternal care and experiences in Kilimanjaro region. Women recognized the importance of institutional delivery but also appreciated cultural practices related to child birth. They integrated medical approaches by health professionals and traditional approaches by the family in childbirth. (Ohnish, Oishi and Leshabari, 2014)

According to Okoth (2014) on the utilization of skilled birth attendants among women of reproductive age in central division, Kajiado County, Kenya, the proportion of births assisted by skilled birth attendants in Kenya was 44% while in Kajiado Central Sub County was 28%. In Kitui County, Kanini (2012) claims that, barriers to utilization of skilled birth attendants included; lack of training of traditional birth attendants who provided free or cheap services at the comfort of their own homes, emergency nature of labor, lack of coordinated and complicated referral systems, poor and unreliable means of transport incase labor starts at night, limited infrastructure, and limited number of skilled birth attendants due to high turnover. The above scholars have shown the relevance of traditional birth attendants on the health of child and the mother. None of the above scholars has investigated on the influence of gender roles and traditional religious beliefs on antenatal and post-natal care in Mwingi Central Sub-County. This study will investigate the influence of traditional maternal health practices and on antenatal and post-natal care in Mwingi Central Sub-County.

1.2 Statement of the Problem

Integrated health care service delivery is the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly to achieve the desired results and provide value for their money. Maternal health care practices among the rural poor communities call for consideration of the integrated concept. Due to poor distribution of Conventional maternal and Child health care services in Mwingi Central Sub-County, there is lack of proper integration of conventional and traditional healthcare care practices. This creates a need to integrate the acceptable traditional maternal health care practices hence complementing the existing effort of mother and child health care.

Traditional health care providers are not viewed as dependable resource in maternal and child healthcare provision. The current health policy (2013-2030) has not identified the role of traditional healthcare workers in maternal and child healthcare either in training or service delivery yet a certain population depends on their services. There is a belief system that conventional medicine is viewed as the only source of quality health care. Few researchers have carried out similar research in the study area. Since the introduction of conventional medical care, traditional health care workers have faced some challenges in their practice. They lose societal trust even though some of them have been trusted to deliver quality health care especially the traditional birth attendants.

According to KNBS ICF Macro, (2010), skilled birth attendance in Kenya has increased from 42% to 44%. Maternal mortality ratio has increased from 414 to 488 per 100,000 live births over the five year period in Kenya. Similarly, Infant Mortality Rate has decreased sharply from 77 to 52 per 1,000 births and Neonatal Mortality Rate from 33 to 31 per 1,000 births in the same period. As per the Kitui District statistics (2009), utilization of skilled birth attendants is at 22%. Many

of the maternal deaths, neonatal deaths and infant deaths are related to the poor health of the woman and inadequate care during pregnancy, at childbirth and the postpartum period (Warren and Lambila, 2004). A mother's death can seriously compromise the survival of her children. It has been observed that the utilization of traditional health care skills may contribute to reducing maternal mortality ratio and neonatal mortality ratio. The role of integrated system where the traditional and modern approaches to maternal health care are complementing each other is crucial in decreasing mortality and morbidity rates of both mother and the child in Mwingi Central Sub County. Relevance of traditional maternal health care is most of the time known to implicate negatively on the health of the mother and the child. After review of empirical literature on this topic, not many authors have written on the relevance of gender roles, food and nutrition, effects of traditional medical practices and religious beliefs on antenatal and post-natal care. There is interventional a gap in that Mwingi central sub county has poor distribution of conventional medical care services hence the utilization of traditional health care services by the residents.

1.3 Research Objectives

Broad Objective

The broad objective of this study was to investigate on the relevance of traditional maternal health practices to the antenatal and post-natal care in Mwingi Central Sub-County.

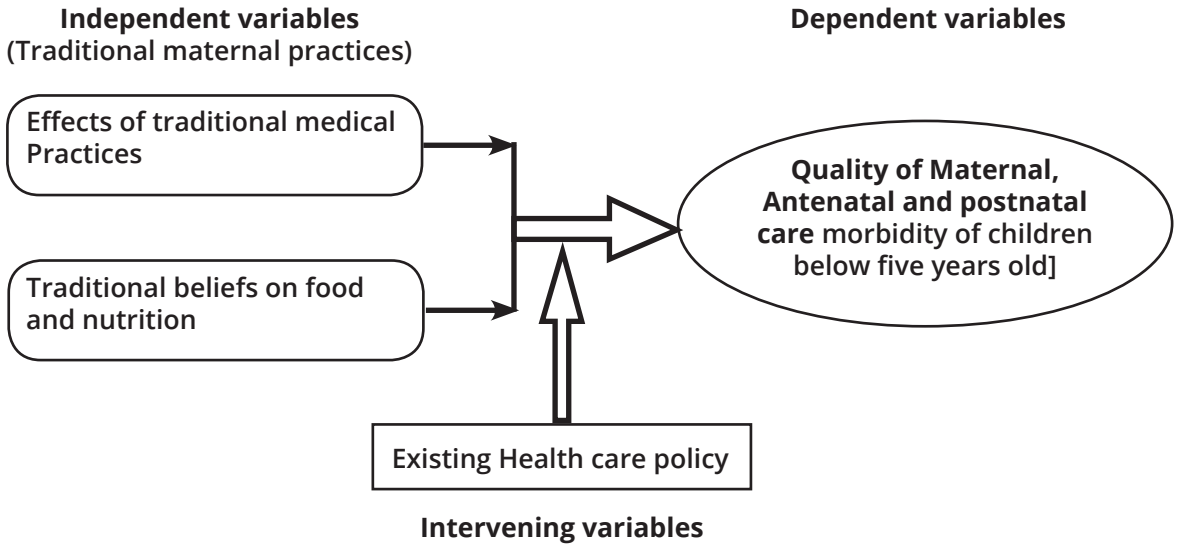
Specific objectives

To achieve the broad objective above, this research was guided by the following specific objectives:

a) To examine the effects of traditional medical practices on antenatal and post-natal care in Mwingi central Sub-County, Kitui County.
b) To investigate on the influence of traditional beliefs on food and nutrition on antenatal and post-natal care in Mwingi Central Sub-County, Kitui County.

1.4 Conceptual Framework

Figure 1 | *Conceptual Framework*



Source: Research data, 2017

It was conceptualized that, independent variables in this study influenced the depended Variable either negatively or positively. Effects of traditional medical practices are thought to determine the health of mothers and children negatively or positively. It was assumed that, traditional beliefs on food and nutrition by the residents of Mwingi central Sub County affect the health of mothers and children positively or negatively. In the interaction process of these variables (both dependent and independent), the existing health care policy is a great determinant on the quality health care in Mwingi Central Sub County.

Literature Review

2.1 Theoretical framework

Health Belief model (HBM) This theory was developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels. It explains and predicts health behaviors such as traditional beliefs that they cannot access conventional medical services. This theory, however, does not explain about moderation of behavior in the process of health care utilization.

Theory of Reasoned Action by Ajzen and Fishbein (1972) predicts an individual's intention to engage in a behavior in a specific time and place. Behaviors over which people have the ability to exert self-control. HBM did not explain how people moderate their attitudes and therefore brings moderation of the belief system.

2.2 Empirical literature

Effects of traditional medical practices on the health of the mother and children below five years

Traditional medical practices have diverse effects on the expectant mother as well as the unborn and new born babies below five years. There are some practices that impact positively and others negatively. Studies all over the world have confirmed this assertion. In India, Reshma and Sujatha (2014) did a study on the cultural practices and beliefs on newborn care among mothers in selected hospitals in Mangalore taluk and found out that, there was a strong relationship between the demographic variables (type of family and religion) and cultural practices and beliefs on newborn care among mothers, this was calling for periodical health education regarding do's and don'ts of newborn care be conducted in postnatal ward, which definitely would minimize the unhealthy traditional practices.

Further, the cultural practices and beliefs regarding feeding revealed that the highest percentage of the mothers gave home remedies for digestion and the lowest percentage of the mothers fed babies with milk mixed with *"kumkumkesar"* (a popular spice among the indians). In the same study, it was revealed that, the highest percentage (87) 55% of the mothers applied ashes or soot or powder or dry cow dung on the umbilical cord of the baby and the lowest percentage (8), 5% made the fathers to place his fore finger on the baby's umbilical cord to invert it if the umbilical cord was not inverted. The cultural practices and beliefs in care during jaundice revealed that the highest percentage of the mothers exposed the baby to sun light when the baby's skin turned yellow and the lowest percentage of the mothers dressed the baby with yellow clothes during jaundice. To prevent "evil eye" the highest percentage of the mothers applied *Kajal* on the baby's face to prevent bad eye and lowest percentage tied a thread with *panchaloham* to the baby.

A study carried out on 2013 by Tagoe-Darko, Razak and Gyasi on traditional teachings and practices for Child Health in Ghana revealed that, there are traditional beliefs and practices in all areas, including health in general and child health in parts. These practices included breastfeeding, massaging and postpartum sexual abstinence, for the health of the suckling infant and toddler, while socialization of good hygiene and nutrition practice was initiated and encouraged for the growing child. These reflected the values and beliefs held by members of the community for periods often spanning generations. Such practices recognized the critical importance of children's right to health and survival, an issue at the heart of the UN charter on the right of the child. The results from the study implicated on health policy and planning regarding the incorporation of traditional health teachings and practices into the child health aspect of Primary Health Care programmes and the UN convention on the rights of the child.

Ngimbudzi, Lukumay, Muriithi, Dhamani, Petrucka (2016) in a study about *Mothers' Knowledge, Beliefs, and Practices on Causes and Prevention of Anemia in Children Aged 6 - 59 Months* at Mkuranga District Hospital, Tanzania, confirmed that, cultural beliefs expressed related to causes of anemia included witchcraft, local remedies (herbal preparations), and

exclusion of certain foods (i.e., lemons). Further, in the same study, only 55% of mothers in this associated anemia with feeding practices, half of the study participants (50%) reported that they were still breastfeeding their children, although a predictable weaning pattern emerged including maize porridge, ugali (a stiff porridge), and beans. As the primary caregivers, most mothers (72.5%) reported three feeds per day. The study further asserted that, mothers (65.0%) were the main persons responsible for feeding the child with nearly three-quarters (72.5%) of children being fed three times a day. Health care accessed for anemia was most frequently an over the counter medication followed by access to services at a dispensary (primary health care) level.

Mituko (2013), on utilization of unskilled birth attendants' services among women in Mbirikani division, Loitokitok district of Kajiado County, Kenya, found out that majority of women were utilizing Unskilled Birth Attendants services despite policy actions in reproductive health , largely due to low literacy levels and cultural influence. From review of Mituko (2013), it was concluded that women were utilizing unskilled birth attendants due to low literacy levels and cultural influence. This leads to a contextual gap in that it was done in a different culture (Maasai) other than the one (Kamba) that was be studied in Mwingi central county.

In 2013, Fedha carried out a study on the influence of cultural traditions on the reproductive health of Somali women refugees in Nairobi County, Kenya found out that Traditional Birth Attendants attitudes towards family planning, female genital mutilation and food taboos were found to influence the reproductive health of Somali refugee women and that Cultural beliefs and misconceptions play a key role in continued use of traditional birth attendants in provision of reproductive healthcare, observance of food taboos and low use of contraceptive to prevent unwanted pregnancies thus exposing women to risk pregnancies. Imera (2016) conducted a study on the knowledge, attitude and practices of mothers with malnourished children less than thirty six months regarding breastfeeding and complementary feeding in Kitui county hospital. This study found out that food restrictions due to cultural beliefs are often greater determinants of malnutrition than even the availability of food. Information on how to feed young children comes from family members, community practices and health workers. From the study, it was concluded that, education positively affects the correct timing of initiation of complementary feeds. A gap in the target population was identified from Imera's (2016) study in that it targeted mothers with children of less than thirty six months while this study targets children of five years of age and below in Mwingi sub county. A thematic gap has been identified in Imera's study since he investigated on the knowledge; attitude and practices of mothers but this study will be more on traditional practices and their effects on mother and child. This means that the concentration of themes is different although the physical context is similar (Kitui County).

Beliefs on food and nutrition on Maternal, antenatal and postnatal care

Culture is defined as peoples' way of life. Among the important elements of culture are belief systems, values, norms, language, clothing, and food and nutrition. Childcare practices of a mother, which could be traced to her ethnic membership, can affect the way in which children are exposed to the contaminants in the household environment. Ethnicity is an important maternal characteristic that can create differences in child care practices. Maternal beliefs and attitude are dictated by some cultural practices acquired within the family setting. This varies greatly from one society to another because societal norms, values and beliefs, which tend to shape the decisions of individual members, differ within and across communities.

Nisha, *et al* (2015) on a qualitative study to investigate the influence of beliefs and practices regarding nutrition during pregnancy and lactation in a rural area in Karnataka, India, conducted a total of four focus group discussions and twelve interviews. From the findings, good practices included consuming green leafy vegetables, rice, bread, *jowar,* meat, eggs and fruits like apple and *mosambi*. The practices which may have had a potential harm to the health included avoidance of food items like *ragi,* papaya, mango and guava during pregnancy and reduced water consumption during the post-natal period. Beliefs like "casting an evil eye" or "colour of the baby" had an influence on the food given to antenatal mother. A contextual gap was identified from Nisha's study of 2015 on the influence of beliefs and practices regarding nutrition during pregnancy in India. This study was carried out in India where people have different cultural beliefs on food which are different from the cultural beliefs on food held by the mothers of Mwingi central sub county. There is a specific gap in that the foods consumed in India a different from those consumed by people of Mwingi central sub county.

Choudhry (1997) claims that, in India, consumption of milk, butter, ghee and some types of fish is encouraged due to the belief that these foods will increase the quantity and quality of breast milk. Nutrition-related practices during pregnancy are based on a belief that 'hot' foods are harmful and 'cold' foods are beneficial. Because pregnancy generates a hot state, pregnant women are advised to attain balance by eating cold food and avoiding hot food. Cold foods are recommended in early pregnancy to avoid miscarriage. Hot foods are encouraged during the last stages of pregnancy to facilitate labor. Nutrition-related practices during pregnancy are based on a belief that 'hot' foods are harmful and 'cold' foods are beneficial. Because pregnancy generates a hot state, pregnant women are advised to attain balance by eating cold food and avoiding hot food. Cold foods are recommended in early pregnancy to avoid miscarriage. Hot foods are encouraged during the last stages of pregnancy to facilitate labour. Some women believe that excessive eating during pregnancy may result in a large foetus and difficult labour. Some women believe that excessive eating during pregnancy may result in a large foetus and difficult labour.

Ajala (2002) pointed out that there are some other constraints on full implementation of breastfeeding by mothers which have some cultural undertone in Nigeria. He stated that constraint on breastfeeding include strenuous work undertaken by mothers, poor feeding habits of the mother and lack of the male supportive role. Even though older women in most of the ethnic groups cook and provide adequate care for mothers after the delivery for 40 days with the belief that variety of food will restore the lost nutrient during pregnancy, restriction on some certain food for mothers can cause malnutrition to the mother and child. Further, among some groups in Nigeria, traditional breastfeeding weaning practices can be detrimental to the health of children.

In Tanzania, UNICEF (2010) on Children and Women in Tanzania confirmed that, unlike child survival, very little progress has been made in reducing chronic malnutrition. About four out of ten children in Tanzania are stunted, denying these children the opportunity to develop to their full mental and physical potential. The most harm occurs during pregnancy and in the first two years of a child's life. Malnutrition is also linked to one-third of all under-five deaths, making it the single largest cause of under-five deaths in Tanzania. Yet, simple, cost-effective, affordable interventions are available that can have lasting impact on a child's prospect. Further, UNICEF ascertains that, exclusive breastfeeding initiated within one hour of birth and continuing for six months is the most effective life-saving intervention. In addition, to breastfeeding – which optimally should continue until two years of age – young children from six months of age need to be fed frequently and given a variety of foods to prevent malnutrition.

A thematic gap has been identified from the study by UNICEF (2010) in Tanzania which stated that Tanzania made little progress in reducing children malnutrition. This gap is seen because the study was only concerned with nutrition but this study will focus on the traditional health care practices and the health of the mother and children below five years of age in Mwingi Sub County. An estimated 35% of children less than 5 years of age in Kenya are stunted, 16% are underweight and 7% are wasted (KNBS and ICF Macro, 2010). Lack of appropriate breastfeeding and complementary feeding practices are main causes of Under-nutrition. Inappropriate breastfeeding and complementary feeding practices can also initiate the problem of overweight and obesity that may only become most apparent in children beyond the age of 2 years. Kenya is among many countries that suffer from the double burden of both types of malnutrition.

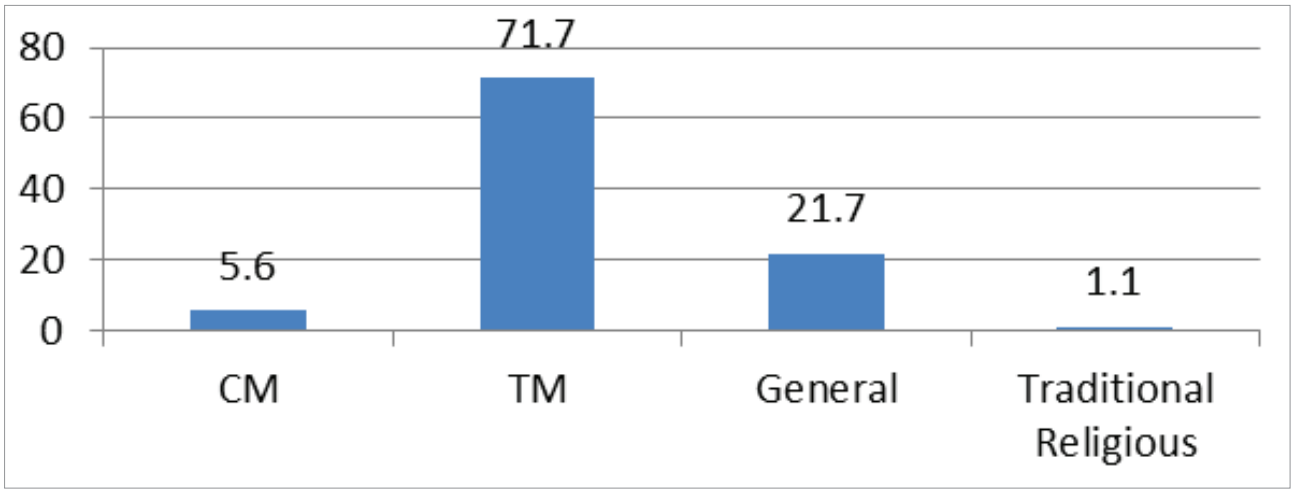
Materials and Methods

The study used descriptive survey research design. The target population comprised of expectant, lactating mothers and those with children below five years of age, fathers caring for their children below five years of age, traditional and conventional health care givers. Mixed method was used for data collection where questionnaires and interview guides were used as the research instruments. From the five wards, the researcher used 30% of these wards and randomly selected two wards to carry out the study (Mwingi Central and Kivou) wards. Through Census method, all the public health care institutions in the two wards were selected for the study due to their uniqueness. Conveniently, twenty conventional health care workers, 258 traditional medical practitioners and 78 members of the general public. They responded to questionnaires through face to face techniques done by the trained researchers. Interviews were also done with the traditional health care givers and the parents until saturation of information.

Results and Discussions

Category of Health Workers

Figure 2 | *Category of Health Workers (Percentage)*

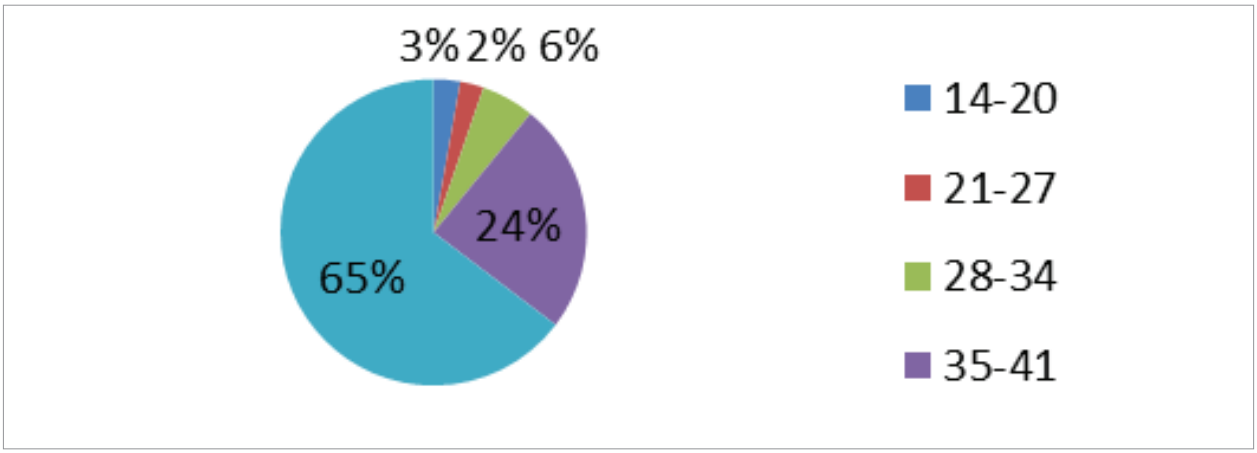


Source: Research data, 2017

Figure 2 shows that majority of the respondents are traditional medical practitioners (71.7% or 258 respondents), followed by general health workers (21.7% or 78 respondents), conventional medical health care providers (5.6% or 20 respondents) and religious leaders (1.1% or 4 respondents).

Age of the Respondents

Figure 3 | *Age of the Respondents*



Source: Research data, 2017

Age of the respondents is one of the most important characteristics in understanding their views about the particular problems. It indicates level of maturity of individuals in that sense age becomes more important to examine the response. Figure 5 shows age group of the respondents. It shows that the majority of the respondents fall under the age group category of 42 years and above (accounted for 64.7% or 233 respondents), followed by the age group of 35 - 41 years old (24.4% or 88 respondents), 28 - 34 years old (5.6% or 20 respondents), age group of 14 – 20 years old (2.8% or 2.8 respondents) and 21 – 27 years old (2.5% or 9 respondents).

Traditional Medical Practices and Antenatal and Postnatal Care

Measurement of central tendencies was used to discover the respondents view in relation to traditional medical practices and antenatal and postnatal care. All the questions were asked using a 5-point Likert scale with 1 indicating - strongly disagree, 2 indicating – disagree, 3 indicating – neutral, 4 indicating – agree and 5 indicating – strongly agree. A total of 32 questions with particular mean score were obtained from the SPSS output. The percentages of responses for each of the items for traditional practices on antenatal and postnatal care are shown in Table 1.

Table 1 | *Traditional Practices on Antenatal and Postnatal Care*

Items	**SD (%)**	**D (%)**	**N (%)**	**A (%)**	**SA (%)**
There are antenatal clinic visit barriers	1.7	15.6	16.4	39.4	26.9
Majority of the expectant women visit conventional health centers for their general treatment	0.6	0.6	8.1	66.4	24.4
Some of the expectant women visit traditional medical practitioners for their general treatment	5.8	13.3	21.1	35.8	22.2
Most of the parents complete well baby and mother clinic as per the health policy	0.6	13.6	6.4	44.2	35.3
Some of the parents do not consult traditional medical practitioners for the health of their children below five years of age	1.1	13.3	30.3	43.1	12.2
Most of the health care workers give adequate information on the nutrition of the mothers and the child	-	3.6	2.2	54.7	39.4
Most of the traditional medical workers give adequate information on the nutrition of the mothers and the child	6.7	11.7	27.8	29.4	24.4

Source: Research data, 2017

Key: SD = Strongly Disagree; D = Disagree; N = Neutral; A= Agree

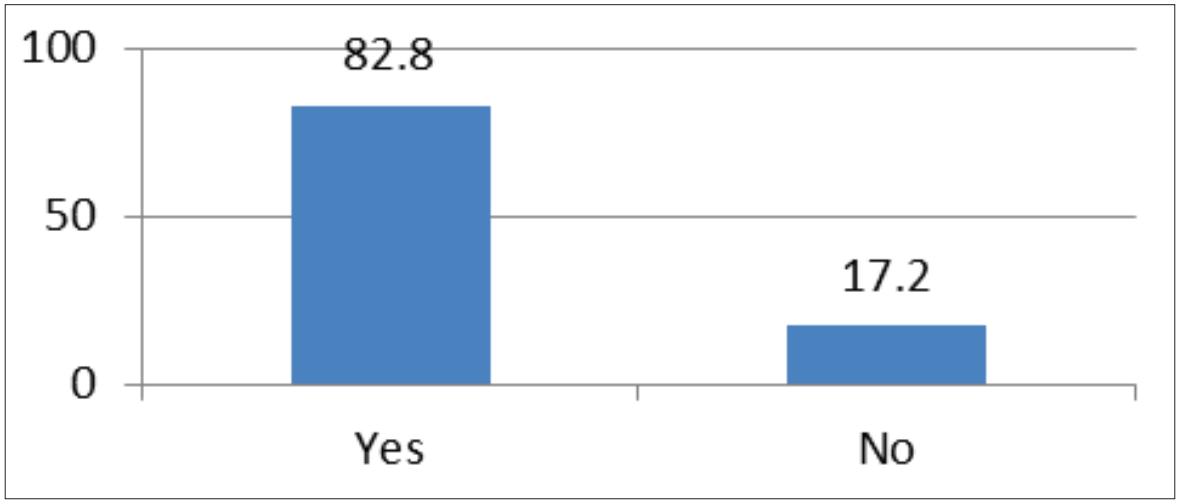
Table 1 above shows that majority of the respondents 142 (39.4%) agreed that there are antenatal clinic visit barriers while 59 (16.4%) were neutral. Majority of the respondents 239 (66.4%) also agreed that majority of the expectant women visit conventional health centers for their general treatment while 29 (8.1%) were neutral. 129 (35.8%) of the respondents agreed that some of the expectant women visit traditional medical practitioners for their general treatment while 76 (21.1%) were neutral. 159 (44.2%) agreed that most of the parents complete well baby and other clinic as per the health policy while 23 (6.4%) were neutral. These results concur with the study conducted by Barennes (2009) on Postpartum traditions and nutrition practices among urban Lao women and their infants in Vientiane, Lao PDR, Brazil, that, reported high antenatal care attendance and delivery under health professional supervision, a high prevalence of traditional practices including exposure to hot beds of embers, use of traditional herb tea as the only beverage (95%) and restricted diets (90%). Majority of the respondents 155 (43.1%) agreed that some of the parents do not consult traditional medical practitioners for the health of their children below five years of age while 109 (30.3%) were neutral. 197 (54.7%) of the respondents agreed that most of the health care workers give adequate information on the nutrition of the mothers and the child. Majority of the respondents 106 (29.4%) agreed that most of the traditional medical workers give adequate

information on the nutrition of the mothers and the child while 100 (27.8%) were neutral. These results concur with the study done by Reshma and Sujatha (2014) in India on the cultural practices and beliefs on newborn care among mothers in selected hospitals in Mangalore taluk which found out that, there was a strong relationship between the demographic variables (type of family and religion) and cultural practices and beliefs on newborn care among mothers, this was calling for periodical health education regarding do's and don'ts of newborn care be conducted in postnatal ward, which definitely would minimize the unhealthy traditional practices.

Prohibited Foods for Pregnant Women in the Community

The researcher sought to find out if there are prohibited foods for pregnant women in the community.

Figure 4 | *Prohibited Foods for Pregnant Women in the Community*



Source: Research data, 2017

Figure 4 shows that majority of the respondents 298 (82.8%) agreed that there are prohibited foods for pregnant women in the community while the remaining 62 (17.2%) of the respondents disagreed that there are prohibited foods for pregnant women in the community.

Table 2 | *List of Prohibited Foods for Pregnant Women in the Community*

Prohibited food	Frequency	Percentage
Mandazi	24	6.7
Avocados	101	28.0
Honey	121	36.6
Eggs	36	10.0
Sugarcane	53	14.7
Bananas	10	2.8
Pumpkins	27	7.5
Cassava	12	6.7
Pepper	20	5.6
Cow peas	42	11.7
Fermented porridge	32	8.9
Rice	10	2.8
Alcohol	12	6.7
Mangoes	5	1.9
Fatty meat	50	13.9
Maize	6	1.7
Raw meat	5	1.9
Soil (mchwa)	4	1.1
Meat at funerals	2	0.6
While sorghum	2	0.6
Lemon	3	0.8
Sukuma wiki	2	0.6

Source: Researcher2017

From the study, 24 (6.7%) of the respondents indicated that mandazi was one of the prohibited food for pregnant women while 101 (28%) indicated avocado as one of the prohibited food for pregnant women in their community. 121 (36.6%) of the respondents indicated that honey was one of the prohibited food for pregnant women in their community while 36 (10%) of the respondents indicated eggs as one of the prohibited food for pregnant women in their community. 53 (14.7%) of the respondents indicated sugarcane as one of the prohibited food for pregnant women in their community while 10 (2.8%) of the respondents indicated bananas as one of the prohibited food for pregnant women in their community.

From the study, 27 (7.5%) of the respondents indicated pumpkins as one of the prohibited food for pregnant women in their community while 12 (6.7%) of the respondents indicated cassava as one of the prohibited food for pregnant women in their community. 20 (5.6%) of the respondents indicated that pepper was one of the prohibited food for pregnant women in their community while 42 (11.7%) of the respondents indicated that cow peas as one of the prohibited food for pregnant women in their community. 32 (8.9%) of the respondents indicated fermented porridge as one of the prohibited food for pregnant women in their community while 10 (2.8%) of the respondent indicated rice as one of the prohibited food for pregnant women in their community. 12 (6.7%) of the respondents indicated alcohol as one of the prohibited food for pregnant women in their community while 5 (1.9%) indicated mangoes as one of the prohibited food for pregnant women in their community.

From the study, 50 (13.9%) of the respondents indicated fatty meat as one of the prohibited food for pregnant women in their community while 6 (1.7%) of the respondents indicated maize as one of the prohibited food for pregnant women in their community. 5 (1.9%) of the respondents indicated raw meat as one of the prohibited food for pregnant women in their community while 4 (1.1%) of the respondents indicated that soil (*mchwa*) as one of the prohibited food for pregnant women in their community. 2 (0.6%) of the respondents each indicated that meat at funerals, white sorghum and sukuma

wiki were some of the prohibited food for pregnant women in their community while 3 (0.8%) indicated lemon as one of the prohibited food for pregnant women in their community.

Why the Foods are prohibited in the Community

Table 3 | Reason Why the Food is prohibited in the Community

Reason	Frequency	Percentage
Baby becomes larger	209	58.0
Poor eyesight of the baby	20	5.6
Limited air to baby	2	0.6
Stomach upset (kiumati)	42	11.7
Constipation	10	2.8
Carbohydrates make baby weak	10	2.8
Has no nutritional value	34	9.4
Reduces breast milk	2	0.6
Baby is delivered with no good shape	1	0.3
Causes coiling of the spinal cord	2	0.6
Makes mother to vomit	2	0.6
Risky to unborn baby	22	6.1
Prevents mother from being fat	6	1.7
Baby is born with no eye lashes	4	1.1
Delivery becomes difficult	106	29.4
Nigh blindness to the mother	2	0.6
Poisons baby	4	1.1
Baby becomes a drunk/stupid	2	0.6
Misfortune befalls on baby and mother	2	0.6
Baby is born with a skin disease	2	0.6

Source: Research data, 2017

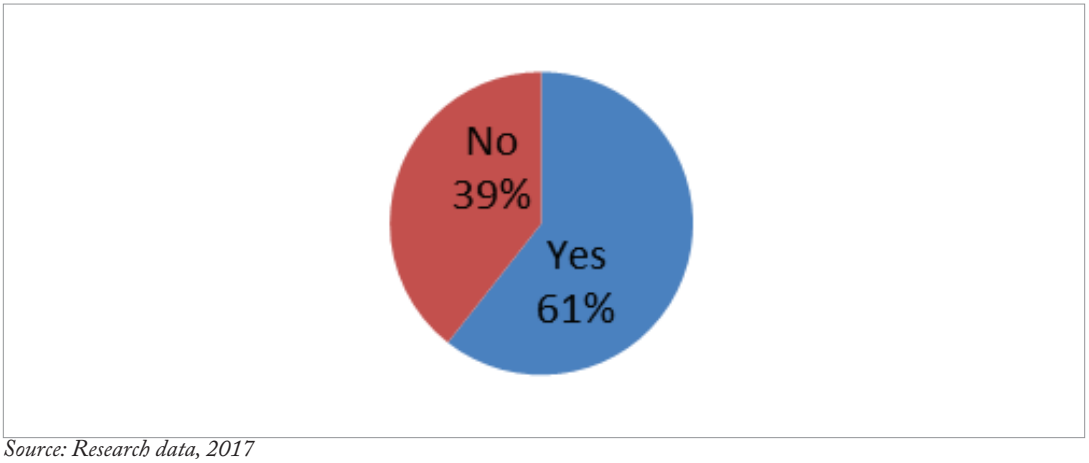
Table 3 above shows that majority of the respondents 209 (58%) indicated that "the baby becomes larger" as one of the reasons some foods are prohibited for pregnant women in the community while 20 (5.6%) of the respondents indicated "poor eyesight of the baby". 2 (0.5%) of the respondents indicated "limited air to baby", "reduces breast milk", "causes coiling of the spinal cord", "makes mother to vomit", "night blindness to mother", "baby becomes a drunk/stupid", "misfortune befalls the baby and the mother" and "baby is born with a skin disease" as some of the reasons why some foods are prohibited for pregnant women in their community. 42 (11.7%) of the respondents indicated "stomach upset (*Kiumati*)" as one of the reasons some foods are prohibited for pregnant women in the community while 10 (2.8) of the respondents indicated "constipation" and "carbohydrates make baby weak" as some of the reasons why some foods are prohibited for pregnant women in the community.

From the results above, 34 (9.4%) of the respondents indicated "the food has not nutritional value" as one of the reasons some foods are prohibited for pregnant women in their community while 1 (0.3%) of the respondents indicated "baby is delivered with not good shape". 22 (6.1%) of the respondents indicated "risky to unborn baby" as one of the reasons some foods are prohibited for pregnant women in their community while 6 (1.7%) of the respondents indicated "prevents mother from being fat" as a reason. 4 (1.1%) of the respondents indicated "baby born with no eye lashes" and "poisons baby" as some of the reasons why some foods are prohibited for pregnant women in their community while 106 (29.4%) indicated "delivery becomes difficult" as one of the reasons. Due to cultural diversity, a study done by Nisha, et al (2015) on a qualitative study to investigate the influence of beliefs and practices regarding nutrition during pregnancy and lactation

in a rural area in Karnataka, India, found out that, good practices included consuming green leafy vegetables, rice, bread, *jowar*, meat, eggs and fruits like apple and *mosambi*. This was centrally to the findings by the researcher on prohibited foods like meat and eggs believed to increase the size of the developing child making it difficult for delivery. From the field, the researcher sought to understand whether traditional beliefs on food and nutrition affected the health of the mother and child. Interviews were done in the study area to ascertain on this. It was noted that, there were traditionally prohibited foods due to the perceived health of the mother and the child. Other reasons further probed found out that, patriarchal societies oppressed women and therefore directives on food choices.

Prohibited Foods for Lactating Women in the Community

Figure 5 | *Prohibited Foods for Lactating Women in the Community*



Source: Research data, 2017

Figure 5 above shows that 218 (61%) of the respondents agreed that there are foods for lactating women that are prohibited in their community while 142 (39%) of the respondents disagreed that there were no foods prohibited for lactating women in their community.

The researcher sought to find out the prohibited foods for lactating women in the community. Table 4 below shows the results

Table 4 | *Prohibited Foods for Lactating Women in the Community*

Prohibited Food	Frequency	Percentage
Green vegetables	22	6.1
Cassava	87	24.2
Lemon	54	15.0
Black tea	24	6.7
Millet	13	3.6
Sour porridge	23	6.4
Githeri	24	6.7
Cow peas	21	5.8
Maize	6	1.7
Nthooko	29	8.1
Maize flour porridge	2	0.6
Fermented foods	29	8.1

Source: Research data, 2017

Table 4 shows that 22 (6.1%) of the respondents indicated green vegetables as one of the prohibited food for lactating women in their community while 87 (24.2%) of the respondents indicated cassava. 54 (15%) of the respondents indicated lemon as one of the prohibited food for lactating women in their community while 24 (6.7%) indicated black tea and githeri. 13 (3.6%) of the respondents indicated raw millet as one of the prohibited food for lactating women in their community while 23 (6.4%) of the respondents indicated sour porridge. 21 (5.8%) of the respondents indicated cow peas as one of the prohibited food for lactating women in their community while 6 (1.7%) of the respondents indicated maize. 29 (8.1%) of the respondents indicated *nthooko* as one of the prohibited food for lactating women in their community while 2 (0.6%) of the respondents indicated maize flour porridge. 29 (8.1%) of the respondents indicated fermented foods as some of the prohibited foods for lactating women in their community.

Choudhry (1997) found out that, in India, consumption of milk, butter, ghee and some types of fish is encouraged due to the belief that these foods will increase the quantity and quality of breast milk. Nutrition-related practices during pregnancy are based on a belief that 'hot' foods are harmful and 'cold' foods are beneficial. This study did not find any information on hot and cold food consumption by the lactating mothers.

Why the Foods are prohibited for Lactating Women in the Community

The study sought to find out why the foods were prohibited for lactating women in their community. Table 5 below shows the results.

Table 5 | *Why the Foods are prohibited for Lactating Women in the Community*

Prohibited Food	Frequency	Percentage
Reduces milk	147	40.8
Reduces mother's blood	6	1.7
Causes diarrhea	6	1.7
Worsens uterus wounds	5	1.4
Nyunyi for baby	18	5.0
Stomach upset (*kiumati*)	62	17.2
Poison for baby	23	6.4
No energy for baby	5	1.4
Causes constipation to mother	5	1.4
Health of child will be sabotaged	13	3.6
Makes baby to vomit	38	10.6
No nutritional value	2	0.6

Source: Research data, 2017

Table 5 above shows that 147 (40.8%) of the respondents indicated "reduces milk" as one of the reasons why some foods were prohibited for lactating women in their community while 6 (1.7%) of the respondents indicated "reduces mother's blood" and "causes diarrhea". 5 (1.4%) of the respondents indicated "worsens uterus wounds", "no energy for baby" and "causes constipation to mother" as some of the reasons why some foods were prohibited for lactating mothers in their community while 18 (5%) of the respondents indicated "*nyunyi* to baby". 62 (17.2%) of the respondents indicated "stomach upset*/kiumati*" as one of the reasons some foods were prohibited for lactating women in their community while 23 (6.4%) of the respondents indicated "poison to baby". 13 (3.6%) of the respondents indicated "health of child will be sabotaged" as one of the reasons why some foods were prohibited for lactating women in their community while 38 (10.6%) of the respondents indicated "makes baby to vomit". 2 (0.6%) of the respondents indicated "no nutritional value" as one of the reasons why some foods were prohibited for lactating women in their community. These findings did not unveil the relationship between full implementation of breast feeding and culture as Ajala (2002) pointed out that there are some other constraints on full implementation of breastfeeding by mothers which have some cultural undertone in Nigeria. He

stated that constraint on breastfeeding include strenuous work undertaken by mothers, poor feeding habits of the mother and lack of the male supportive role.

Conclusion

The study concluded that there are antenatal clinic visit barriers in their community. Expectant women visit both conventional health centers and traditional medical practitioners for their general treatment. There are also prohibited foods for pregnant and lactating women in their community

Recommendation

The study recommends that the government's health policy should clearly stipulate the roles played by the various health practitioners in the Sub-County. It also recommended that the government should organize for continuous trainings for the health care practitioners both traditional and conventional especially in the rural areas. The study recommends further that, traditional birth attendants be provided with delivery kits to help women who deliver in the rural areas.

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