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CULTURAL NORMS THAT EXPECTANT MOTHERS IN KIBERA SLUM UPHOLD

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Abstract

Purpose: The purpose of this study was cultural norms that expectant mothers in Kibera slum uphold.

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 instruments to 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 professionals. The researcher analyzed both quantitative and qualitative data.

Results: The medical practitioners indicated that expectant mothers uphold cultural customs, cultural practices, cultural beliefs and cultural agreement values.The expectant mothers indicated that they observe various cultural norms .Results also revealed that the existence of cultural norms affect the intercultural communication of health information among expectant mothers. However, some of the expectant mothers take up advice that goes against their cultural beliefs and norms. They take up advice on various issues such as vaccination, giving birth in clinics, taking of drugs, going to prenatal clinics, family planning and undergoing caesarean during birth.

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 The MOH should also lead campaigns that condemn outdated cultural customs which subject expectant mothers to adverse risks even to the point of losing their lives.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

Keywords: *cultural norms*

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(GiveWell, 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 cultural norms that expectant mothers in Kibera slum uphold.

1.3 Objectives of the Study

i) To find out the cultural norms that expectant mothers in Kibera slum uphold.

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.

2.1 Literature 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.

Table 1: 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 4.

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.

Cultural Norms Upheld by Expectant Mothers

The study sought to establish the cultural norms that expectant mothers in Kibera slum uphold. Results in Table 5 show the results.

Table3: Cultural Norms Upheld by Expectant Mothers

Statement	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Expectant mothers uphold cultural customs.	0.00%	3.70%	25.90%	70.40%	0.00%
Expectant mothers uphold cultural practices.	0.00%	0.00%	0.00%	66.70%	33.30%
Expectant mothers uphold cultural beliefs.	0.00%	0.00%	0.00%	77.80%	22.20%
Expectant mothers uphold cultural agree values.	0.00%	0.00%	3.70%	74.10%	22.20%

Seventy point four percent (70.4%) of the medical practitioners indicated that expectant mothers uphold cultural customs. All the medical practitioners (100%) agreed that expectant mothers uphold cultural practices while all (100%) the medical practitioners agreed that expectant mothers uphold cultural beliefs. Further, results in Table 5 showed that 96.3% of the medical practitioners agreed that expectant mothers uphold cultural agreement values.

The peer professionals who were involved in the key informant interviews revealed that expectant mothers uphold various cultural norms. These norms included; when a mother is pregnant she is not supposed to walk around which contradicts the hospitals requirement to go for antenatal visits during pregnancy; in some cultures, a woman is not allowed to or supposed to show her belly yet when they go to hospital, they are required to show their belly to the medical practitioner during examination; in some cultures, women are not allowed to expose their body parts to any other person other than their husband and/or an approved TBA (who has to be a woman). During consultations in the hospital/clinic, doctors sometimes ask women to undress and this is against their cultural norm hence they are scared; expectant mothers shy off from going back to the clinic after they have attended for the first time and they thus prefer to give birth at home; some cultures do not believe in eating or not eating some certain types of foods

and drinks. During a consultation, a doctor will often advise an expectant mother to take or not take some certain types of foods; a woman is not supposed to get a child out of marriage; a young girl cannot become pregnant as she is seen as a disgrace and disappointment which leads to unsafe abortions; expectant mothers are not supposed to work and they are required to stay at home until about 4 to 6 months after giving birth; expectant mothers should only seek advice and medical examination from a female TBA; expectant mothers should not be seen roaming in the streets, as the pregnancy is usually a private affair; and some cultures require that expectant mothers should stay away from some certain types of foods.

The peer professionals also indicated that in the past medical practitioners were not aware of the cultural norms that expectant mothers uphold. However, in the recent past some of the medical practitioners have become conversant.Their awareness has changed the attitudes of the expectant mothers for the better whereby expectant mothers are encouraging each other to go to clinics, which shows that they are slowly becoming aware and informed about the value of consulting a health expert. They also added that being conversant with the cultural norms enables the medical practitioners toadvise the expectant mothers accordingly and hence this makes the mothers feel safe as they will feel that they do not have to dismiss what they believe. Hence the expectant mothers will not have a negative attitude towards medical practitioners and 'hospital phobia' will be reduced.

Results from the focus discussion group with expectant mothers revealed that indeed expectant mothers upheld veracious cultural customs. These customs included: they were not allowed to show our belly; when a girl gets pregnant out of wedlock it is considered a taboo; while pregnant a woman should rest and not work; expectant mothers are supposed to stay at home and not walk around; a male doctor is not allowed to examine them; they do not believe in the tetanus jab that is given to expectant mothers during pregnancy; they are scared of some of the immunizations that doctors give children immediately after birth; they have a negative perception about taking contraceptives;and that they believed that many children are good because atleast one of them will emerge a winner and remove you from poverty. Hence children are an investment.

Effect of Cultural Norms on Intercultural Communication

The study sought to establish whether upholding of cultural norms affect the intercultural communication of health information among expectant mothers. Results in Table 6 reveal that 92.6% of the medical practitioners agreed that upholding cultural norms affect the intercultural communication of health information among expectant mothers.

Table 5: Effect of Cultural Norms on Intercultural Communication

Response	Frequency	Percent
No	2	7.4
Yes	25	92.6
Total	27	100

One of the peer professional also agreed that cultural norms indeed affect intercultural communication between expectant mothers and the medical practitioners. This was due to the

fact thatexpectant mothers feel intimidated about the authority of the doctor, they are also afraid to ask questions as they feel intimidated. These findings are consistent with those of Ivry's (2010) who found that, in Japan and Israel, 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.

Advice against Cultural Norms

The study sought to find out whether expectant mothers can take up advice that goes against their cultural beliefs and norms. Results in Table 7 show that 88.9% of the medical practitioners agreed that mothers can take up advice that goes against their cultural beliefs and norms.

Table 6: Advice against Cultural Norms

Response	Frequency	Percent
No	3	11.1
Yes	24	88.9
Total	27	100

The medical practitioners indicated that expectant mothers take up advice regarding various aspects. These aspects include vaccination, giving birth in clinics, taking of drugs, going to prenatal clinics, family planning and undergoing caesarean during birth. These findings can be supported by those of Caluser (2007) who argued that identifying with the needs of different cultures with regard to maternal health care can assist to reduce maternal mortality.

However, results from the expectant mother involved in the FGD indicated that many women die due to pregnancy complications whereby many die while giving birth as they lack information about what is good/wrong, acceptable and not acceptable. They added that there are campaigns geared towards informing them about different things before during and after pregnancy but they hardly listen to this advice. These findings concur those of Ukwenya, Yusufu, Nmadu, Garba and Ahmed (2008) who carried out a cross-sectional study at a teaching hospital in Kaduna, Nigeria to investigate the extent and reasons for the delay between onset of symptoms and admission for treatment of symptomatic breast cancer. The study showed that delayed treatment of symptomatic breast cancer at this centre in Nigeria is as much related to the quality of medical care as it is to local beliefs, ignorance of the disease and lack of acceptance of orthodox treatment.

They added that there are many posters that give information about best practices in pregnancy (what to do and what not to do). However, the residents only look at the pictures. They also indicated that previously, the posters were written in English which was a barrier as a high percentage of Kibera residents are to some extent not literate and English is not their primary language. However, they have adopted a different approach in the recent past whereby the posters are written using Kiswahili but the readership has not improved either.

The busy nature of the residents was another reason cited for low readership of the posters even in hospitals, clinics and chemists. The expectant mothers further indicated that the community radio which is quite popular is used to pass information about the best practices during pregnancy. However, they are unable to follow the advice, such as going to hospital and give birth there as well as talking to a doctor at least 3 times during pregnancy, considering the high poverty rates in the region. Most of the residents are struggling to get food and school fees for

their children and thus going to hospital just to talk to a doctor really is not a priority. They claim that if they die during child birth, 'hiyo ni mpango wa Mungu'.

5.0 SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

Cultural Norms Upheld by Expectant Mothers

The first objective of the study was to find out the cultural norms that expectant mothers in Kibera slum uphold. The medical practitioners indicated that expectant mothers uphold cultural customs, cultural practices, cultural beliefs and cultural agreement values. The peer professionals indicated that expectant mothers upheld various cultural norms. These included: restrictions to walk aroundfor pregnant mothers which contradicts the hospitals requirement to go for antenatal visits during pregnancy; restrictions for expectant mothers against showing their belly yet when they go to hospital, they are required to show their belly to the medical practitioner during examination; restriction for expectant mothers to expose their body parts to any other person other than their husband and/or an approved TBA (who has to be a woman) whereas during consultations in the hospital/clinic, doctors sometimes ask women to undress; cultural norms that restrain one from eating certain types of foods and drinks;a woman is not supposed to get a child out of marriage; a young girl cannot become pregnant as she is seen as a disgrace and disappointment which leads to unsafe abortions; expectant mothers are not supposed to work and they are required to stay at home until about 4 to 6 months after giving birth; and expectant mothers should only seek advice and medical examination from a female TBA.

The expectant mothers indicated that they observe various cultural norms. These include; restrictions to show their belly; when a girl gets pregnant out of wedlock it is considered a taboo; while pregnant a woman should rest and not work; expectant mothers are supposed to stay at home and not walk around; a male doctor is not allowed to examine them; they do not believe in the tetanus jab that is given to expectant mothers during pregnancy; they are scared of some of the immunizations that doctors give children immediately after birth; they have a negative perception about taking contraceptives;and that they believed that many children are good because atleast one of them will emerge a winner and remove you from poverty. Hence children are an investment.

Results also revealed that the existence of cultural norms affect the intercultural communication of health information among expectant mothers. However, some of the expectant mothers take up advice that goes against their cultural beliefs and norms. They take up advice on various issues such as vaccination, giving birth in clinics, taking of drugs, going to prenatal clinics, family planning and undergoing caesarean during birth.

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;

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.

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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