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ATTITUDE OF EXPECTANT MOTHERS TO MEDICAL PRACTITIONERS' ADVICE AND ITS EFFECT ON MATERNAL MORTALITY IN KIBERA SLUM, NAIROBI

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Attitude of Expectant Mothers to Medical Practitioners' Advice and its Effect on Maternal Mortality in Kibera Slum, Nairobi

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Abstract

Purpose: The purpose of this study was to examine the attitude of expectant mothers to medical practitioners' advice and its effect on maternal mortality in Kibera slum, Nairobi

Methodology: The study utilized a correlation research design. The target population comprised all expectant mothers within Kibera slums who were present at the selected clinics during antenatal day at the time of data collection. The target population also constituted all the twenty eight medical practitioners working at the five selected clinics as well as all the peer professionals who listen to the expectant mothers' complaints. The study conducted a census for the medical practitioners and used convenience sampling for the expectant mothers and peer professionals. The sample size was 38 respondents. The study used a questionnaire, focus group discussion and a key informant interview guide as research instrumentsto obtain primary data.The questionnaires were self-administered with the help of two research assistants while the researcher conducted the focus group discussion with the expectant mothers and the key informant interview with the two peer proffessionals. The researcher analyzed both quantitative and qualitative data.

Results: Based on the findings the study concluded that expectant mothers' in Kibera slum uphold various cultural norms which affect intercultural communication between the mothers and medical practitioners negatively. The study also concluded that expectant mothers in Kibera slum had expectations about the medical practitioners' intercultural communication skills. These expectationsaffect intercultural communication of health information among expectant mothers. Further, the study concluded that expectant mothers have negative attitudes towards the medical practitioners which significantly contributed to maternal mortality in Kibera slum.

Policy recommendation: The Ministry of Health should take the initiative to educate the residents of Kibera slum on the importance of attending antenatal and prenatal clinics. The MOH should also lead campaigns that condemn outdated cultural customs which subject expectant mothers to adverse risks even to the point of losing their lives. This can be done through the local media

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1.0 INTRODUCTION

1.1 Background of the Study

Traditionally cultural differences are viewed as possible hindrances to quality and effective health care. Various studies commonly show that the main barrier to good prenatal care is differences in language, which result to fear and cultural misunderstanding (Flores, 2006; Timmins, 2002; Wheatley, Kelley, Peacock, &Delgado, 2008). Hence, there is need for better cultural competency among medical practitioners. This creates the need for additional services in the health care context, such as medical translators who would help to decrease patients' deficiencies in receiving quality health care. However, various authors in health communication have objected to this preposition. For instance, Dutta(2008) and Down (2008) have criticized this approach, they argue that there is more to intercultural encounters in the health care context than focusing on providers' and patients' deficiencies alone.

Nevertheless, the counter-productivity of cultural differences to acquisition of quality healthcare is still prevalent in health communication research. For instance, the productivity of cultural differences and the dialogic experiences to specific types and ways of knowing among different cultural scripts are not considered. Hsieh (2011) suggests that despite the fact that there are interactional challenges; unique meanings of health and health care are collaboratively produced through bilingual health communication interactions including patients, health care providers and medical interpreters.

According to Dutta (2008), the need for embracing a cultural-sensitive approach in healthcommunication cannot be overlooked. The assumption of the approach is that there are experts on culture and health who facilitate to convey health information in a way that is cultural sensitive. In addition, use of the cultural sensitive approach assists in locating (non-dominant) communities.

Intercultural Communication and Maternal Mortality in Developed Economies

A study by Ivry's (2010) on pregnancies in Japan and Israel revealed that the cultures within which families expect andprepare for the arrival of their children influences the experience of pregnancy and prenatal care as well as pregnant women's physiologicalexperiences. Prenatal care was regarded as a collaborative achievement involving the health care providers, pregnant women and their families. In addition, interpersonal mindsets on gender,expectations and beliefs about pregnant women determined how medical professionals undertook prenatal visits(Tracy, 2002).

Intercultural Communication and Maternal Mortality in Emerging Economies

In 2000, China introduced a Programto Reduce Maternal Mortality and Eliminate Neonatal Tetanus. The program aimed at reducing maternal andinfant mortality by promoting hospital delivery. Initiated in 378 counties, it now covers the entire country. The program focuses on health education, affordable care, quality of care, and socialmobilization to reduce maternal and infant mortality. It provides subsidies to mothers from poor counties in the nation hat have high maternal mortality ratio (MMR) and neonatal tetanus cases compared to the average provincial

rate. Obstetric professionals from provincial tertiary hospitalsare also in charge of primary maternal care centers for at least two weeks each year to build localcapacity through direct support, training, and to facilitate intercultural communication and referralnetworks among the different tiers of service delivery. Effort has also been made to improve thespecialized capacity of pediatric workers by sending experts to counties for on-site training andconducting health education and social mobilization (WHO, 2012).

Intercultural Communication and Maternal Mortality in Developing Economies

In developing countries, many births are assisted by traditional birth attendants (TBAs) who acquire their skills through experience and apprenticeship, rather than through the formal training that characterizes skilled birth attendants such as doctors, midwives and nurses (GiveWell, 2011).Programs providing short training courses to TBAs aiming at teaching them how to respond to minor complications as well as recognize and refer major complications were recommended by the World Health Organization in the 1970s through 1990s. The World Health Organization believed that such training courses could reduce maternal mortality rates (WHO, 2010). Evidence suggests that TBA training increases knowledge among TBAs and may reduce infant mortality, but does not have a demonstrable impact on maternal mortality (WHO, 2010

Intercultural Communication and Maternal Mortality in Kenya

Maternal mortality is a particularly serious problem in Kenya. A woman in Kenya has a one in 36chance of dying from pregnancy-related causes, compared to her counterpart in Europe, who faces aone in 4,000 chance. Estimates of maternal mortality range from 590 to 1,300 maternal deaths per100,000 live births, with considerable variation from province to province, and even more between districts. Some districts claim rates of up to three times the national average(Give Well, 2007).

1.2 Statement of the Problem

The rates of maternal mortality in Kenya are high whereby maternal morbidity and mortality in Kenya results from the interplay of social, cultural, economic and logistical barriers, coupled with a high fertility rate and inadequate and under-funded health services (GiveWell, 2007). The social cultural barriers exist due to poor intercultural communication while the economic barriers are due to poverty (GiveWell, 2007). Strengthening the health system and improving quality of healthcare delivery is pivotal to reversing the trend of high maternal morbidity and mortality (Ziraba, 2009). Effective intercultural communication can be achieved by ensuring that the doctor encourages and gives the patients the required advice and the patient, on the other hand, should have a positive response to the advice given (Miller, Kinya, Booker, Kizito and Ngula, 2010).

Past studies have researched into the effects of intercultural communication; for instance,Kirsten(2012) reveals how healthcare discourses on ethnic minority patients reflect shifting intercultural communication paradigms and advocates for the uptake of a critical intercultural communication approach with regard to ethnicity-based health inequality.Miller, Kinya, Booker, Kizito and Ngula, (2010) explored Kenyan patients' perceptions on the role of ethnicity in the doctor–patient relationship.Literature review reveals that there exists a research gap with regard to the influence of intercultural communication on maternal mortality. Hence,

this study seeks to fill in this gap by establishing the influence of intercultural communication on maternal mortality in Kibera slum, Nairobi, Kenya.

1.3 Objectives of the Study

Objectives of the Study

1. To examine the attitude of expectant mothers to medical practitioners' advice and its effect on maternal mortality in Kibera slum, Nairobi

2.0 LITERATURE REVIEW

Theory of Intercultural Communication

The mainfoundation of this theory brings out a new perspective of the culture concept – the so-called 'heterogeneous' culture concept. The heterogeneous culture concept depicts culture as anti-essentialist and dynamic. It emphasizes the elusive and constructed character of cultural identities. The theory suggests a critical intercultural communication approach, which represents a paradigmatic shift since culture,communication and cultural identity are subjected to inquiry and reformulation (Halualani& Nakayama, 2010; Moon, 2010). The notion that the phenomenon of culture is intimately related to the need of human beings to experience their world as meaningful has probably never been articulated with larger impact that in Geertz' famous dictum: "man is an animal suspended in webs of significance that he himself has spun, these webs represent the culture" (Geertz,1973).Understandings of the culture concept in coherence with Geertz' definition led intercultural communication scholars to conceptualize intercultural communication situations as contact between individuals who happen to draw on divergent universes of meaning and thereby produced mutually unintelligible utterances, even in cases where a shared lingua franca was used.

A wide range of studies provide evidence that even the tiniest verbal or nonverbal move in such encounters maygenerate unintended interpretations because of the interlocutors' propensity to ascribe meaning to every detail of communication (Gumperz,1982;Carbaugh, 2005). Specific contributions drawing on the strong British sociolinguistic tradition convincingly made the point that inter-ethnic communicative encounters play a major role in the production of social identities of members of various ethnic groups and thereby in the distribution of resources in multi-ethnic societies, including access to jobs, education, and health services. However, according to critical intercultural communication scholars, more attention should be paid to political, institutional, and not least historical factors in the production of social and cultural identities (Mendoza, Halualani&Drzewiecka, 2002).This theory was relevant to this study since it posits that a critical intercultural communication approach represents a paradigmatic shift since culture, communication and cultural identity should be subjected to inquiry and reformulation. Hence, it argued that culture affects communication.

2.1Literature Review

A cultural sensitive perspective in health communication is presentin research on pregnancy and prenatal care. For example, Lazarus (2007) finds thatwomen of different socio-economic classes have different needs for prenatal care. Similarly, much of Brigitte Jordan's (1997) work focuses

on how birth knowledge differs among cultures and goes at great lengths to describe those different patterns of birthing.

Baxter (2011) argues that one should viewinteraction as diagnostic of cultural differences that needs to be acted upon as opposed to viewing each interaction as itsown process in which knowledge is negotiated and produces a cultural sensitive approach. Furthermore, in much "training" literature, the responsibilityof diagnosing a patient's cultural box is placed (unsurprisingly) upon the medicalprofessionals, arguing that "cultural sensitivity" is something they need to develop in order to provide better care. This has a twofold effect whereby first, it works to inscribeagency to act upon cultural matters onto the medical professional, and second, it erases the possibility that the medical professional him/herself might be negotiating multiple sets of cultural knowledge and that experiencing culture, for both patient and medicalprofessional, could be fragmented, fluid and multi-dimensional.

Mazzoni (2002) finds that many 'old wives' tales" are folded into biomedical prenatal care advice, pointing that theknowledge in this advice is not singular in itself, but rather is divided and multiplies intercultural communication in a way that it of problematic origins. Advocating for a social value ofsingular and unified representations is in itself a cultural construction dating back, asMazzonidemonstrates, to European Renaissance ontological beliefs embraced in sciencethat the being-within-being configuration of "mother and fetus was emblematic of theunity of the world and of the magic relations that governed the universe. This, in turn,confirmed the connection between human beings and the cosmos, between microcosmand macrocosm, between body and soul. In addition to critically centeringprocesses of knowledge formation, such explorations that disturb the linearity of time andspace also bring to focus questions of power as contextual and unstable "regimes oftruth" that are constantly in flux (Foucault, 2008).

3.0 METHODOLOGY

The study utilized a correlation research design. The target population comprised all expectant mothers within Kibera slums who were present at the selected clinics during antenatal day at the time of data collection. The target population also constituted all the twenty eight medical practitioners working at the five selected clinics as well as all the peer professionals who listen to the expectant mothers' complaints. The study conducted a census for the medical practitioners and used convenience sampling for the expectant mothers and peer professionals. The sample size was 38 respondents. The study used a questionnaire, focus group discussion and a key informant interview guide as research instrumentsto obtain primary data.The questionnaires were self-administered with the help of two research assistants while the researcher conducted the focus group discussion with the expectant mothers and the key informant interview with the two peer proffessionals. The researcher analyzed both quantitative and qualitative data.

4.0 RESULTS FINDINGS

Presentation, Analysis and Interpretation

Response Rate

The number of questionnaires that were administered was 28. A total of 27 questionnaires were properly filled and returned. This represented an overall successful response rate of 96.4 % as shown in Table 3. The high response rate can be explained by the fact that the sample size was small. This can also be explained by the fact that the questionnaires were self-administered. According to Mugenda and Mugenda (2003) and also Kothari (2004) a response rate of 50% is adequate for a descriptive study. The study also recorded a 100% response rate of the key informants and the FGD.

Table1: Response Rate

Response	Frequency	Percentage
Returned	27	96.4%
Unreturned	1	3.6%
Total	28	100%

Demographic Characteristics

This section consists of information that describes basic characteristics such as the gender, age, level of education, position and number of years in employment of the respondents. The gender of the respondents assisted to establish whether the number of male was more than female and their representation. The level of education helped to assess the literacy level of the respondents while the years worked in their current position revealed the experience of the respondents and hence the quality of information obtained from them during data collection. Results are as presented in Table 2.

Table 2: Demographic Characteristics

Demographic Characteristics	Response	Frequency	Percent
Gender	Male	14	51.9
	Female	13	48.1
	Total	27	100
Age	21-30 years	1	3.7
	31-40 years	14	51.9
	41-50years	12	44.4
	Total	27	100
Level of Education	Tertiary college	10	37
	University	17	63
	Total	27	100
Position	Medical Officer	7	25.9

	Clinical Officer	5	18.5
	Nurse	13	48.1
	Laboratory assistant	2	7.4
	Total	27	100
Number of Years	1 to 3 years	6	22.2
	4 to 6 years	2	7.4
	More than 6 years	19	70.4
	Total	27	100

Results show that 51.9% of the respondents were male while 48.1% were female. This implies that most of the medical practitioners in Kibera Slums are male. Results also show that 51.9% of the medical practitioners are aged between 31-40 years, 44.4% of the medical practitioner were aged between 41-50 years while 3.7% of the medical practitioners were aged between 21-30 years. This is an indicator that most of the medical practitioners were elderly. Further, results in Table 4 reveal that the medical practitioners were educated since 63% had attained education up to the university level while 37% had attained education up to tertiary level.

Results also revealed that 48.1% of the medical practitioners were nurses, 25.9% were medical officers, 18.5% were clinical officers while 7.4% were laboratory assistants. Results also revealed that 70.4% had served as medical practitioners for more than 6 years, 22.2% had served as medical practitioners 1 to 3 years while only 7.4% of the medical practitioners had served for 4 to 6 years.

Attitudes of Expectant Mothers

The study sought to examine the attitude of expectant mothers to medical practitioners' advice and its effect on maternal mortality in Kibera slum, Nairobi. Results are as presented in Table 11.

Table 3: Attitudes of Expectant Mothers

Statement	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Expectant mothers have different preferred styles of communicating in medical encounters.	0.00%	0.00%	22.20%	70.40%	7.40%
Expectant mothers reference different explanatory models of health and illness.	0.00%	0.00%	18.50%	51.90%	29.60%
Expectant mothers have perceptual biases regarding the Medical practitioner who will attend to them.	0.00%	3.70%	25.90%	40.70%	29.60%

Results show that 77.8% of the medical practitioners agreed that expectant mothers have different preferred styles of communicating in medical encounters. Eighty one point five (81.5%) of the medical practitioners agreed that expectant mothers reference different explanatory models

of health and illness. Further, results in Table 11 show that 70.3% of the medical practitioners agreed that expectant mothers have perceptual biases regarding the Medical practitioner who will attend to them.

Other Attitude of Expectant Mothers towards Medical Practitioners

The study sought to find out whether the theexpectant mothers have any other attitude towards medical practitioners' advice. Results in Table 12 show that 66.7% of the medical practitioners disagreed that expectant mothers have other attitude towards medical practitioners' advice while 33.3% agreed. They indicated that other attitudes include the perception that male doctors are better than female doctors.

Table 4: Other Attitudes of Expectant Mothers

Response	Frequency	Percent
No	18	66.7
Yes	9	33.3
Total	27	100

The peer professionals involved in the key informant interview indicated that the expectant mothers attitudes towards medical practitioners result from fear. Women are scared of antenatal visits mostly because of the HIV test that they are required to have done prior. The fear the medical practitioners as they intimidate women; they are scared of being shouted at about issues like family planning. Women are also scared of being diagnosed by male doctors as this goes against some cultures of people living here. They also indicated that some women are scared of the vaccines that they are required to get, as most people believe they will make them unable to give birth. Finally, they indicated that some women are afraid as they are only allowed to visit a TBA for consultation during their pregnancy.

The expectant mothers involved in the FGD also indicated that their attitudes towards medical practitioners result from fear. For instance they were afraid of nurses (especially the female nurses). Since they live in the informal settlement they share their experiences with the nurses which forms an attitude among the woman has about visiting clinic. They are also afraid of being diagnosed by the male medics. They also indicated that woman who got pregnant outside wedlock was afraid to consult let alone go to hospital because 'people will talk'. This sometimes led to unsafe abortions.

Methods used by Medical Practitioners to Communicate to Expectant Mothers

The expectant mothers involved in the FGD indicated that medical practitioners used various methods to communicate to them. These included written communication, authoritative conversation, participatory communication and cultural sensitive communication. For written communication, the mothers indicated that important information is written on posters. For instance information on the importance of going for a HIV test once you know that you are expectant.

In the case of authoritative conversation the mothers indicated that in most cases the medical practitioners do not listen to the expectant mothers concerns. They added that it is very difficult to listen to someone who cannot and will not listen to you. In fact, they feel disrespected because

as much as the doctor is a professional and most likely has the answers to many things you may not know, you understand too where you come from and the degree in which any advice given is acceptable and not acceptable. However, they sometimes listen and advise the mother on the importance of taking up something so as to protect mother and child from death.

For participatory communication the doctors sometimes after having a look at the mother listen to her and then explain the problem and proposed solution and the mother will go ahead to explain further why the problem is happening. Feedback from the peer professionals indicated that through participatory communication medical practitioners are slowly involving the expectant in the communication process. The just don't tell them what to do but rather, advise them on what is good for them and the child.

In the case of cultural sensitive communicationthe doctor who is giving advice knows and is aware of the culture of the mother and advices based on the culture. Thus, the doctor tries to convince an expectant mother to take up health advice that may not be acceptable in their culture but is important for the well-being of both parent and child and in protecting against maternal mortality.They indicated that medical practitioners who communicate using a cultural sensitive approach empower them, educate and inform them rather than tell. The peer professionals also indicated that medical practitioners who use a cultural sensitive approach to communicate are 'sensitive' to the cultural beliefs of the mothers and advice accordingly. The peer professionals also reiterated that if the medical practitioner takes time to listen to and advise the expectant mothers then this can help influence by reducing maternal mortality as the expectant mothers will seek and take the advice of the medical practitioners. These findings are supported by those of Dutta (2008) who posited that the need for embracing a cultural-sensitive approach in healthcommunication cannot be overlooked.

Effects of Attitudes on Advice given by the Doctor

The expectant mothers were asked to indicate whether the some of the attitudes influence an expectant mother's decision to take up advice given by a medical practitioner. In response they indicated that their attitudes towards medical practitioner's advice indeed influence their decision to take up or ignore advice given by medical practitioners.

One of the expectant mothers Mary said ''I am 8 weeks pregnant and i attend Tabitha clinic. This is my 4th pregnancy and all the previous 3 have been a mess as I have had to deal with TBA's. Every time I had a complaint, my relatives would take me 'kukandwa' at the TBA. They warned me against visiting clinics with male attendants and they also said that it would be very costly (and they cannot afford). Since I was jobless, i had to conform. I too almost had a near death experience with my last-born. I was in intense labour for 5 days which was awful. This time, i am working doing casual jobs and i am able to pay my consultations fee at the clinic. Actually, it is not true that antenatal clinics are expensive the cost is reduced and you cannot compare this cost to your life and that of your child. However, if one doesn't have money it may be difficult. I hear government hospitals too have reduced the cost too''.

These findings are consistent with those of Norredam and Krasnik (2010) who observed that ethnically distinct clients often showed beneficial improvements when a counselor effectively acknowledged and validated clients' inner world of experiences, which was previously un-

communicated to others. Consequently, in counseling, communication process has been viewed as an intervention for client change in itself and not just the medium by which a counselor applies his or her counseling approaches.

Results of Expectant Mothers Attitude

The study sought to establish whether the attitudes result to behaviours that lead to maternal mortality. Results in Table 13 show that 59.3% of the medical practitioners agreed that these attitudes result to behaviours that lead to maternal mortality while 40.7% disagreed.

Table 5: Results of Attitudes of Expectant Mothers

Response	Frequency	Percent
No	11	40.7
Yes	16	59.3
Total	27	100

The medical practitioners indicated that the results included; following outdated traditional ways of medication, ignoring advice led to death or complications, conflicts led to maternal mortality, unborn babies die due to failure to attend clinics and poor communication and relationships in the hospitals.

The expectant mothers involved in the FGD reiterated that in Kibera, the attitudes of expectant mothers towards medical practitioners can increase or reduce maternal mortality. They explained that if an expectant mother has a negative attitude towards a medical practitioner they are less likely to visit a clinic to seek advice regarding their pregnancy and this in-turn may increase maternal mortality because of lack of knowledge. On the other hand, if they have a positive attitude they are more likely to go and seek advice regarding a challenge they are experiencing with pregnancy. The medical practitioner will give advice that the expectant mother will take up and this in turn may reduce maternal mortality.

They reiterated that they rely on mother-to-mother advice. When an expectant mother goes to see a good doctor they share the advice and we take it up. They added that nowadays, cases of maternal mortality are not as high as they were in the past though mothers continue to die during child labour (especially in the hands of TBA's because in as much as they may be experienced they do not have the necessary equipment to save a life from an emergency. In addition, TBA's will do not help them detect and prevent early pregnancy complications but experienced medical practitioners will by giving advice and offering resource options that will help prevent complications.

Another woman indicated that these days, women are advising each other to go to hospital. She indicated that recently there 4-5 very good doctors in the area who listen and give advise accordingly. They are slowly learning that my problems are not necessarily yours and these have to be dealt with in different ways. As they wound up another expectant mother indicated that in the past, doctors treated them like 'nobodies'. They 'commanded' and never listened and this in turn gave women a phobia/fear for health institutions. However, this is slowly changing whereby

they even have experts who walk around from door to door to make sure that women are at least aware of the importance of visiting a hospital during pregnancy

5.0 SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

Summary of Findings

Discussions

Attitudes of Expectant Mothers

The third objective of the study was to examine the attitude of expectant mothers to medical practitioners' advice and its effect on maternal mortality in Kibera slum, Nairobi. The medical practitioners indicated that expectant mothers have different preferred styles of communicating in medical encounters, expectant mothers reference different explanatory models of health and illness, expectant mothers have perceptual biases regarding the medical practitioner who will attend to them and expectant mothers have the perception that male doctors are better than female doctors.

The peer professionals indicated that the expectant mothers attitudes towards medical practitioners result from fear. Women are scared of antenatal visits mostly because of the HIV test that they are required to have done prior. The fear the medical practitioners as they intimidate women; they are scared of being shouted at about issues like family planning. Women are also scared of being diagnosed by male doctors as this goes against some cultures of people living here. They also indicated that some women are scared of the vaccines that they are required to get, as most people believe they will make them unable to give birth. Finally, they indicated that some women are afraid as they are only allowed to visit a TBA for consultation during their pregnancy.

The expectant mothers also indicated that expectant mothers have attitudes towards medical practitioners which result from fear. For instance they were afraid of nurses (especially the female nurses). Since they live in the informal settlement they share their experiences with the nurses which forms an attitude among the woman has about visiting clinic. They are also afraid of being diagnosed by the male medics. They also indicated that woman who got pregnant outside wedlock was afraid to consult let alone go to hospital because 'people will talk'. This sometimes led to unsafe abortions. They also indicated that their attitudes towards medical practitioner's advice influence their decision to take up or ignore advice given by medical practitioners.

Further, the medical practitioners agreed that expectant mothers' attitudes towards medical practitioners result to behaviours that lead to maternal mortality. The results included; following outdated traditional ways of medication, ignoring advice led to death or complications, conflicts that led to maternal mortality, unborn babies die due to failure to attend clinics and poor communication and relationships in the hospitals. On the other hand, the expectant mothers involved in the FGD reiterated that in Kibera, the attitudes of expectant mothers towards medical practitioners can increase or reduce maternal mortality. They explained that if an expectant mother has a negative attitude towards a medical practitioner they are less likely to visit a clinic to seek advice regarding their pregnancy and this in-turn may increase maternal mortality

because of lack of knowledge. However, if they have a positive attitude they are more likely to go and seek advice regarding a challenge they are experiencing with pregnancy. The medical practitioner will give advice that the expectant mother will take up and this in turn may reduce maternal mortality.

Conclusions

Based on the findings the study concluded that expectant mothers' in Kibera slum uphold various cultural norms which affect intercultural communication between the mothers and medical practitioners negatively. The study also concluded that expectant mothers in Kibera slum had expectations about the medical practitioners' intercultural communication. These expectations affect intercultural communication of health information among expectant mothers. Further, the study concluded that expectant mothers have negative attitudes towards the medical practitioners which significantly contributed to maternal mortality in Kibera slum.

Recommendations

Based on the findings the study made the following recommendations;

1. The medical practitioners in Kibera slum should embrace a cultural sensitive approach when interacting with the expectant mothers. This would influence the mothers to abandon the cultural practices that endanger their lives and that of their unborn children. By so doing the levels of maternal mortality would go down.
2. The medical practitioners should look into the expectations of the expectant mothers and change their way off operation taking into consideration these expectations. These would yield better results as they would come down to the level of the expectant mothers. Hence, the mothers would hearken to their advice which would go along way into reducing the levels of maternal mortality in Kibera slum.
3. The Ministry of Health should take the initiative to educate the residents of Kibera slum on the importance of attending antenatal and prenatal clinics. The MOH should also lead campaigns that condemn outdated cultural customs which subject expectant mothers to adverse risks even to the point of losing their lives. This can be done through the local media.

Recommendations for Further Studies

Based on the study findings, the following suggestions are made for further study:

1. A study on other factors that cause maternal mortality in Kibera slum.
2. A study on other effect of intercultural communication in Kibera slum.
3. A similar study in another location (Mathare Slum) for comparison purposes.

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