

**SOCIO-CULTURAL FACTORS CONTRIBUTING TO MATERNAL
MORTALITY IN LONGIDO DISTRICT, ARUSHA CITY**

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**A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE
REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN GENDER
STUDIES**

**DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK
OF THE OPEN UNIVERSITY OF TANZANIA**

2023

CERTIFICATION

The undersigned certifies that she has read and here by recommends for acceptance by the Open University of Tanzania a dissertation entitled, “*Socio-cultural factors contributing to maternal mortality in Longido District, Arusha City*” in partial fulfilment of the requirements for the award of Masters degree of gender studies.



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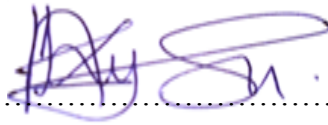
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A handwritten signature in blue ink, appearing to be 'Lucy Albert Kyungu', written over a horizontal dotted line.

Signature

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Date

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DEDICATION

I dedicate this dissertation work to my family members. A special feeling of gratitude to my late husband Mr. Adam J. Moshi. To my children, whose words of encouragement and push for tenacity ring in my years.

ACKNOWLEDGEMENT

First and foremost, praise and thanks to the Almighty God for his showers of blessings throughout the whole time I pursued my coursework and accomplished this dissertation. I am forever grateful to God. Secondly, I would like to express my sincere appreciation to my supervisor, **Dr. Betty Mntambo**, for her constructive guidance, assistance, counseling, and endless support that helped me accomplish this dissertation.

Thirdly, I would like to thank my family members for their never-ending love, prayers, caring, sacrifices, and maximum support to complete this research work. Their noticeable contribution is worth a lot.

Last but not least, my special thanks go to the government authorities from Longido district for their outstanding support in providing detailed information and logistics for meeting with target groups for interviews and focus group discussions (FGD).

ABSTRACT

This study aimed to assess the socio-cultural factors contributing to maternal mortality using the case of Longido district, in the Arusha region. The study adopted a cross-sectional research design. Also, the study employed a systematic (pseudo-random) sampling to select a sample size of 380 respondents from the study area. A questionnaire survey, FGD, and key informant interview were used to collect data. Statistical Package for Social Sciences (SPSS) version 20 was used as the data analysis tool. The findings revealed that women are not decision-makers on issues regarding maternal health in their families and community at large, where most of the decisions are influenced by their husbands. In addition, half of the 49% of respondents revealed that men do not provide maximum support to their pregnant wives during pregnancy difficulties, thus why the maternity mortality rate is high. Due to this, the study suggests that effective interventions are needed to encourage men to effectively cooperate with their wives on maternal issues so as to reduce the maternal mortality rate in Tanzania, especially in rural communities like the Maasai in Longido district. Furthermore, the findings noted that women are more active in attending healthcare centers for maternal issues compared to men with reasons that, men are busy with different economic activities. Thus, the study recommends that both government and other stakeholders should work together to raise awareness about maternal health in the community and encourage husbands and the community at large to be fully involved in maternal issues.

Key Word: *Social-Culture, Maternal, Mortality.*

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
BP	Bloomberg Philanthropies
BRN	Big Results Now
CHW	Community Health Worker
DC	District Council
EmONC	Emergency Obstetric and Neonatal Care
FCI	Family Care International
FGD	Focus Group Discussion
FYDP	Five-Years Development Plan
HAART	Highly Active Antiretroviral Therapy
HiAP	Health in All Policies
HIV	Human Immune Virus
HSSP	Health Sector Strategic Plan
IMR	Infant Mortality Rate
IPT	Intermittent Preventive Treatment
ITN	Insecticide-Treated Net
LDADPR	Longido District Annual Development Projects Report
LDCSP	Longido District Council Strategic Plan
LGAs	Local Government Authorities
MCH	Maternal Child Health
MDG	Millennium Development Goal
MDSR	Maternal Death Surveillance and Responses

MM	Maternal Mortality
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MOHSW	Ministry of Health and Social Welfare
NBS	National Bureau of Statistics
NMR	Neonatal Mortality Rate
OCGS	Office of Chief Government Statistician
PMTCT	Prevention of Mother to Child Treatment
RCH	Reproductive and Child Health
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDG	Sustainable Development Goal
SPSS	Statistical Package for Social Science
TDHS	Tanzania Demographic Health Survey
UN	United Nations
UNICEF	United Nations Children's Fund
URT	United Republic of Tanzania
USAID	US Agency for International Development
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

In the past two decades, there has been a noticeable decrease in maternal mortality worldwide during the period that the international community was attempting to attain Millennium Development Goal 5 (Kassebaum *et al.*, 2014; Alkema *et al.*, 2016). Despite various efforts by the World Health Organization, UNICEF, and World Bank worldwide to reduce maternal mortality, the decreasing rate is still unsatisfactory, with about 295,000 deaths in 2017, which are far from the Millennium Development Goal (MDG) target of 70% reduction in maternal mortality globally (WHO, 2017). According to WHO (2014), Tanzania is the third-highest number of maternal deaths in sub-Saharan Africa and the third-highest in the world.

The World Health Organization, UNICEF, the United Nations Population Fund, and the World Bank's 2019 report shows that from 2000 to 2017, the global maternal mortality ratio declined by 38.3% from 342 deaths to 211 deaths per 100,000 live births, according to UN inter-agency estimates. This translates into an average annual rate of reduction of 29%. While practically this is less than half the 6.4% annual rate needed to achieve the Sustainable Development Global Goal of 70 maternal deaths per 100,000 live births (World Health Organization, 2019).

The Millennium Development Goal 5 national target was to reduce maternal mortality to 193 maternal deaths per 100,000 live births by 2015 through high-skilled

birth attendance (80% of all births), the provision of comprehensive emergency obstetric care in 100% of hospitals, the provision of basic emergency obstetric care in 70% of health centers and dispensaries, and a contraceptive prevalence rate of 60% (MHSW, 2014). The millennium targets set were not efficiently met; hence, in September 2015, the General Assembly adopted the 2030 Agenda for Sustainable Development, which includes 17 Sustainable Development Goals (URT-MHSW, 2014).

Building on the principle of "leaving no one behind", the new Agenda emphasizes a holistic approach to achieving sustainable development for all. Among the 17 SDGs, Goal 3 is to ensure healthy lives and promote well-being for all at all ages. Among its several targets, the first two, which were aimed at reducing maternal, newborn, and under-five mortality rates, state: By 2030, to reduce the global maternal mortality ratio to less than 70 per 100,000 live births; by 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

On the contrary, maternal mortality is still high in developing countries, where estimates by the WHO (2015) showed that in 2015, roughly 303,000 women died during and following pregnancy and childbirth. Every day, approximately 830 women die from preventable causes related to pregnancy and childbirth, and 99% of maternal deaths occur in developing countries (WHO, 2016).

According to Tanzania's National Plan for Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (2021-2026), also known as One Plan III, Tanzania is committed to international, regional, and national policies to achieve sustainable and rapid reduction of maternal, newborn, and child deaths (URT-MHCDGEC, 2021). The plan is guided by the Global Women's, Children's, and Adolescent Health of 2016–2030. One Plan III is expected to encompass the Third National Five-Year Development Plan (FYDP III; 2021/22–2025/26). The FYDP III is a continuation of the government's efforts in achieving the goals set in the National Development Vision 2025 of enduring exertion to further improve the standard of living for all Tanzanians. The aim of One Plan III is to expand coverage and improve reproductive, maternal, newborn, child, and adolescent health (RMNCAH) services, as well as access to immunization and nutrition.

On top of that, Tanzania has effectively committed to reducing the maternal mortality rate by implementing several policies and plans. For example, through its fifth Health Sector Strategic Plan (HSSP V) 2021-2026, the government aims to continue improving its healthcare systems and increasing accountability among stakeholders (MHCDGEC, 2021). The mid- and annual reports of the HSSP (IV) 2015–2020 highlight the achievements made in the health sector during the first five years of implementing the MDG. Currently, through HSSP (V), the government aims to further strengthen health systems in order to sustain the achievements attained in improving reproductive, maternal, newborn, and child health as well as controlling both communicable and non-communicable diseases (MHCDGEC, 2021).

The plan also aims to incorporate Local Government Authorities (LGAs) in reaching all communities in implementing health policies and guidelines in order to achieve HSSP (V) goals. Also, HSSP (V) will employ a cross-sector collaboration approach under the guidance of the Prime Minister's office to ensure that the Health in All Policies Approach (HiAP) is effective. The plan aims to guide all stakeholders in the health sector, including development partners and non-state actors, in allocating resources for the health and inter-sectoral roles with a health impact (URT, 2017).

Furthermore, the government provides free reproductive health services. The services cover free vaccines for expectant mothers, free antenatal and postnatal clinic attendance, and free delivery kits as ways of solving the maternal mortality problem (U-National Health Policy, 2017). Other efforts include advocacy and awareness to discourage female genital mutilation (FGM), law amendments to discourage early marriages and pregnancies, gender-based violence, and gender inequality (Law of the Child Act, Cap. 13 R.E. 2019).

Moreover, numerous studies have been conducted to address maternal mortality; for instance, the population-based surveys by URT-MoHCDGEC (2016) indicated that the mean maternal mortality rate (MMR) in Tanzania was 556 per 100,000 live births, while the United Nations figure was 950 per 100,000 live births (Mbwana *et al.*, 2019). Different authors, such as Ujah *et al.* (2005), Atuhaire (2016), and Kaberuka (2016), reported that the problem is caused by various factors, including health system factors (poor health infrastructures, limited access to quality health services, inadequate human resources, shortage of skilled health personnel,

underutilization of modern family planning services, lack of equipment and supplies, and general poor health management systems) and non-health system factors (poor community involvement in planning and implementing several health services plans and policies, improper behavior of the society, and some socio-cultural practices). All of these studies show that the maternal mortality ratio (MMR) in Tanzania is still high compared to other countries in the world, where most deaths occur among women living in rural areas and in poorer communities.

Studies by Lowe *et al.* (2016) and Omer *et al.* (2021) pointed out that social-cultural factors are among the major causes of maternal mortality (MM) in developing countries, especially in rural areas. Those factors include early marriage, religious beliefs, gender inequality, traditional birth attendance, and bearing many children as social factors that contribute to MM. The authors went further by saying that inadequate health units, illiteracy, employment, and poverty are the leading social factors causing MM.

Since maternal mortality figures are far from reaching the SDG goal, further investigations are needed to obtain accurate, reliable, and relevant information to effectively reduce maternal mortality in Tanzania, especially in rural areas. This study is aimed at addressing the socio-cultural factors hindering the reduction of maternal mortality, particularly in Longido district in Arusha, Tanzania, where there is still a high maternal mortality rate.

1.2 Statement of the problem

Despite significant efforts undertaken to reduce maternal mortality in Tanzania, maternal mortality rates have increased to some extent compared to child mortality rates, which have greatly decreased in recent years, especially in rural areas (Tull, 2020). In the Arusha region, Longido district has been reported by URT-MoHCDGEC (2021) as having a higher maternal mortality ratio (MMR) than other districts, with 74 deaths per 100,000 live births.

Because of the unacceptable outcomes resulting from systematic and practical women's reproductive healthcare interventions and the patriarchal nature of Maasai communities, as well as the way of life that is largely based on traditional practices, the researcher was prompted to investigate sociocultural factors that may contribute to maternal mortality rates in Longido. Also, it is worth noting that no similar studies have been conducted in the study area to address this issue, as existing studies have mainly focused on understanding the magnitude, trends, and characteristics of maternal mortality (URT-LDADPR, 2022).

1.3 Objectives of the study

1.3.1 General objective

To examine socio-cultural factors contributing to maternal mortality in Longido district, Arusha City.

1.3.2 Specific objectives

- i) To examine how women make decisions over access to maternal services.

- ii) To investigate male involvement in maternal affairs.
- iii) To identify efforts done by the government and other stakeholders to reduce maternal mortality.
- iv) To suggest measures toward reduction of maternal mortality in Longido district.

1.3.3 Research questions

- i) How do women make decisions over access to maternal services and how does it contribute to maternal mortality?
- ii) How are males involved in fighting maternal mortality?
- iii) Are there any current efforts done to address the challenges towards the reduction of maternal mortality?
- iv) What can be done to reduce maternal mortality?

1.4 Significance of the study

Maternal health improvement attracted global attention at the 1987 Safe Motherhood Conference in Nairobi, Kenya. Since then, improving women's health issues pertaining to pregnancy and delivery has become the centerpiece of national development efforts in developing countries (World Health Organization, 2019). Though deaths from complications during pregnancy, childbirth, and the postnatal period have declined by 38% in the last two decades, at an average reduction of just under 3% per year, this pace of progress is far too slow.

Moreover, WHO reports that we have the opportunity to end preventable deaths among all women, children, and adolescents and greatly improve their health and

well-being. Moreover, improving maternal health is one of WHO's key priorities, grounded in a human rights approach and linked to efforts on universal health coverage (WHO, 2019), but to do so, we need to understand factors contributing to maternal mortality in our local communities. Thus, this study will provide information to policymakers, WHO, UNICEF, and other health-related NGO's at regional and local levels, the government, health service providers, and the community at large on how to effectively prevent maternal mortality in Africa and Tanzania in particular.

1.5 Organization of the study

This study comprises five chapters, as follows: Chapter one presents an introduction to the study, covering background information about the study, a statement of the problem, research objectives, research questions, and the significance of the study. Chapter two contains a literature review. Chapter three presents research methodology, while Chapter four presents research findings and a discussion of the obtained results. Chapter five presents a summary of results and gives a conclusion and recommendation, as well as sheds some light on further research. Lastly, extensive bibliographies, references, and appendices are included.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter covers the relevant literature for this study. It consists of definitions of key terms, a theoretical and empirical literature review, a research gap, the conceptual framework of the research, and a summary.

2.2 Definitions of the concepts

2.2.1 Socio-cultural factors

Refers to the lifestyle of a group of people, their customs and their value system (Shole, 2015). Mainly, the socio-cultural factors of a group of people is influenced by their beliefs, attitudes, family structures, social organization, demographic characteristics and religion (*Ibid*). Socio-cultural practices in rural areas may limit the resources available to pregnant women, resulting in adverse health consequences.

Other factors include female illiteracy, marriage at an early age, pregnancy often occurring before the maternal pelvis is complete, and harmful traditional medical practices, among others. Maasai women's land rights have been a major focus of empowerment efforts, yet only in a few regions in Tanzania do women constitute even one-quarter of the landowners (Moyo, 2017).

This gender disparity in land ownership impacts the economic status of women and further perpetuates a high level of dependency on their husbands, leading to male dominance. The dynamics of the relationship between a woman and her husband can

also determine a woman's access to healthcare and can lead to varying levels of partner-controlling behaviors, such as gender-based violence, which studies have shown is associated with poor maternal health (Maluka *et al.*, 2020).

Other Maasai traditional practices based on patriarchal beliefs also affect women's psychological and physical health. Polygamy, a common marital practice in many African countries, including Tanzania, particularly Ketumbeine, is deeply engrained in Maasai culture, where multiple partners are considered part of Maasai masculinity. As a result of this practice, men have abandoned older wives in favor of younger ones, leading to a vicious cycle of abuse toward women. Women in polygamous unions, especially senior wives, may suffer from more psychological disorders as well as more familial and economic problems compared to their counterparts in monogamous marriages.

2.2.2 Maternal mortality

According to Muoghalu (2010), maternal mortality is the death of a woman during pregnancy or within 42 days after pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from an accident or incidental causes. This definition allows the identification of maternal deaths based on their causes as either direct or indirect. Direct maternal deaths are those resulting from obstetric complications of the pregnant state (pregnancy, delivery, and postpartum), interventions, omissions, incorrect treatment, or a chain of events resulting from any of the above.

Deaths due to, for example, obstetric hemorrhage or hypertensive disorders in pregnancy, or those due to complications of anesthesia or caesarean section, are classified as direct maternal deaths. Indirect maternal deaths are those resulting from previously existing diseases or from diseases that developed during pregnancy and were not due to direct obstetric causes but were aggravated by the physiological effects of pregnancy (McGill *et al.*, 2015). For example, deaths due to aggravation of an existing cardiac or renal disease are considered indirect.

According to Mboera *et al.* (2018), the maternal mortality rate (MMR) is the number of women who die out of 100,000 live births in a given year from causes related to or aggravated by the pregnancy or its management (excluding accidental or incidental causes). It includes deaths during pregnancy, childbirth, or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy.

On the other hand, Shabani *et al.* (2018) reported that maternal mortality is defined by the timing of female deaths in relation to pregnancy as any death occurring during pregnancy, childbirth, or within two months after birth or pregnancy termination. This is similar to those of Muoghalu (2010), who perceives maternal mortality as the death of a woman during pregnancy or within 42 days after pregnancy, is adopted since this is the case mostly in Longido district.

2.3 Theoretical Literature Review

2.3.1 Gender Stratification Theory

This study lies on the theory of ‘Gender Stratification Theory’ developed by

Blumberg (1984). This theory tends to address several shortcomings of the modernization theory that has a relationship with the factors contributing to maternal death. From a gender stratification perspective difference such as gender, social class and ethnicity play a major role in ensuring we have a working social system. Women empowerment both economically and in decision-making, places women in a good position to positively influence their lives.

Breaking Noah's Ark, by demolishing the patriarchy system and bringing equality to both men and women in the division of house responsibilities especially house responsibilities, where women tend to do all the house tasks regardless of their health status. Community awareness on gender-based violence, male involvement, support and participation from conception to delivery and proper nutrition to pregnant women is very important. This line will translate to better health and less mortality. This theory is of great importance to this study since it gives an insight into maternal mortality which is the major theme of this study.

2.4 Empirical Literature Review

2.4.1 Trend of Maternal Mortality

2.4.1.1 Global maternal deaths

Bearing a child is a natural human process; however, it can be associated with a number of problems that may result in the death of either the baby, the mother, or both (Mbwana *et al.*, 2019). In a global perspective, the maternal mortality ratio (MMR) was estimated at 216 per 100,000 live births (Bishanga *et al.*, 2018). The recent investigation made by Atuhaire and Kaberuka (2016) on maternal deaths indicated that 107 million women died due to maternal causes between 1990 and

2015, although there was an overall decrease of 43.9% during the same period. Despite the overall decline in MMR since 1990, the ratio is 15 times higher in low-income countries than in high-income countries.

2.4.1.2 Maternal deaths in sub-Saharan Africa

According to the study by Atuhaire and Kaberuka (2016), the maternal mortality ratio in sub-Saharan Africa stands at 546 per 100,000 live births, accounting for about two-thirds of the global maternal deaths. Maternal mortality is one of the most neglected problems of healthcare in developing countries, including Tanzania (Shole, 2015); it is a major health problem in Sub-Saharan Africa as well. Estimates by the World Health Organization (WHO) (2015) and United Nations Children Fund (UNICEF) (2015) show that each year, all over the world, approximately 585,000 women die due to issues related to pregnancy and childbirth. Every day, 1,500 women die due to pregnancy or childbirth-related complications, and most of these deaths occur in developing countries (Gene, 2018).

According to Nyamtema *et al.* (2016), about 99% of all maternal deaths occur in developing countries, where 85% of the population lives. Women in developing countries carry pregnancies frequently on average, and their lifetime risk reflects the overall burden of these women. Women die from a wide range of complications in pregnancy, childbirth, or the postpartum period. There are five major causes of maternal mortality: severe bleeding (mostly postpartum), infection (mostly soon after delivery), hypertensive disorders in pregnancy (eclampsia), obstructed labor, and

unsafe abortion. There are, however, socio-cultural factors that contribute to women dying in pregnancy and labour that most of the times are neglected (Shole, 2015).

2.4.1.3 Trend of maternal deaths in Tanzania

Tanzania is among the countries in Sub-Saharan Africa with the highest figure of maternal deaths (Mbwana *et al.*, 2019). For almost three decades (1990–2016), MMRs in Tanzania have remained high, with no sign of a significant reduction despite several efforts, as pointed out by Dutta *et al.* (2015).

Maternal deaths are associated with both direct and indirect obstetric causes. The direct causes, which include hemorrhage, hypertensive disorders, obstructed labor, and sepsis, are responsible for about three-quarters of maternal deaths worldwide. On the other hand, indirect causes of maternal death include the effects of pre-existing disorders such as HIV, malaria, tuberculosis, mental diseases, epilepsy, a lack of emergency obstetric and neonatal care (EmONC), and diabetes (Shoo *et al.*, 2017). Many other factors have been associated with maternal deaths, including antenatal care, maternal education, age, and gravidity (Bishanga *et al.*, 2018). For instance, the highest parity-specific maternal mortality ratios have been reported among the grand multi-parous women (*Ibid*).

Together with the fact that maternal deaths have been included in the national surveillance systems since 2004, there is a limited utilization of data on hospital-based maternal mortality in Tanzania and other Sub-Saharan African countries, as reported by URT-MoHCDGEC (2016). By 2010, nearly one-third of sub-Saharan

African countries had not integrated maternal mortality data systems, as reported by Bishanga *et al.* (2018). Furthermore, a review of the status of maternal mortality surveillance in 2012 showed that data on maternal deaths is lacking or incomplete in about half of the countries involved (Shoo *et al.*, 2017). Weak health information systems are one of the key factors mentioned in most low-income countries, including Tanzania, that have resulted in very few attempts to analyze and use hospital-based data systems on maternal mortality, which could provide local-specific evidence for appropriate planning and management of the maternal mortality rate (Shoo *et al.*, 2017).

The latest national Demographic and Health Survey of 2017 reported a maternal mortality ratio of 556 deaths per 100,000 live births, with no evidence to conclude that the ratio has changed substantially over the last decade (URT, 2017). The perinatal mortality rate for the 5 years preceding the survey was 39 deaths per 1,000 pregnancies, with higher rates among the youngest mothers (less than age 20), the oldest mothers (ages 40-49 years), and urban populations (Shoo *et al.*, 2017). As the world transitions to achieving the SDGs, including targets 3.1 and 3.2 related to reducing maternal mortality and ending preventable new-born deaths, it is clear that Tanzania must accelerate efforts to improve outcomes for its women and babies.

URT (2017) noted that maternal health care in terms of antenatal care, including malaria in pregnancy, prevention of mother-to-child transmission of HIV (PMTCT), nutrition, and postnatal care, has improved. The majority of women about 74 percent received two or more doses of tetanus immunization in 2009, and the proportion

steadily increased to 88 percent in 2015. Efforts to combat malaria among pregnant mothers were done through the provision of two or more doses of SP for intermittent preventive treatment (IPT) of malaria during routine antenatal care visits, and the trend of using the doses improved from 32 percent in 2012 to 35 percent in 2015. 63 percent of births occurred in a health facility in 2015, compared to 50 percent in 2010 (URT, 2017).

According to URT-MHSW (2017), the number of women who had a live birth and were examined within two days of giving birth increased from 13 percent in 2004 to 32 percent in 2015. By September 2007, only 1,311 health facilities with prevention of mother-to-child treatment (PMTCT) services had been established within reproductive and child health (RCH) clinics throughout the country. However, by December 2015, a total of 5659 out of 6,067 health facilities were providing PMTCT services in RCH clinics. The number of births assisted by skilled health workers rose from 51 percent in 2010 to 64 percent in 2015. Despite these achievements, maternal and child health still has some weaknesses in the emergency system during the delivery process, including its infrastructure, the limited scale of maternal and child health services, and limited awareness of the importance of maternal and child health services in the community (URT, 2017).

2.4.1.4 Status of Maternal Health in Longido District

Longido District is one of the Districts in Tanzania faced by maternal problem in Tanzania (Hanson *et. al.*, 2017). The district has 27 health facilities of which 3 of them are health centers and 24 dispensaries. The entire 27 health facilities offer

maternal health services, and PMTCT six health facilities offers CTC. However, access to quality health care remains one of the major public health concerns attributed to inadequate human resources for health, limited health expenditure, and problems associated with the breakdown of the drug and medical supply chain particularly in Longido district.

According to LDADPR (2018) in Longido, 97% of mothers received one antenatal care (ANC1) visit, and 76% received 4 visits (ANC4) during their pregnancy. 54 percent had deliveries in a health facility, and 72% of mothers received postnatal care from health personnel within two days of delivery. Anaemia in women ages 15-49 is prevalent, with approximately 45% of women classified as having any type of anaemia in both DHS survey periods. The prevalence among women was 1.7%. Fifty-three percent of pregnant women reported sleeping under an insecticide-treated net (ITN) the previous night (LDADPR, 2018).

According to Hanson *et. al.*, (2017) nearly all (98%) women aged 15-49 received Antenatal Care (ANC) from a skilled provider (doctor/AMO, clinical officer, assistant clinical officer, nurse/ midwife, assistant nurse, or MCH aide). The timing and quality of ANC are also taken into considerations. Despite high coverage of ANC, only 1 out of 4 women had their first ANC visit in the first trimester, as recommended, and half (51%) of women made 4+ ANC visits. Women attending 4+ ANC visits have increased from 43% to 51% since 2015 (URT, 2017). 8 out of 10 women took iron tablets or syrup during pregnancy with the aim of

reducing/preventing maternal deaths. 88% of women's most recent births were protected against tetanus (URT-TDHS, 2016).

Among women who attended ANC for their most recent birth, 71% had their blood pressure measured, 60% had a urine sample and 87% had a blood sample taken to check for anaemia, urine protein, sugar, blood and signs of infection (URT-TDHS, 2016). The report by the 2015-16 TDHS-MIS indicates that the maternal mortality ratio (MMR) for Tanzania is 556 deaths per 100,000 live births (URT, 2017).

Most maternal deaths are preventable through cost effective public health measures. Having learned lessons from the Millennium Development Goals (MDGs) (WHO, 2015) Longido district is aligned with the aspirations of the world to eliminate maternal deaths as part of the Sustainable Development Goals (SDGs). According to the SDGs, countries with very high maternal mortality need to bring down their maternal mortality ratio to 140 maternal deaths per 100,000 live births (WHO, 2015). To achieve the above objectives, key strategic priorities in the plan include rolling out an enhanced Community Health Workers (CHW) programme that will support pregnant women to access services. Moreover, upgrading 29 facilities to care for pregnant women and newborns (25 'basic' and 4 'comprehensive' facilities) by upgrading standards including sanitation and hygiene as well as improving emergency obstetric services, and strengthening the MDSR system (LDADPR, 2018) which will eventually help curbing maternal deaths. This report (LDADPR) aims to demonstrate the efforts that were put in place to realize a functional MDSR system and structure in the country.

2.6.1 Male involvement in maternal death

WHO (2005) reported that urban-rural migration, high cost of goods, unemployment, gender inequality, lack of money, transportation, distance to a health facility, fear of going alone to health facilities, inability to make informed choices and the need to obtain permission from some authority such as husband for the married women are the major factors contributing to maternal mortality.

Weiss (2011) commented on women marginalization that, “women bear almost all responsibilities for meeting basic needs of the family yet are systematically denied the resources, information and freedom of action they need to fulfil.” Furthermore, the author pointed out that the majority of the world poor are women, two-thirds of the world’s illiterates are women, the millions of school-age children not in school are girls and HIV/AIDS today is rapidly becoming a woman’s disease.

Evjen-Olsen *et. al.*, (2008) conducted a study on the risk factors for maternal death in the Highlands of Rural Northern Tanzania. The findings indicated that increasing maternal age, ethnic and religious affiliation, and low formal education of the husbands were associated with an increased risk of maternal death. Furthermore, the authors emphasized that; education to the male decision-makers should be given high priority since their decisions greatly affects the survival of pregnant and delivering of women. Nevertheless, the authors assumes that most of the above-mentioned factors are caused by the situation whereby men marginalize women by not giving them chance to make decisions. In developed countries where both men and women have the right to make decisions, the mortality rate is very low. For instance the increasing

maternal rate which mentioned by Evjen-Olsen as a factor in maternal mortality, it is because of denied decision making to the women. A woman cannot decide on herself to stop bearing children even if she thinks that she is not at the right age to bear children.

According to ZEGRAHM (2018), Maasai society is firmly patriarchal, and women are not involved in development decisions but guided to carry out home-based activities including taking care of their children and their husbands. At the time of women pregnancies, men are not engaged either in ensuring hospital attendance or giving rest to the pregnant women which might be one of the causes of maternal deaths. Therefore, this study intends to establish that, if women would be able to decide for their families and community, the maternal mortality rate will significantly decrease.

The Tanzanian Ministry of Health, in line with WHO recommendations, emphasizes the particular importance of male involvement during ANC, but in common with everywhere else in the developing world where such aspirations exist, there is a gap between aspiration and reality in the county (Vermeulen *et. al.*, 2016). The African Women Foundation, through its Woman Centered Care Project, set about finding out why this is the case in a rural district of Tanzania, Magu. The research consisted of observations, focus groups and interviews whereby from the research findings it was noted that, together with other factors of maternal mortality like women's burden during pregnancies; but males were not full engaged on issues related to women's pregnancies.

2.6.2 The socio-cultural factors that contribute to maternal deathx

Cham *et. al.*, (2005) conducted a study with the main aim of describing the socio-cultural and health service factors associated with maternal deaths in the rural Gambia. The findings showed that women do seek access to care for obstetric emergencies, but dueto a variety of problems encountered, appropriate care is often delayed. In addition, the authors revealed that disorganized health care with a lack of prompt responses to emergencies is a major factor contributing to the increase of mortality rate.

According to URT (2005) the Maternal and Neonatal Program Effort Index reveals that factors such as women's low status in society, lack of access and control over resources, limited educational opportunities, poor nutrition and lack of decision-making power contribute significantly to unfavorable pregnancy outcomes. Cultural norms and values like those which require a woman to first obtain permission from her husband or parents may also discourage women and girls from seeking needed health care services.

Health care services such as family planning, safe abortion and treatment of STDs are naturally sensitive. The requirement to ask for permission is likely to make one fail and so remain with the problem and as a result, leads to health risks. Other traditional practices which affect maternal health outcomes include early marriage and Female Genital Mutilation (FGM). United Nations (2007) reported that, each year more than 500,000 women die from treatable or preventable complications of pregnancy and childbirth in developing countries. However, in reality the so-called

treatable diseases are conditions which are caused by socio-cultural factors.

According to Moyo (2017), culture is one of the noted causes of maternal deaths in Longido communities. The dominating ethnic group in Longido is Maasai. The Maasai are one of the Nilotic large groups dwelling in northern, central and southern Kenya and northern Tanzania. Maasai society is firmly patriarchal in nature, with elder Maasai men sometimes joined by retired elders, determining most major matters for the Maasai tribes. The Maasai people are monotheistic, and their God is named Engai or Enkai (ZEGRAHM, 2018).

The Maasai belief system is monotheistic. The god is called Engai and has a dual nature both benevolent and vengeful. The most important figure in the Maasai religion is the Laibon, a kind of priest and shaman, whose role traditionally includes healing, divination, and prophecy. In today's society, they also have a political function, as most Laibon belong to the elders' council (ZEGRAHM, 2018). Maasai villages are usually polygamous. When a woman marries, she doesn't just marry her husband, but his entire age group as well. Traditionally, a man was expected to give up his bed to a visiting male guest. This custom is now disappearing, but it is not uncommon for the woman of the house to join the guest in bed if she so desires.

The main role of Maasai women who are patriarchal is to have children, who are introduced to raising cattle as soon as they're able to walk. Due to high infant mortality in the past, babies are not named until they reach three months of age (ZEGRAHM, 2018). Following the socio-cultural behavior of Maasai, women do

deliver at home on their own or sometimes under local midwives. According to Shabani (2018), bearing a child is one of the important health aspects to both infant and mother and that neglecting this may lead to maternal death. These conditions would have been prevented if women and specifically pregnant women were able to participate in the decision-making process at all levels as well as being able to decide on the issues related to their health which is the major concern with socio-cultural behaviors in the Maasai ethnic group (ZEGRAHM, 2018).

2.5 Health Policies Framework

2.5.1 Health quality improvement

According to URT (2017) Tanzania strives to reach middle income status, the health sector has resolved to give more attention to the quality of health services in tandem with the pursuit of universal access. In the same vein, better health for the entire population has been promoted through the construction of health centers in all wards all over the country. With consideration of the severity of Maternal Mortality Rate (MMR) in Tanzania, the reduction of maternal, newborn and child deaths are a high-ranking priority. This commitment has been demonstrated in various national documents, which include Tanzania Vision 2025, the National Strategy for Growth and Reduction of Poverty (NSGRP), National Health Policy, and the Health Sector Strategic Plan IV which all denotes existence of mortality rate in Tanzania and the battle against it.

According to McGill *et. al.*, (2015), in 2013, Tanzania's Ministry of Health and Social Welfare (MOHSW) reviewed its national, medium-term maternal, neonatal,

and child health strategic plan that aimed to accelerate the country's progress toward MDGs 4 with the intention of alleviating maternal deaths. In local areas within Tanzania, maternal, newborn, and child mortality is high and disparities between urban and rural uptake of services are great. In recognition, the government of Tanzania sharpened the plans to fight against this situation with the aim of scaling up interventions with the highest potential impact, such as family planning, care at birth, postpartum care, and postnatal care; mechanisms to avert stock-outs of commodities essential to Reproductive Maternal, Neonatal, Child, and Adolescent Health (RMNCAH); and increased accountability and transparency at every level of the health system responsible for RMNCAH.

2.5.2 Big Results Now (BRN)

BRN according to URT (2015) was an initiative across multiple development sectors within the country. The government reported the results of its work on the healthcare sector in January 2015. Over its three phases, the BRN for health was focused in four areas: human resources for health distribution, health commodities, performance management, and RMNCH. For RMNCH, the stakeholders proposed to reduce maternal and neonatal mortality in five regions within the Lake and Western zones by 20 percent by June 2018.

BRN was expected to scale up high-impact interventions to complement those under the Sharpened One Plan. It was expected to raise community awareness and hence upgrade facilities to offer these services, use mobile phone messaging to support use of the services at the upgraded facilities, and increase voluntary blood donations to

keep pace with the demand associated with expansion of emergency care. Since among the objectives of BRN was to ensure all people acquire good health in order to have positive development results, it is obvious that this policy is of significant importance to be involved in this study as one of the tools to be used in assessing the response of different health stakeholders involved in this study.

2.7 Research gap

Poor understanding of the interplay of many socio-cultural factors and poor health services are the basic challenges facing women in rural areas. The reviewed literature shows that most of the studies conducted focused directly on understanding the magnitude, population, and economic factors, strengths and weaknesses of policies, and characteristics of maternal mortality (Armstrong, 2014; Afnan-Holmes *et al.*, 2015; Alkema *et al.*, 2016; Shoo *et al.*, 2017). This leaves a gap in the understanding of other antecedent factors, such as socio-cultural factors, combined with poor health services, especially in rural settings where healthcare services are relatively scarce and customs and traditions prevail. Thus, this study noted that the inability of women to make decisions is one of the cultural factors that are the root causes of diseases such as hemorrhage, sepsis, hypertension, eclampsia, and anemia. The situation in Longido district is more prominent since the culture of the Maasai society does not allow women to attend clinics, particularly at pregnancy stages; rather, they use local herbs that are not recognized by the authority. Moreover, women in the Longido district are facing serious poverty, which is associated with their culture since they are not allowed to own properties, which in turn hinders their access to health care services. Within their families, men are the decision-makers, whereas women have

no say even on their maternal health issues. Therefore, the current study intends to assess the socio-cultural factors that contribute to maternal mortality, which in turn will advise on alleviating the situation in Longido district.

2.8 Conceptual Framework

In this study, the researcher employed the cause-and-effect relationship conceptual framework where four variables were used. The first one is the independent variable, the second is the dependent variable, the third one is the moderator variable and the fourth is the mediator or background variable as represented diagrammatically in Figure 2.1. The dependent variable is the major theme of the study while independent variables include socio-cultural factors which accelerate maternal mortality rate. The moderator variables usually alter the effects of the independent variable on the dependent variables while the mediator variables link the independent and dependent variables.

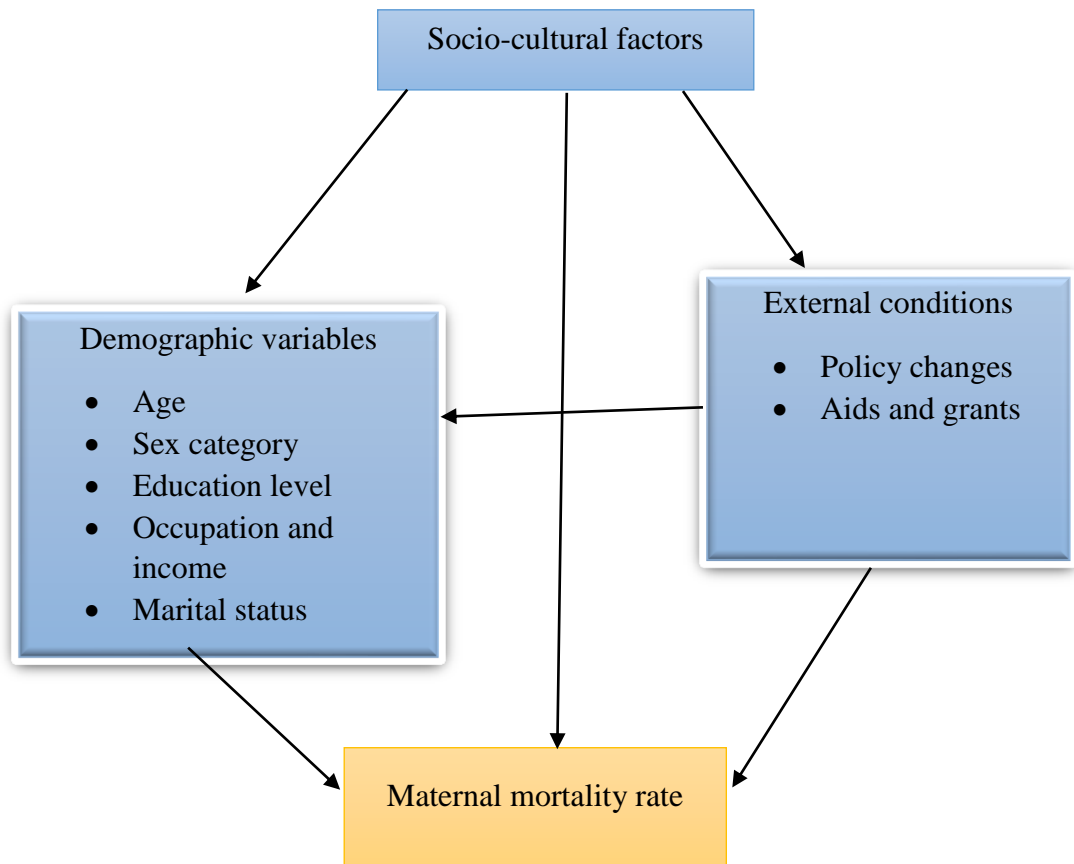


Figure 2. 1: Conceptual framework

Source: Researcher(2013)

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research design, study area, demographic characteristics, sampling procedures and techniques. The other part was data collection methods and analysis as well as ethical issues.

3.2 Research Design

The study adopted a cross-sectional research design whereby data collected at a single point in time. According to Kothari (2008) a cross-sectional design allows data to be collected at a single point in time without repetition from a sample selected to represent a large population. This design is considered useful for descriptive purposes and the determination of a relationship between variables (Oliver, 2006). Thus, the design was suitable for this study because of the limited time and financial resources needed during data collection.

3.3 Study area

The study was conducted at Longido District in Arusha region where Ketumbeine division was visited. The selection of the study area was based on several facts including the cultural significance of the area, its relevance to the study topic and its novelty which provided an opportunity for new insight and discoveries because in the past the research topic has never been extensively studied in the study area.

Longido was established in July 2007 by provisions of sections 8 and 9 of the Local Government (District Authorities) Act 1982. Currently, the District has 22

Councillors of which 16 were elected from the wards within the council, six councillors as special seats and one member of parliament to represent the constituency of Longido. Longido District Council is amongst six district councils that form Arusha Region. The district is located between 36⁰ 00' and 37⁰ 30 East 1⁰ 00 and 3⁰ 00 East, which in the north it borders the Republic of Kenya, Arusha municipal council borders in the east, Rombo district council in the south, borders Monduli and Siha district councils to the south-east and in the west borders Ngorongoro district council.

Administratively the district is divided into four divisions (Longido, Ketumbeine, Engarenaibor and Enduiment), 18 wards and 49 villages. The main ethnic group in the district is the Maasai community who are mostly pure pastoralists.

Longido district has an area of 7,782 Square Kilometers of which square kilometre 9.4% is arable land, equivalent to 73,164 hectares while 6,392.35 square kilometres is grazing land, or 639,235 hectares, which is equivalent to 82.14 %. Also, 365.75 square kilometres of land is covered by forests and rocks, or 36575 hectares equivalent to 4.7%. According to the 2012 National Population Census, the district had a total population of 123,153 of which 60,199 are male and 62,954 being female, with a growth rate of 3.8% compared as compared to the 2002 National Population Census which counted a total number of about 74,074 people of which 37,999 was female and 36,075 males.

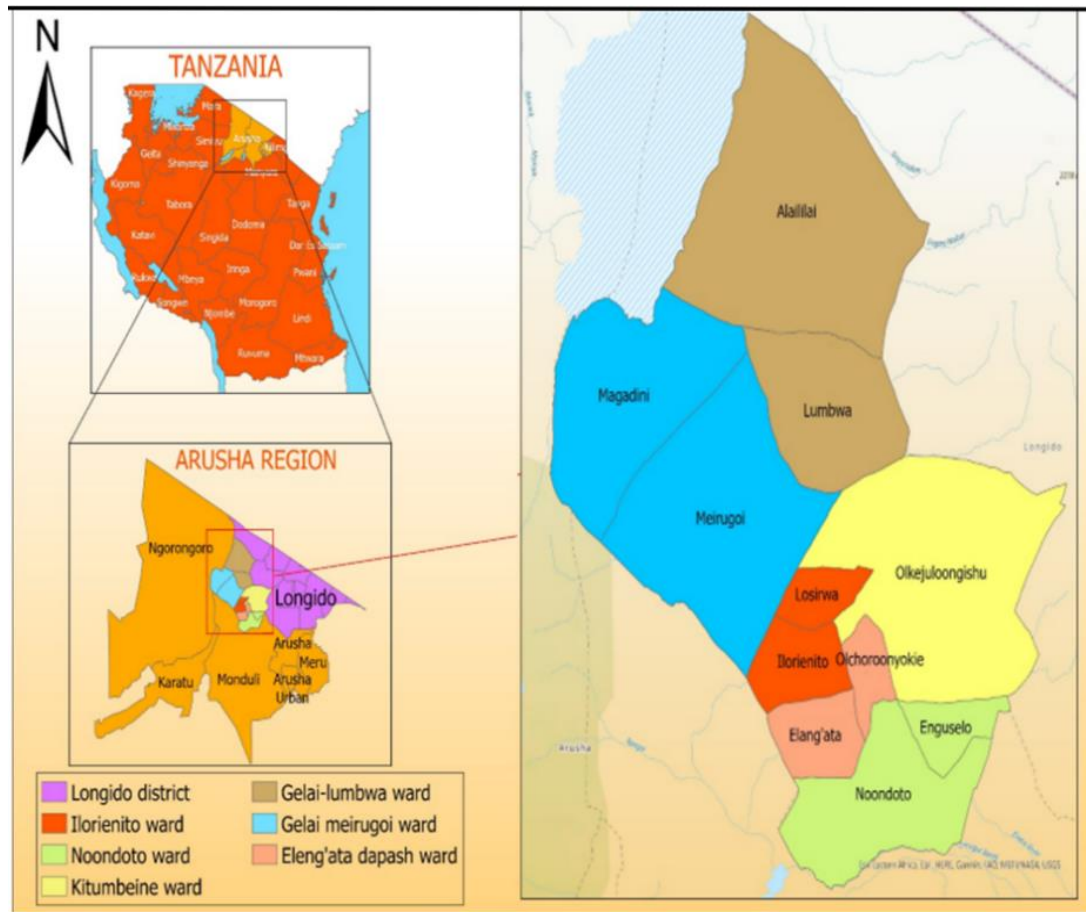


Figure 3. 1 Map of Longido district

Source: Longido DC, 2019

3.3.1 Health Facilities in the Study Area

Longido district council has two (2) government healthcare centres, 1 Faith-Based Organization (FBO) healthcare centre, 22 government dispensaries and 3 FBO dispensaries. The district has no district hospital, moreover, the required health centres are 16 and it has only 3 healthcare centres the required dispensaries are 41 and the existing are 25 including FBO dispensaries. There are 123 healthcare staff out of 292 needed. There are no expert doctors due to the lack of a District hospital, there is one medical doctor out of the four needed. Assistant medical doctors are 3

out of 8 needed, Clinical officers are 16 out of 52 needed. There are 42 registered and enrolled nurses out of 72 needed. The top ten diseases for under five and above five are, ARI, pneumonia, malaria, intestinal worms, minor surgical condition, diarrhoea, eye conditions, skin diseases, ear conditions, and UTI. Also, PID and neurosis are among the top ten to above five. There is a shortage of healthcare services according to the National Health Policy. Therefore, the need for healthcare services in the district council is still very high. Also, accessibility of healthcare services to some health facilities becomes difficult because the district has a network of rough roads with difficult passage during the rainy season.

3.3.2 Sample size

In this study, a sample size of 380 individuals was drawn from the population of individuals selected from nine villages of the Ketumbeine division. The study adopted a formula by Yamane (1967) to calculate the sample size. According to Israel (1995) for the calculation of the sample size of the known population 5% to 10% sampling error can be used. The study population was estimated to be 7,233 individuals (LDADPR, 2022). This is the number of people affected either directly or indirectly by maternal deaths. The formula is given as follows;

$$n = \frac{N}{1 + Ne^2}$$

Where; n = sample size

N = population size

e = 5% \approx 0.05

So, the sample size was calculated as

$$n = \frac{N}{1 + N(e)^2} = \frac{7233}{1 + 7233 * 0.05^2} \approx 380$$

Therefore, the sample size for this study comprised 380 individuals.

3.3.3 Sampling technique

In different situations, the choice of a specific sampling method may be affected by some factors like geographical location of respondents, cost and time considerations, hence sampling frame and the sample size is required (Chander, 2017). This study employed a systematic (pseudo-random) sampling method since the objective of this study was to generalize the findings to the other divisions of Longido district. With this method, the first member of the sample was selected randomly like in simple random sampling. Then every tenth member of the study population was selected after the first one until a sample of 380 respondents was attained.

3.4 Data collection Method

Several data collection methods were used in this study in order to obtain sufficient information related to socio-cultural factors to maternal mortality.

3.4.1 Primary Data Collection

The study involved multiple data collection methods to collect primary data such as a questionnaire, focus group discussion, and information from key informants. Questionnaires consisted of both closed and open-ended questions. The open-ended questions sought to collect information on the respondents' understanding of socio-cultural factors contributing to maternal mortality in the Longido district. On the other hand, focus group discussions and key informant interviews helped to identify

challenges, the current situation of maternal health as well as explore the strategies to effectively reduce maternal mortality in Longido district and Tanzania at large.

3.4.1.1 Questionnaire

The questionnaire developed contained information on demographic characteristics of participants, economic factors that contribute to maternal deaths, male involvement in maternal health, social factors contributing to maternal mortality, cultural practices affecting maternal health, current efforts and challenges toward reduction of maternal mortality as well as strategies for reduction of mortality rate before, during and after childbirth in the communities and healthcare services in Longido district. Data were collected using a self-administered questionnaire to 380 respondents who are in their reproductive age. The questionnaire was translated into the Swahili language.

3.4.1.2. Focus Group Discussion (FGD)

This study employed FGD to obtain depth understanding of how women make decisions over access to maternal services and how it contributes to maternal mortality, male involvement towards fighting maternal mortality, current efforts done and the challenges towards the reduction of maternal and strategies of women towards fighting maternal mortality in Longido district. One group made of males and females of reproductive age contained 8 to 10 respondents were purposively formulated in two villages of Ketumbeine ward making a total of 2 groups. The participants were mixed depending on age, gender and class background to stimulate the activeness of the discussion. Concerning objectives, reflective questions were

constructed and used throughout the discussion in which a group facilitator was the centre of the discussion and one assistant to record and collect the information.

3.4.1.3. Interview

The interview was conducted with key informants who were District Reproductive Health Coordinator, District Nutrition Officer, District Medical Officer, District Health Officer, District Social Welfare Officer, midwife officers, ward and village leaders and Traditional birth attendants. Key informants were individuals who have specialized knowledge, expertise and experience in the area being studied. Including key informants provided valuable insights and perspectives that were difficult to capture through other research methods. For example, healthcare officials provided valuable insights into the effectiveness of public health interventions and programs. Furthermore, key informants had access to information that is not available to the general public. This includes confidential information, specialized databases, or insider knowledge of communities. Including key informants helped a researcher to gain access to this information, which was critical for understanding the research topic.

Also, including key informants helped to increase the credibility and validity of the research study since key informants provided expert opinions and helped to validate the findings of the study. Lastly, village leaders and traditional birth attendants provided insights into cultural norms, practices, and beliefs that were important for interpreting the findings of the study.

Personal interviews were conducted to acquire much reliable information on social factors contributing to maternal mortality, cultural practices affecting maternal health, male involvement in maternal health, efforts to reduce maternal health, challenges facing maternal health and strategies to reduce maternal mortality in Longido district. Key informants were selected in a way that they can provide relevant information on maternal health and factors affecting maternal health.

3.4.2 Secondary Data

The secondary data were collected from the district offices and other sources such as journal articles, books, health reports at the hospital and other health facilities were consulted. The documents used by the researcher include internal Longido health services reports (such as a quarter or annual reports) and external records (such as records of funds from donors). Documents used included hard copy and softcopy of , program logs, performance ratings, funding proposals.

3.5 Pre-Testing the Instruments

Before the actual data collection, the questionnaires were tested by involving a few twelve (12) respondents. The aim of pre-testing, as pointed out by Kajembe *et. al.*, (1996), was to check the validity and reliability of the questions. Then the initial draft of the questionnaire was modified to fit the conditions based on the pre-test results.

3.6 Data Processing and Analysis

Quantitative data were cleaned, coded, sorted, organized, checked, and analyzed using Statistical Package for Social Sciences (SPSS) version 20. Verbal responses

from key informants and focal group discussions were analyzed using a thematic analysis approach. The central theme for discussion was based on how women make decisions over access to maternal health, how their decisions influence maternal mortality, and male involvement in relation to maternal health. The method was used to establish patterns of data and group respondents' views, opinions, and experiences according to their similarities based on the defined theme. The output was summarized in descriptive statistics such as frequency, mean, and sums and presented using tables, charts, and figures.

3.7 Ethical clearance

To perform this research effectively, all ethical considerations were adhered to. For effective data collection, an approval for ethical clearance for carrying out this study was obtained from the Open University of Tanzania which indicated all necessary particulars including the name of the research, the name of the University and the intention of the study. The letter to request permission to do the study on the selected ward in Longido District was obtained from the OUT then submitted to the Longido District office for approval. The information obtained was used for research purposes only. Confidentiality of participant information from the data collection to analysis was observed, participants did not write their name on the data collection too.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents the results and discussions of research findings. Results are presented according to the research objectives. Furthermore, this chapter incorporates some important information that acts as building blocks in achieving the research objectives.

4.2 Demographic characteristics of the respondents

The ability to interpret the impact of socio-cultural factors contributing to maternal death depends on many factors whereby in this context demographic information is among the priorities (Shoo *et. al.*, 2017).

4.2.1 Distribution of respondents by gender

The findings indicate that 65% of the respondents were female whereas 35% of the respondents were male as shown in Table 4.1. It should be noted that the ratio of male-female was not symmetrically proportional due to the subject matter of the study as maternal problems affect females and males in different ways since their roles are interdependent although females are mostly affected.

Longido like other rural areas of Tanzania, gender stratifies individuals within society into different classes either by education, income or occupation which may provide room for some limitations, especially to women and girls as they are dominated and receiving minimal attention from their early childhood.

Table 4. 1: Distribution of respondents by gender

Sex	Frequency	Percent
Male	133	35
Female	247	65
Total	380	100

Source: Field data(2023)

4.2.2 Age of the respondents

An age limit is required in many aspects, including the time required to start and stop giving birth. It is worth considering since the study incorporated individuals who are not beyond reproductive age due to several reasons. Firstly, participants who are beyond reproductive age can provide valuable insights into the long-term effects and consequences of reproductive issues. For example, they may be able to provide information on the impact of reproductive health issues on overall health and well-being in later life. Also, reproductive issues can have a significant impact on not just the individual but also their family members and future generations. Including participants beyond reproductive age can help capture the intergenerational impact of reproductive issues. Furthermore, including participants from a diverse range of ages and life stages can help ensure that the study findings are applicable to a wider range of individuals and populations. Lastly, a comprehensive approach to studying reproductive issues should include individuals from different age groups and life stages. This can help provide a more complete picture of the issue being studied and lead to more effective interventions and policies.

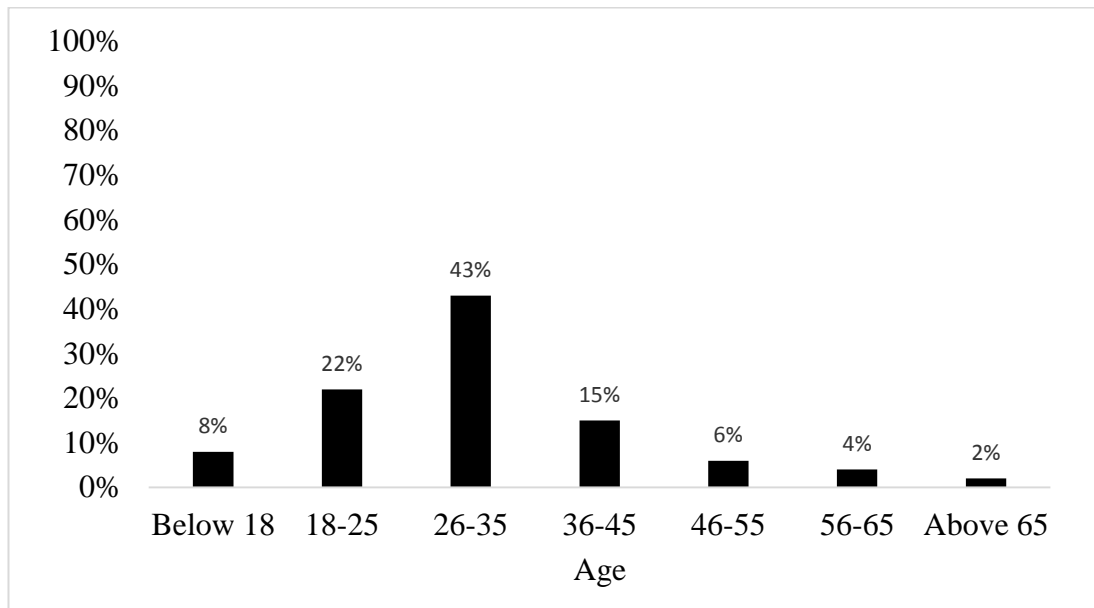


Figure 4. 1: Age of the respondents

Source: Field data(2023)

The study findings indicate that 43% of all respondents were in the age group of 26–35 years, while 22% of the respondents were between the ages of 18–25 years. Another group of 15% of the respondents were between the ages of 36–45 years; 6% were between the ages of 46–55 years; 4% were between the ages of 56–65 years; and the last group of 2% of the respondents were above the age of 65 years. These findings imply that age is not the main reason for maternal mortality since the majority (80%) of the respondents were in the recommended reproductive age range (18–45 years). This is consistent with Ujah *et al.*(2005)’s study that age has a direct relationship with maternal mortality, meaning that teenagers and older women are at greater risk of maternal death compared to other age groups.

4.2.3 Education of the respondents

Numerous definitions of education exist. However, for this study, education means learning knowledge, skills, and attitudes to develop the powers of reasoning and judgment (Oxford dictionary, 2019). Learning means deciding about your lifestyle. The impact of education is well prominent in health management and deciding to follow the best cultural practices. This research classified education into five levels which can be categorized into two categories of those with formal education and non formal education.

Table 4.2: Distribution of the respondents by education

Education level	Frequency	Percentage
Primary education	92	25
Secondary education	43	11
Certificate holder	27	7
Diploma holder	13	3
Degree and above	7	2
No formal education	198	52
Total	380	100

Source: Field data(2023)

The results indicate that 52% of the respondents had no formal education, as illustrated in Table 4.2. No formal education it means that an individual has not attended a formally agreed-upon trend of education as outlined in government policies and regulations. However, it should be noted that these individuals with no formal education can gain very wide knowledge on a particular theme through experience. According to the study done by Evjen-Olsen *et al.* (2008), findings indicate that low formal education of the husbands is associated with an increased

risk of maternal death and that education of the male decision-makers should be given high priority since their choice greatly affects the survival of pregnant and delivering women.

The study further noted that respondents who attained primary education were 25% of all respondents, while respondents who managed to attain secondary education were found to contribute 12% of all respondents. The study also noted that respondents with diploma education levels comprised 3% of all respondents involved in this study, and those having attained certificate levels were 7%, as illustrated in Table 4.2, while the final academic level attained was the degree and above, which comprised 2% of all respondents involved in the study. The findings signify that the majority of the community has a lower level of education or no education, which may have direct or indirect implications for maternal education. Similarly, Karlsen *et al.* (2011) reported that **lower** levels of maternal education are associated with higher maternal mortality, even among women able to access facilities providing intrapartum care.

4.2.4 Main occupation of the respondents

It was important for the researcher to know the major economic activity of the respondents as one way of determining income level where at the end could give the picture of his or her ability to attend and pay for health services. Although the type and workload matter when it comes to maternal health, for instance overworking have adverse impacts on maternal health including pre-term delivery, low birth weight, birth defects and spontaneous abortion.

Table 4.3: Main occupation of the respondents

Occupation	Frequency	Percentage
Employed	23	6
Business	8	2
Farming	65	17
Mining	34	9
Livestock keeping	114	30
Livestock keeping and farming	95	25
No specific job	42	11
Total	380	100

Source: Field data(2023)

From Table 4.3, the findings revealed that 30% of the respondents were livestock keepers, while 25% of the respondents were both livestock keepers and crop cultivators. The two economic activities (livestock and farming) were noted to be dominant in the study area. Farming was also reported by 17% of the respondents, while 11% of the respondents had no specific job. Other economic activities noted to be undertaken in the study area were mining, which constituted 9% of the respondents; another 6% of the respondents were employed; and the remaining 2% of the respondents were engaged in businesses. This signifies that the majority of the respondents in the study area can have access to maternal healthcare services since they involve themselves in various economic activities; however, some economic activities, such as mining activities, can have a negative impact on pregnant women as they involve chemicals and a heavy workload. According to the study done by Casas et al. (2015), employment during pregnancy is associated with a reduction in

the risk of preterm birth, and work in certain occupations may affect pregnancy outcomes.

4.2.5 Marital status of the respondents

Marital status of the respondents plays significant role in the maternal health as married people tend to enjoy greater health and well-being than non-married due to the support from the partner participation in the socially accepted role of marriage.

Table 4.4: Marital status of the respondents

Marital status	Frequency	Percentage
Married	257	68
Single	56	14
Separated	25	7
Widow(er)	42	11
Total	380	100

Source: Field data(2023)

The findings indicate that 68% of the respondents were married while 32% were not in married by being either single, separated, or widow(er) as shown in Table 4.4. The study findings suggest that majority of the respondents are likely to get assistance from their partners in case of maternal complications since most of them are married. These results are similar to those of Bennett (1992) that marital status has long been recognized as a major factor associated with maternal health. The author went on by saying that marriage provides a protective environment for women and children before, during and after childbirth unlike those who are unmarried, divorced or widows in the healthcare services.

4.3 Women's decision making over access to maternal services.

Decision making plays an integral part in determining an individual's future since it allows making decisions per somebody's advantages. In rural areas, especially in Maasai communities' women are not free to make decisions on their matters including maternal health. During FGDs respondents were asked how women make decision over access to maternal services and whether it has contribution to the maternal health in the community. One of the respondents aged 58 years from Loposek ward said:

“In the Maasai community women do not have authority to make decisions on any matter, normally decisions are made by their husbands, their parents or elders.”

This situation hinders women autonomous in deciding the best practice to manage their maternal health. For example, one of the respondents aged 19 years from Noondoto ward said:

“When I find out I am pregnant I visit the nearby health centre for checkup and consultation”

The researcher noted that, despite some traditional and cultural beliefs (that, it is considered bravery to get traditional maternal services) among Maasai communities still few women consider visiting health services is the best option for their maternal health. Moreover, some women claimed that they make decision based on experience from other women in their family/ community who had given birth already. Generally, from the discussion researcher observed that women are not sole-decision makers in matters concerning maternal health in their families and community at

large. Women decisions on access to maternal health are influenced by their husbands, parents and elders as well as experienced women in their society. The fact that women are not allowed to make their own decisions and how decision are made have contributed to the increase of maternal mortality rate. According to the study done by Ghose, *et al.*, (2017) neither making decisions alone nor deciding jointly with husband/partner was always positively associated with the utilization maternal health service. Thus, spousal cooperation on household and health issues could lead to higher and better utilization of maternal health services.

4.3.1 Women participation in maternal health decision making

The researcher also wanted to understand how women participation in making decision and its contribution toward reduction of maternal mortality in the study area.

Table 4.5: Participation level in maternal health decision making

Decision maker	Frequency	Percent
Father	198	52
Mother	42	11
Both father and mother	72	19
Others	11	3
family members	57	15
Total	380	100

Source: Field data(2023)

The study's findings from Table 4.5 shows that 52% of the respondents reported that husbands were the main involving in decision making process whereas only 19% of the respondent said that the husbands involve their wives in making decisions for the sake of the household's benefits.

Moreover, 15% of the respondent reported that all adults' family members in the family had the mandate to make decisions for the household while mothers were reported to have a say for the household according to 11% of the respondents. Other relatives like uncles and aunt also were noted to have been contributing to decision making as reported by 3% of the respondents. These findings indicate that within the households and community settings, women have limited autonomy and control over their reproductive health decisions this was support by 52% of the respondents. This implies that major efforts from the government and the specific community is needed to reduce patriarchy systems so as to reduce the maternal mortality rate. This is in line with the study by Ganle *et. al.*, (2015) who argue that interventions to improve women's use of maternity services should move beyond individual women decision rather to target different stakeholders at multiple levels, including husbands and mothers-in-law. Similarly, Rizkianti *et. al.*, (2020) reported that women's decision-making independence had a significant effect on the use of adequate antenatal care services only.

4.4 Male involvement in maternal affairs.

Men have greater influence over household resources and decision making to facilitate care seeking and navigate challenges accessing care for women and newborns (Greenspane *et. al.*, 2019). The findings were well presented in Table 4.6.

Table 4.6: Male's participation in maternal health issues

Do male involve themselves in maternal issues?	Frequency	Percent
Yes	118	31
No	186	49
Rarely	76	20
Total	380	100

Source: Field data(2023)

Table 4.5 shows that 49% of the respondents said that men do not provide assistance to their pregnant wives, 31% of the respondents said that men were assisting their wives at the time of pregnancy difficulties, while 20% of the respondents agreed that men rarely offer supportive measures to their wives. Thus, there is a need to have effective interventions that could encourage men to be positively and proactively involved in maternal and newborn health so as to effectively reduce maternal health complications including death. This is consistent with the Mersha's (2018) study that due to very poor male involvement in maternal issues in the community it is recommended to advocate policies and strategies that can improve awareness of men and enhance their engagement in the maternal care processes.

4.4.1 The extent of male involvement in maternal issues

Taking into consideration from respondents that men are less concerned with maternal issues (refer section 4.3), the researcher was interested to explore the extent of their involvement in maternal issues. This is due to the fact that men's involvement in maternity care is recognized as a key strategy in improving maternal health and accelerating reduction of maternal mortality (Nyasiro *et.al.*, 2019). The results were illustrated in Table 4.7 below.

Table 4.7: Extent of participants' involvement in maternal issues

Responsible	Frequency	Percent
Women	250	66
Men	38	10
Both women(Mother) and Men (father)	65	17
In-laws	27	7
Total	380	100

Source: Field data(2023)

The findings above revealed that 66% of the respondents reported that women are more responsive to attend at hospital and healthcare centers for maternal issues compared to their men(husbands) as illustrated in Table 4.7. Also, 10% of the respondents said that men attend maternal issues, while 17% of the respondents mentioned that both men and women attend and involve in maternal issues. Another group of respondents which constituted 7% said in-laws are more responsible for maternal issues. Conclusively, the findings implies that women are more active in reducing/preventing maternal complications in the study area as compared to their men(husbands) counterpart. The study done by Rizkianti *et. al.*, (2020) suggested that to increase men's awareness of the importance of maternal health services gender-sensitive initiatives should be conducted to promote husband involvement.

4.4.2 Reasons for poor males' involvement in maternal issues

Taking into consideration from respondents that men are less concerned with maternal issues, the researcher went further by investigating the reasons for them not to engage on maternal issues. The results were well illustrated in Table 4.8.

Table 4.8: Reasons for poor male involvement in maternal issues

Reasons for poor male involvement in maternal issues	Frequency	Percentage
Men are busy with economic activities	133	35
It is women's and not parental issue	99	26
Not Maasai culture	68	18
Men are not allowed to enter labour ward	57	15
Don't know the reason	23	6
Total	380	100

Source: Field data(2023)

Table 4.8 indicates that 35% of the respondents claimed that men do not participate in maternal issues because they are busy with different economic activities, which sometimes involve travel, which makes it difficult to accompany their wives to attend maternal issues in the healthcare centers. Other respondents, about 26%, suggested that maternal issues are more of women's concern and are their primary responsibility. Furthermore, 18% of the respondents claimed that men perceive maternal issues as not their responsibility according to their culture.

15% of the respondents said that men do not involve themselves in maternal issues because they are not allowed to enter labor wards. However, the issue was not to enter the labor ward but to provide maternal health assistance from conception to delivery and after delivery. Although men are mostly involved in daily economic activities, that should not be taken as an excuse for not participating in maternal issues. Therefore, from this discussion, it is worth concluding that men need to be educated on the issues of maternal complications, and if they could accept to assist pregnant wives, perhaps maternal deaths could not happen. This is well supported by Mersha's (2018) findings that men's involvement in maternal issues makes it very recommended to come up with some measures that could improve men's awareness of engaging in maternal care.

4.5 The efforts done by the government and other stakeholders to reduce maternal mortality

Through key informant interview with District Executive Director (DED), District Reproductive Health Coordinator, District Nutrition Officer, District Medical Officer, District Health Officer, District Social Welfare Officer, midwife officers,

ward and village leaders. Specifically, through Longido District Council Strategic Plan 2014-2019 pg. 40, DED reported that, *‘‘District planned to’’*;

- *‘‘Enhance staffing level from 41% to 100% by June 2019 through training 59% of available staffs and recruitment of new staffs’’.*
- *‘‘Improve health infrastructure by construction of one district hospital by June 2016, building 5 staff houses from 2017 to June 2019, construction of OPD, administration and IPD block’’.*
- *‘‘Improve dispensaries infrastructure by constructing 4 new dispensaries in order to increase the number of dispensaries from 24 to 28 by June 2019, Construction of RCH, OPD and staff houses as well as establishing Partnership with FBOs facilities’’.*
- *‘‘Improve Medical equipment, medicines and hospital supplies by ensuring sustainable availability of medical equipment, medicines and hospital supplies from 65% to 100% by June 2019, efficient procurement of medical equipment, medicines and hospital supplies Increasing cost sharing collection, CHF and NHIF timely submitted report and request for medical equipment, medicines and hospital supplies to enter into contract with other suppliers in case of out of stock from MSD’’.*
- *‘‘Reduce Maternal Mortality rate from 74/100,000 to 50/100,000 by 2019 through improvement of reproductive and Child Health Services as well as increasing number of mobile clinics sites from 16 to 25 and outreach service from 12 to 20’’.*

Thus, understanding from the communities' point of view whether maternal mortality can be reduced was an important aspect of this study in order to investigate the efforts done towards the reduction of maternal mortality at Ketumbeine division in Longido district. According to Bergsjö and Villar (1997), many antenatal interventions have been shown to reduce neonatal morbidity and mortality. Furthermore, antenatal care can also encourage birth preparedness and the use of skilled assistance in labor and delivery.

According to the Longido District Executive Director, the prospective challenges facing efforts towards reducing maternal mortality are inadequate availability of financial resources, poor participation by individuals and groups as a whole (including other stakeholders), political changes, and management changes.

4.6 Suggested ways toward reduction of maternal mortality

In response to the possibility of reducing and preventing maternal deaths in the study area the researcher was interested to find out the opinion of respondents on the possible ways to reduce or prevent maternal deaths totally. The findings are presented in the figure below;

Table 4.9: Strategies to reduce maternal deaths

Strategy	Frequency	Percentage
Providing maternal education	95	25
Attending clinics	103	27
Improvement of health services	38	10
Banning local maternal services providers	23	6
Increase number of health attendants	76	20
Introduce free health services	46	12
Total	380	100

Source: Field data(2023)

The study findings revealed that 25% of the respondents suggested the provision of maternal education to create more awareness on maternal health. While 27% suggested pregnancy women to attend clinics and 20% proposed the increase in number and quality of health professionals and improving terms and conditions in the health facilities. Also, 12% and 10% of the respondents suggested that government should introduce free health services policy and improve health services respectively. Moreover, 6% of the respondent in the study area urged that government should ban local or traditional health services providers and herbalist which happen to be the reason for women not to attend clinics. Report by UNFPA, 2019 agrees that cases of maternal mortality are preventable where by 74% of maternal deaths could be averted if all women have access to the interventions for preventing or treating pregnancy and birth complications, in particular emergency obstetric care.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The chapter summarises the findings of the study and provides conclusions and recommendations. The chapter is arranged into three sections; includes section one which provides a summary of the study and its findings, while section two gives conclusions of findings of the study. The third section presents recommendations depend on findings and conclusion of the study as well as area for further study.

5.2 Summary of the study

This study was conducted at Ketumbeine division in Longido district, Arusha region, where the main objective was to assess the socio-cultural factors contributing to maternal mortality. Specifically, the study assessed how women make decisions over access to maternal services and how it contributes to maternal mortality. Moreover, the study explored male involvement in fighting maternal mortality as well as identified efforts made to fight maternal deaths. Furthermore, the study identified the challenges to the reduction of maternal mortality and recommended strategies for reducing the mortality rate before, during, and after childbirth in our communities and health services in Longido district.

The study adopted a cross-sectional research design. Also, the study employed a systematic (pseudo-random) sampling method to select respondents for the study area, whereby a sample size of 380 respondents was drawn from the selected villages of Ketumbeine division. A questionnaire survey, FGD, and key informant interview

were used to collect information related to socio-cultural factors related to maternal mortality. Statistical Package for Social Sciences (SPSS) version 20 was used as the data analysis tool.

The findings revealed that women are not decision-makers on issues regarding maternal health in their families and community at large, where most of the decisions are influenced by their husbands, thus the maternal mortality rate has increased. These findings, supported by 52% of the respondents in Table 4.5, indicate that within households and community settings, women have no part in making family and their own decisions.

In addition, half of the 49% of respondents revealed that men do not provide maximum support to their pregnant wives during pregnancy difficulties. Due to this, it suggests that effective interventions are needed to encourage men to effectively cooperate with their wives on maternal issues so as to reduce the maternal mortality rate in Tanzania, especially in rural communities like Maasai in Longido district. in Longido. Furthermore, the majority of the respondents about 66% contended that women are more active in attending healthcare centers for maternal issues compared to their men counterparts.

However, the reasons mentioned for the men not participating in maternal issues are that they are busy with different economic activities, which has made it difficult for them to accompany their wives to attend maternal issues in the healthcare centers. Moreover, for the measures taken by the Longidi district management to reduce

maternal mortality rates, the government improved reproductive and child health services by increasing the number of mobile clinic sites from 16 to 25 during the year 2019. Also, the findings suggested that through the provision of maternal education, the aim is to create more awareness in the community, especially among men in rural settings, about engaging maternal health services.

5.3 Conclusion

Conclusively, the study's findings revealed that women in the community, especially in rural settings like Longido, have no autonomy in making their own decisions regarding access to maternal services. This situation hinders the whole process of reducing maternal deaths since women who are mainly affected by maternal complications are left behind in the decision-making process. Additionally, the study revealed the major reasons for women not being involved in decision-making were Maasai traditions, customs, and gender norms, which deny women a chance to make decisions or seek care without their husbands or other family members.

Moreover, the study concluded that males were rarely involved in maternal issues, as the study noted that women were more responsive to maternal issues compared to their male counterparts. Furthermore, the study identified various efforts done to reduce maternal mortality in the study area, such as increasing staffing levels, improving health infrastructure through the construction of one district hospital, improving dispensary infrastructure, improving medical equipment, and increasing medical supplies. Other efforts included improving reproductive and child health services as well as increasing the number of mobile clinic sites.

5.4 Recommendations

The following recommendations were made in light of the conclusions of this study to improve maternal health in order to reduce maternal mortality in the study area and Tanzania in general.

The study recommends deliberate efforts should be given priority to promote women's autonomy by providing education to create awareness of the importance of women's autonomy in decision-making regarding maternal health issues. This can be achieved through community-based interventions and engagement with traditional and religious leaders to challenge the existing cultural practices that limit women's participation in decision-making.

Also, health education and promotion campaigns targeting men should be developed to encourage them to take an active role in maternal health issues. This can be achieved through the involvement of male community leaders in maternal health programs.

Furthermore, efforts to reduce maternal mortality should be supported by strengthening the health system, including increasing the number of health workers, improving the quality of health services, and ensuring the availability of essential medicines and medical equipment.

Lastly, the study recommends regular monitoring and evaluation of maternal health programs to help in identifying gaps and challenges and inform decision-makers. This should involve the use of data to track progress towards reducing maternal mortality and identify areas for improvement.

5.4 Areas for further studies

This study concentrated only on socio-cultural factors which contribute to maternal deaths in the study area. It should be noted that, maternal death is a big and complex phenomenon. Thus, the study could not explore everything for the reader to get informed. Thus, the following outlines are important areas for other researchers to continue with unexhausted areas especially to family living in rural areas.

- Why people particularly in the study area would prefer tradition birth attendants than attending health facilities.
- Impact of low income and poverty in relation to maternal deaths.

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APPENDICES

Appendix 1: Work plan

ACTIVITY	TIME TO BE TAKEN													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Weeks														
Months	May		June			July								
Orientation/ Familiarization														
Research design														
Data collection														
Data analysis & interpretation														
Research report re-writing														
Submission of final research report														

Appendix 2: Budget for research work

Items	Amount TZS	
	COST	TOTAL
Stationery and Printing:		
(a) Three reams of photocopy and printing papers @ TZS 7,500	12,500.00	
(b) Writing, printing and photocopy 600 pages @ TZS 350	210,000.00	220,500.00
Internet Services:		
(a) Browsing for downloads 6 times x 5 months @ TZS 1000	30,000.00	
(b) Printing the downloads - est. at TZS 20,000	30,000.00	60,000.00
Field Survey Expenses:		
(a) (a) Per diem; 6 days @50,000	600,000.00	
(b) Transport costs	300,000.00	400,000.00
Data analysis and reporting costs:		
(a) Data processing and analysis	600,000.00	
(b) Secretarial services	230,000.00	
(c) Report production & binding	750,000.00	1,630,000.00
Total cost		1,310,500.00
Contingency: 10% of total		131,050.00
GRAND TOTAL		3,130,550.00

Appendix 3: Questionnaire for respondents

A: Introduction

Dear Sir/Madam

My name is **Lucy Albert Kyungu**, a Master's student from Open University of Tanzania (OUT). I am conducting research titled "*Socio-Cultural Factors Contributing To Maternal Mortality In Longido District, Arusha City*" I request you to give me your time in responding to this questionnaire. Your information will help me to accomplish my dissertation and will be treated as confidential. I assure you that the information you provide will be used only for the aim of this study.

B: Demographic Information

Choose the correct alphabet for your answers.

1. Sex category

(a) Male

(b) Female

[]

2. Village

(a) Gelaibomba

(b) Gelailumbwa

(c) Losirwa

(d) Ilorienito

(e) Orkejuloongishu

(f) Olopoloseki

(g) Noondoto

(h) Paramanjaa

(i) Elang'atadapash []

3. Age

(a) 18-25 years

(b) 26-35 years

(c) 36-45 years

(d) 46-55 years

(e) 56-65 years

(f) >65 years []

4. Education Level

(a) Primary education

(b) Secondary education

(c) Certificate education

(d) Diploma education

(e) Degree and Above []

5. Main occupation/department?

(a) Human Resource Department

(b) Accounts Department

(c) Operations Department

(d) Farmer

(e) Housewife

(f) Health Sector Department

(g) f) No specific occupation []

(h) Others (specify).....

6. Marital status

(a) Married

(b) Single

(c) Widow

(d) Separated

(e) Divorced []

C: Factors contributing to maternal death at Ketumbeine ward

7. How many years have you been in this village?

.....
.....
.....

8. Indicate number of health facilities available in your village

No	Facility	Number	Ownership	Other comments
1	Number of dispensaries		(a) Government (b) Private (c) Military (d) Others (specify) []	
2	Number of health centres		(a) Government (b) Private (c) Military (d) Others (specify) []	
3	Number of hospitals		(a) Government (b) Private (c) Military (d) Others (specify) []	
4	Number of mobile clinics		(a) Government (b) Private (c) Military (d) Others (specify) []	

9. Is maternal mortality a problem in this village?

(a) Yes

(b) No

(c) Not sure

[]

10. How many health workers in this village?

.....
.....
.....
.....

11. Is the number of health workers sufficient?

(a) Yes

(b) No

(c) Not sure

[]

12. What are the major causes of maternal deaths ever happened in this village?

.....
.....
.....

13. What are the other causes maternal deaths do you know?

.....
.....

.....
.....

14. How many maternal death cases have you ever witnessed in this village?

.....
.....
.....

D: Contributions of the male and female involvement towards fighting maternal mortality

15. Do you think the community is well informed on the impact of maternal health care?

- (a) Yes
- (b) No
- (c) Not sure []

16. Do males offer supportive measures to their wives at the time of pregnancy?

- (a) Yes
- (b) No
- (c) Not sure []

17. Where do normally pregnant mother go for maternal check-up during pregnancy?

- (a) Dispensary
- (b) Health centre

- (c) Hospital
- (d) Mobile clinic
- (e) Local midwife
- (f) Herbalist []
- (g) Home
- (h) Others (specify)

18. During pregnancy stage, who normally go for maternal check-up?

- (a) Mother
- (b) Mother and father
- (c) None of the above
- (d) Not sure []

E: Efforts done towards the reduction of maternal mortality at Ketumbeine ward in Longido District

19. Do you think maternal deaths can be Reduced/prevented?

- (a) Yes
- (b) No
- (c) Not sure []

20. If the answer for the above question is 'yes' how can it be Reduced/prevented?

.....

.....

.....

21. If the answer for the above question is 'no', why can't it be Reduced/prevented?

.....

.....

.....

.....

22. Do you have any existing village health committee in this village?

(a) Yes

(b) No

(c) Not sure []

23. Do you think the government is supporting to fight against maternal mortality?

(a) Yes

(b) No

(c) Not sure []

24. If the answer for the above question is 'yes' how does the government support?

.....

.....

.....

.....

25. If the answer for the above is 'no' why not?

.....

.....

.....

.....

26. Who is makes decision on your household matters?

- (a) Father
- (b) Mother
- (c) Both mother and father
- (d) Children
- (e) Uncles
- (f) Relatives
- (g) All family members []

27. Who is responsible for maternal issues in your family?

.....

.....

.....

28. Why do men tend to be less concerned with maternal issues?

- a) Busy with economic activities
- b) Negligence
- c) It is maternal and not paternal issue

d) Responsibility distribution

e) Men are not allowed to enter labour unity

f) Contrary to our culture

[]

g) Others (specify).....

Thanks in advance for your cooperation

Appendix 4: Interview schedule for key informants

A: Introduction

Dear Sir/Madam

My name is **Lucy Albert Kyungu**, a Master's student from Open University of Tanzania (OUT). I am conducting research titled "*Socio-Cultural Factors Contributing To Maternal Mortality In Longido District, Arusha City*" I request you to give me your time in responding to this questionnaire. Your information will help me to accomplish my dissertation and will be treated as confidential. I assure you that the information you provide will be used only for the aim of this study.

B: Demographic Information

1. Sex category

(a) Male

(b) Female

[]

2. Age

(a) 18-25 years

(b) 26-35 years

(c) 36-45 years

(d) 46-55 years

(e) 56-65 years

(f) >65 years

[]

3. Education Level

- (a) Primary education
- (b) Secondary education
- (c) Certificate education
- (d) Diploma education
- (e) Degree and Above []

4. Main occupation and designation

.....

5. Marital status

- (a) Married
- (b) Single
- (c) Widow
- (d) Separated
- (e) Divorced []

C: Factors contributing to maternal death at Ketumbeine ward

6. Are you a native from this ward?

- (a) Yes
- (b) No []

7. What is the dominant marriage type in this ward?

8. Who is normally responsible for household decisions?

9. What is the situation of maternal mortality in this ward?

10. What could be the root causes of maternal mortality in this ward?

11. Where do pregnant women go for health services?
12. How many health centers available in this ward?
13. How is male participation in maternal health?
14. How is maternal mortality perceived by the community in this ward?
15. On your views, are there any measures in place to deal with abolishing maternal mortality in the ward?
 - (a) Yes
 - (b) No
16. If the answer for the above is yes outline them, and if no explain the reason
17. What do you think are the proper way to curb maternal mortality in this ward?

Appendix 5: Focus Group Discussion Questions

Question 1

Based on Tanzania context, women have been disregarded in making decisions related to maternal health issues rather decisions are made by elders and spouses. Coming to Maasai communities, do women get the opportunity to make decisions related to access to maternal health?

Question 2

According to the United Republic of Tanzania constitution chapter 3 section 3.18 law number 15 of 1984, states that everyone has the right to make decisions. In most cases, decisions made by an individual affects an individual either negatively or positively. What is the situation in the Maasai communities? Do Maasai women make decisions on access to maternal health? Are those decisions given any priority? What are the impacts concerning maternal health?

Question 3

Majority of Tanzanian culture men dominate and make decisions over almost everything concerning their families. However, they are less concerned to reproductive, maternal and child health issues and they regard them as women issues. How male are involved in maternal health issues in your family and community at large?