THE INFLUENCE OF SOCIAL-CULTURAL DETERMINANTS ON MATERNAL MORTALITY RATE AMONG PREGNANT WOMEN IN BABATI DISTRICT - TANZANIA

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A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE MASTER OF SOCIAL WORK (MSW)

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CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by Open University of Tanzania (OUT), a Research Report entitled **"The Influence of Social-Cultural Determinants on Maternal Mortality Rate among Pregnant Women in Babati District – Tanzania** In partial fulfillment for the requirements of the master's degree in social work (MSW) of The Open University of Tanzania.

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Dr. Johnas Buhori

(Supervisor)

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Date

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DECLARATION

I, **Yusuph Kinambike,** declared that the work presented in this dissertation is original. It has never been presented to any other university or institution. Where other people's works have been used, and references have been provided. It is in this regard that I declare this work as originally mine. It is hereby presented in partial fulfilment of the requirements for the master's degree in Social Work (MSW).

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Signature

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Date

DEDICATION

This work is dedicated to my beloved father, Daudi Kinambike, my mother, Grace Yohane for giving me the best upbringing, laying the foundation of education and continuing to encourage me to study for my master's degree. Also, to my beloved sons Daudi, Hemedi and Mussa for their prayers, love, encouragement, tolerance, care and support during my studies.

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ABSTRACT

The study titled "The Influence of Socio-Cultural Determinants on Maternal Mortality Rate among Pregnant Women in Babati, Tanzania" examined how social and cultural factors contribute to maternal mortality and explored pregnant women's perceptions of these influences. It was guided by the Social Determinants of Health (SDH) theory and employed a pragmatic philosophy with a cross-sectional design. Data were collected from 400 participants using unstructured questionnaires and analyzed using SPSS version 23 alongside thematic analysis. Findings revealed that major social factors influencing maternal mortality in Babati include low socio-economic status (22%), marital status, and early marriage (18%). The study also found that 87% of respondents were aware of how social and cultural issues affect maternal mortality rates. On the cultural side, many pregnant women still prefer home deliveries assisted by traditional doctors and elderly women, followed by post-delivery rituals. These practices, coupled with misunderstandings and negative attitudes toward modern healthcare, increase maternal health risks. The findings further indicated that male dominance in decision-making restricts women's autonomy in seeking professional maternal health services. The study concluded that tackling maternal mortality requires addressing both social and cultural barriers. It recommends that the government invest in community sensitization and mobilization to eliminate harmful traditional practices, promote positive health-seeking behaviors, and involve men as change agents in supporting women's reproductive health rights and safe childbirth practices.

Keywords: *Social-Cultural, Maternal Mortality, Pregnant Women, Women.*

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LIST OF ABBREVIATIONS

ANC	prenatal care
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
FANC	Focused Antenatal Care
FGDs	focus group discussions
FGM	female genital mutilation
HSSP	Health Sector Strategic Plan
KIIs	Key Informant Interviews
MDGs	Millennium Development Goals
MDSR	Maternal Death Surveillance and Response
MMEIG	Maternal Mortality Estimation Inter-Agency Group
MMR	Maternal, Mortality Rate
MOI	Medical Officer in charge
MSW	master's degree in Social Work
PHSDP	Primary Health Sector Development Program
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
RMNCH	reproductive, maternal, newborn, and child health
SDH	Social Determinants of Health
SSA	Sub-Saharan Africa
TBAs	traditional birth attendants
URT	United Republic of Tanzania
WHO	World Health Organizatio

CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Chapter Overview

This study presents on the study entitled" The influence of Social cultural Determinant on the maternal mortality rate in in Babati district., this study intended to investigate the socio-cultural factors impacting maternal mortality rates by highlighting its importance as a critically important worldwide public health issue. In Tanzania, where maternal mortality is still a significant concern, special attention is paid to Babati District as the focus of this study. This chapter presents on the background of the study, Statement of the problem, research objective, Research Question, Significant of the study and Scope of the study.

1.2 Background to Study

Maternal mortality remains one of the most pressing global health challenges. According to the World Health Organization (WHO), an estimated 287,000 women died from pregnancy and childbirth-related causes in 2020, with about 95% of these deaths occurring in low- and middle-income countries (WHO), 2023). Despite global efforts under the Sustainable Development Goals (SDG 3.1) to reduce the maternal mortality ratio (MMR) to fewer than 70 deaths per 100,000 live births by 2030, progress has been slow and uneven, with some regions recording stagnation or reversals in recent years (United Nations, 2023).

The World Health Organisation (WHO) monitors maternal mortality worldwide using various data sources to evaluate progress towards the SDGs. Despite progress, disparities exist between nations because of poor healthcare, financial constraints,

cultural standards, and environmental issues. Enhancing access to healthcare, competent birth attendance, emergency services, contraception, and the robustness of the health system are the main areas of attention. Targets for lowering child mortality and enhancing maternal health were included in the Millennium Development Goals (MDGs), which were established by the United Nations (UN) in 2000 because of international discussions in the 1990s, especially the Cairo and Beijing conferences, which focused on improving population and women's issues.

During the Millennium Development Goal (MDG) period from 2000 to 2015, maternal mortality decreased by 2.7% year worldwide. However, progress significantly slowed during the first five years of the Sustainable Development Goal (SDG) era (2016–2020). The global maternal mortality ratio (MMR) was expected to be 223 deaths per 100,000 live births in 2020, a significant decrease from 339 in 2000 and 227 in 2015. While Southeast Asia showed improvement with an MMR of 190 per 100,000 and 51% skilled birth attendance, a crucial indicator of maternal health, MDG 5 targets were still unfulfilled in some regions of Asia despite advancements.

The United Nations Maternal Mortality Estimation Inter-Agency Group (MMEIG), which includes WHO, UNICEF, UNFPA, the World Bank, and UNDESA/Population Division, reported that approximately 800 women died every day in 2020 from preventable pregnancy and childbirth-related causes, or one every two minutes, despite the Sustainable Development Goal (SDG) Target 3.1's goal of reducing maternal mortality to less than 70 deaths per 100,000 live births by 2030. Global maternal death rates decreased significantly between 2000 and 2015 but did not

change on average between 2016 and 2022. Furthermore, the rate of decline slowed in several areas, with rises in MMR noted in Western Europe, North America, Latin America, and the Caribbean between 2016 and 2022 (UNICEF, 2023).

To lower maternal death rates and enhance maternal health outcomes across the continent, Agenda 2063 highlights the significance of giving all Africans, particularly women, access to high-quality healthcare. The larger goal of Agenda 2063, which is to empower women in all spheres of society and advance gender equality, aligns with this goal. Tanzanian research directly supports the objectives of Agenda 2063 by examining the cultural influences on gender roles and childbearing habits. The research aims to enable women to make knowledgeable decisions about their maternal health by promoting culturally appropriate healthcare practices. In the end, the study seeks to establish a future where women are empowered, maternal health is given priority, and avoidable maternal deaths are eradicated by harmonizing with Agenda 2063.

It is important to note that from 1969 to 2018, maternal death rates in Central America and the Caribbean experienced a historical decline before recently rising, with Haiti, Belize, the Dominican Republic, Jamaica, and Guatemala experiencing exceptionally high rates. Recent patterns indicate a revival, with rates increasing from 9.9 deaths per 100,000 live births in 1999 to 17.4 in 2018, despite a 68% drop between 1969 and 1998. Black women are 2.4 times more likely than White women to die as mothers, demonstrating the persistence of racial inequities. Maternal mortality risks are greatly influenced by factors including marital status, nativity, education level, and rural residency; between 2002 and 2018, discrepancies grew,

especially in underprivileged areas (Singh, 2021). The health systems of the eight nations that make up South Asia continue to struggle with maternal, perinatal, and newborn mortality. The maternal mortality ratio (MMR) has significantly decreased from 384 per 100,000 live births in 2000 to 157 in 2017, despite these obstacles, because of increased access to qualified physicians and higher-quality maternity care. Disparities still exist, though, with an estimated 620 deaths in Afghanistan, 174 in Nepal, 154 in Pakistan, 123 in Bangladesh, and 108 in India per 100,000. Social-cultural factors like abuse, disrespect, and subpar care continue to be significant obstacles (Kaphle, Vaughan, & Subedi, 2022).

By 2030, the worldwide maternal mortality rate (MMR) is expected to drop to less than 70 per 100,000 live births, according to the Sustainable Development Goals of the UN. Nonetheless, maternal mortality rates in African nations continue to be startlingly high; South Sudan, Chad, Nigeria, and the Central African Republic all have MMRs of 1,223, 1,063, and 835, respectively, higher than the global average of 290 maternal deaths per 100,000 live births. Several factors influence maternal mortality, including parity, socioeconomic position, and living in a rural area. Political instability and civil conflicts also have a significant effect on the health of mothers and infants.

Inadequate family planning programs and uneven policy implementation in reproductive, maternal, newborn, and child health (RMNCH) make it difficult for the Sub-Saharan African region to meet MDG 4 and MDG 5 targets. With only 5.5 doctors, nurses, and midwives per 10,000 people, much fewer than the WHO recommendation of 23, and a lack of competent delivery attendants, the problem is

made worse. The difficulties are exacerbated by a lack of funding, differences in the health workforce between rural and urban areas, and weaknesses in national maternal reproductive health programs. Drawing attention from Chid, it was indicated that MMR would still be high at 300 per 100,000 live births even with a 6.3% annual reduction, while Gabon would need to drastically improve its present MMR annual fall rate of 0.8% to reach an MMR of 70 per 100,000 live births by 2030.

High maternal mortality rates, ranging from 259 to 530 deaths per 100,000 live births in 2022, remain a serious public health concern in East African nations like Burundi, Kenya, Uganda, and Rwanda. To address this issue, the African Union Commission and the East Africa Community launched the CARMMA plus campaign during the Eastern Africa Regional Early Childhood Conference to improve reproductive health outcomes by 2030. The program aims to raise awareness among stakeholders, improve regional ownership, improve coordination, and encourage more domestic investment in RMNCAH. The CARMMA program, which was first introduced in 2009, sought to enhance health outcomes and lower pregnancy-related fatalities. A notable success was made in RMNCAH measures. A 2019 assessment led to creating a revised CARMMA Plus campaign strategy that focused.

Tanzania's Ministry of Health is aggressively tackling maternal mortality through initiatives like the Primary Health Sector Development Program (PHSDP), which aims to increase skilled birth attendance. Improvements in reproductive, maternal, baby, child, and adolescent health are the focus of the National Road Map Strategic Plan, including the Health Sector Strategic Plan (HSSP) and One Plan II. The goal in

Babati district is to record maternal deaths as soon as possible and respond to them within 48 hours. Action plans have been created to address the deficiencies in maternal healthcare services (John, Mkoka, Frumence, & Goicolea, 2018).

In Tanzania, the maternal mortality burden has declined over the past two decades but remains high compared to global and regional targets. The 2022 Tanzania Demographic and Health Survey reported an MMR of 104 deaths per 100,000 live births, showing significant progress but also persistent inequities across regions (NBS & ICF., 2023) Many preventable maternal deaths are linked to delays in decision-making at the household level, limited women's autonomy, cultural reliance on traditional birth attendants, and poor utilization of skilled obstetric care (Mollel et al., 2024).

Facility-based reports and maternal health audits highlight low early antenatal care attendance, lower rates of skilled birth attendance, and persistent reliance on traditional delivery practices compared to national averages (Kamala et all, 2021). These socio-cultural determinants—combined with systemic gaps in referral and emergency obstetric care—sustain a high burden of maternal mortality in the district. Thus, while global initiatives and national strategies aim to reduce maternal deaths, localized socio-cultural barriers in districts such as Babati continue to undermine progress. A district-focused study is therefore necessary to identify and address the specific social-cultural determinants that influence maternal mortality in this setting.

1.3 Statement of Research Problem

Every woman of reproductive age has the fundamental human right to safe childbirth, which includes the right to affordable, respectable maternal healthcare

services. To safeguard the health of the mother and the unborn child, this entails receiving proper prenatal care, professional help during birthing, and postpartum support. International accords such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Universal Declaration of Human Rights uphold these rights. Nevertheless, despite these pledges, maternal mortality is still a major global health issue, especially in Africa (Chojenta, Harris, M., Oldmeadow, & Loxton, 2022).

Despite the indicated ideal situation on reproductive health, the maternal mortality ratio (MMR) was estimated to be 216 per 100,000 live births worldwide in 2015. Between 1990 and 2015, 10.7 million women died from maternal causes, representing a 43.9% overall drop. Even with this decrease, the MMR is still 15 times higher in low-income countries than in high-income ones. There are still regional and national differences in maternal survival, which are particularly noticeable in sub-Saharan Africa, where there were 545 maternal deaths for every 100,000 live births in 2020, compared to 4 in Australia and New Zealand. In 2020, 70% of maternal deaths worldwide occurred in Sub-Saharan Africa alone (Batist, 2019).

Seeing the indicated reality of high maternal death rates, the government of Tanzania has placed a strong emphasis on putting the Maternal Death Surveillance and Response (MDSR) system into place by World Health Organisation (WHO) principles. This method seeks to direct national initiatives to raise the standard of healthcare while also customizing answers to regional problems. All maternal deaths must be detected, reported, and reviewed as part of MDSR to identify the medical

causes. These systemic flaws contributed to the deaths and suggestions for resolving concerns that were found. Focused Antenatal Care (FANC), which requires at least four visits throughout pregnancy, is one of the tactics used. Its goal is to provide timely and adequate prenatal care to lower mother morbidity and mortality while guaranteeing favorable results for the unborn child (Chamani, Mori, & Robberstad, 2021).

Tanzania is still ranked 38th in the world for maternal mortality, with an expected 238 deaths per 100,000 live births in 2020, despite the government's efforts to reduce the rate. Since prior research has focused chiefly on factors connected to medicine and the healthcare system, there is a significant knowledge gap regarding the specific social and cultural factors that contribute to maternal fatalities among pregnant women. By examining the complex interactions between social-cultural factors and maternal mortality, this study aims to close this gap and guide specialized interventions and policy approaches to improve maternal health outcomes in Tanzania.

1.4 Research Objective

This study was guided by both general and specific objectives as indicted;

1.4.1 General Objective

The General objective for this study is to examine the influence of Social-Cultural Factors on Maternal Mortality Rate among Pregnant Women in Babati district - Tanzania

1.4.2. Specific Objective

i. To investigate on the social factors influencing maternal mortality rates among Pregnant Women in Babati District

ii. To Examine the cultural factors impacting on the maternal mortality rate among Pregnant Women

iii. To explore the perception of pregnant women regarding the impact of social-cultural factors on maternal mortality rates among Pregnant Women

1.5. Research Questions

i. What are the social factors influencing maternal mortality rates among women of reproductive age in Babati district?

ii. What are the cultural factors impacting on the maternal mortality rate among Pregnant Women in Babati District?

iii. What are the perceptions of pregnant women regarding the impact of social-cultural factors on maternal mortality rates among pregnant Women?

1.6 Significant of the Study

This study provides critical evidence to guide health policy formulation and implementation at the district, regional, and national levels. By identifying the specific socio-cultural determinants contributing to maternal mortality in Babati District, the findings will inform targeted interventions that go beyond clinical care and address community-level barriers. Policy makers can use the results to strengthen maternal health programs, allocate resources effectively, and align local strategies with Tanzania's commitments to the Sustainable Development Goals (SDG 3.1) of reducing maternal mortality. By investigating the influence of social-

cultural factors on maternal death rates, the study intends to provide helpful information for healthcare professionals who work with pregnant women in Tanzania's Babati district. This knowledge can guide the creation of culturally aware interventions and support networks, effectively reducing maternal fatalities.

The study contributes to the body of knowledge on the intersection between socio-cultural factors and maternal health outcomes in sub-Saharan Africa. It offers empirical evidence from a district-level context, which is often underrepresented in literature compared to national-level analyses. The study's findings will be valuable for teaching, curriculum development, and academic discussions on public health, sociology, anthropology, and health systems strengthening in low-resource settings. The study will serve as a foundation for further research on maternal health, especially in understanding how cultural norms and practices interact with health systems to influence maternal outcomes. It provides data that can inspire future comparative studies across districts or regions, as well as interdisciplinary research involving public health, gender studies, and development.

Researchers can also use its findings to design context-specific interventions and evaluate the effectiveness of community-based maternal health initiatives. This study will raise awareness about the impact of cultural practices, beliefs, and decision-making processes on maternal health. By highlighting the importance of timely health-seeking behavior, the findings can empower women, families, and local leaders to make informed choices that prioritize safe motherhood. In addition, community engagement with the study results may foster collaboration between health facilities and community structures, leading to sustainable improvements in

maternal health outcomes in Babati District. This study enhances the global understanding of how social-cultural factors impact maternal death rates and contributes to Tanzanian maternal health research. Broadening the current body of knowledge encourages more research in related settings and may help shape future initiatives to improve maternal health outcomes worldwide.

1.7 Scope of the Study

The study was conducted in Babati District, Manyara Region, Tanzania, an area characterized by rural settlements, socio-economic diversity, and cultural practices that influence maternal health outcomes.. The study focused on examining the influence of social and cultural determinants on maternal mortality rates among pregnant women. The study employed a mixed research approache with cross-section design while employing systematic random sampling with semi structure question together information. The study focused on pregnant women, healthcare provider and other stakeholder with involved in health care provisions. With the sample size of 400 respondent obtained using Yamen formula.

CHAPTER TWO

LITERATURE REVIEW

2.1 Chapter Overview

With a thorough literature review on maternal mortality that covers global and Tanzanian contexts, theoretical frameworks, and methodological considerations, chapter two lays the groundwork for understanding the complexities of social-cultural influences on maternal health outcomes. It would examine how social and cultural factors affect maternal mortality rates and suggest a conceptual framework to direct the current investigation while pointing out areas that require more investigation.

2.2. Conceptual Definitions of Terms

In research, conceptual definitions provide a clear and precise understanding of the meanings of key terms or concepts used in a study. Specific definitions are essential to promote a common understanding among academics, readers, and stakeholders. On the other hand, operational definitions specify how a concept will be measured or observed in a particular study. According to Khatooni (2023), these definitions describe the concrete procedures or processes used to convert abstract variables into conceptualized meaning.

2.2.1. Maternal Mortality Rate

The number of maternal fatalities (MMR) per 100,000 live births in a given population over a specific time, usually a year, is measured by the Maternal Mortality Ratio (MMR), a crucial public health indicator (Souza, Day, Rezende-Gomes, Zhang, Mori, Baguiya, & Oladapo, 2024). Maternal mortality rates can be

significantly impacted by social-cultural factors such as gender norms, traditional birthing practices, access to healthcare services, and educational attainment. For example, cultural beliefs that favor home births attended by traditional birth attendants over hospital deliveries may result in higher maternal mortality rates because they cause delays in receiving emergency obstetric care.

In a similar vein, adverse maternal outcomes may result from gender stereotypes that restrict women's autonomy in healthcare decision-making or prevent them from seeking medical attention while pregnant. Consequently, this study sees sociocultural factors as the construct of traditional norms guided by scrutiny dominance without considering the views and aspirations of women about reproductive health

2.2.2. Social Cultural Factors

The different socioeconomic and cultural components that influence Tanzanian communities' attitudes, behaviors, and practices related to maternal health are social-cultural factors. Traditional practices, cultural norms, social status, educational attainment, healthcare availability, gender roles, religious convictions, and societal perceptions of pregnancy and childbirth are a few factors that fall under this broad category. It is essential to comprehend these social-cultural elements to thoroughly investigate their effects on Tanzania's maternal mortality rates among expectant mothers.

2.3. Theoretical Review

This study will be guided by the Social Determinants of Health (SDH) theory as indicates;

2.3.1. Social Determinants of Health Theory

The Social Determinants of Health (SDH) theory, popularized by Sir Michael Marmot through the World Health Organization's Commission on Social Determinants of Health (2005–2008), argues that health outcomes are largely shaped by the conditions in which people are born, grow, live, work, and age, rather than by healthcare alone (Marmot, 2005). The theory emphasizes that inequities in education, income, gender roles, and cultural practices directly produce health disparities, making maternal mortality not merely a medical issue but a social one.

The Social Determinants of Health (SDH) are the non-medical factors influencing health outcomes (WHO, 2008). These include the surroundings in which people are born, grow, work, live, and age and more general forces and systems influencing day-to-day living situations. These include political systems, societal norms, economic policies, development objectives, and McLemore, Neilson, and Lewis Johnson (Crear-Perry, Correa-de-Araujo, Lewis Johnson, & Wallace, 2021).

Additionally, this theory has developed because of the efforts of numerous academics and researchers in sociology, public health, and related sciences. Nonetheless, Sir Michael Marmot, who has researched the social determinants of health and health fairness, has promoted the idea since it became well-known in the late 20th century. The SDH theory's central claim is that reducing health disparities and enhancing population health depends on tackling social and economic inequality. It emphasizes how crucial elements like social support networks, work, education, money, and access to healthcare services are in determining health outcomes for various groups (Borovečki, 2023).

2.3.1.1 Relevancy of the Theory to this Study

The theory is relevant to this study as it helps the researcher investigate how the social and cultural elements interact and affect Tanzania's maternal mortality rates using the SDH theory. Further, the theory is instrumental in helping the means that can be used to alleviate inequities and enhance maternal health outcomes. Targeted interventions and policies can be developed with an understanding of these variables (Souza et al., 2023). For instance, programs that promote culturally competent maternal healthcare services or address socioeconomic disparities in access to healthcare could lower Tanzania's maternal death rates among expectant mothers.

According to the Social Determinants of Health (SDH) theory, a person's birth, development, living, employment, and age impact their health outcomes, including maternal mortality rates. Several characteristics, including social, economic, and environmental factors, influence the quality and accessibility of healthcare services. By supporting policies that guarantee universal access to high-quality, reasonably priced maternal health services, education initiatives that equip women and communities with reproductive health knowledge, and community-based interventions that address harmful cultural practices while honoring cultural contexts, the SDH framework offers a lens through which to address maternal mortality (Yarney, 2019). Because it emphasizes upstream socioeconomic determinants, the SDG is beneficial.

The SDH theory advocates for systemic improvements that lower maternal mortality and advance equity in health outcomes. According to the Social Determinants of Health (SDH) theory, cultural factors influence maternal mortality rates and other

health outcomes. These factors are part of broader social determinants (Tajvar et al., 2022). The SDH theory offers a thorough method of tackling maternal mortality rooted in cultural determinants by emphasizing the interaction of institutional injustices and cultural norms. Education and awareness campaigns, policy implementation, and community participation can all be used to address the interaction aspects.

2.4 Empirical Literature Review

An empirical literature review thoroughly analyzes previous studies on a particular research problem or subject. In contrast to standard literature reviews, empirical reviews prioritize studies, including gathering and analyzing empirical data. The procedure entails methodically determining the research problem, conducting an exhaustive search for pertinent studies, critically assessing each study's quality and methodology, synthesizing the most important findings, formulating conclusions based on synthesized information, and proposing future research directions (Aspers & Corte, 2019).

2.4.1. The Social Factors Influencing Maternal Mortality Rates

Studies reveal that social determinants have been consistently shown to influence maternal mortality outcomes more profoundly than medical interventions alone. (Wang, et al., 2020) conducted a global synthesis of studies and highlighted that maternal deaths are often associated with poverty, low educational attainment, gender inequality, and limited decision-making power within households. Using secondary data drawn from the Global Burden of Disease (GBD) database and Demographic and Health Surveys (DHS), the study demonstrated that countries with

weaker social structures and inequitable access to resources record higher maternal mortality ratios. While the findings underscore the importance of social determinants in shaping maternal outcomes, they remain at a macro level and fail to account for micro-level socio-cultural dynamics that vary by district or community. This limitation leaves a gap that the present Babati study seeks to address by exploring context-specific social determinants that directly contribute to maternal deaths at the local level.

Evidence from the Caribbean region also illustrates the role of social exclusion in maternal outcomes. A report by the Pan American Health Organization (PAHO, 2024) noted that women living in marginalized or remote communities experience disproportionately higher maternal mortality ratios due to poverty, limited education, and cultural exclusion. The study synthesized administrative health data and country-level case studies to assess maternal health disparities. Although useful for highlighting broad regional trends, the findings do not disaggregate the specific cultural practices or intra-household decision-making processes that contribute to maternal deaths. This gap demonstrates the need for localized research, such as the current Babati study, to uncover the specific social and cultural pathways through which maternal mortality persists.

Omer (2019) highlighted the social determinants that impact maternal mortality rates and found that pregnant women's household poverty restricts their access to adequate healthcare, nutrition, and education—all of which are critical for maternal health. In other words, because of the high expense of healthcare services, women in low-income households frequently postpone or forego prenatal treatment. On the same

note, transportation was mentioned as another element that prevents pregnant women from attending or having access to medical facilities and services.

Alkema (2016) added that studies show that low-income areas have disproportionately higher rates of maternal death because of a lack of funding and inadequate healthcare facilities. Low levels of education, which are closely associated with higher rates of maternal death, exacerbate these variables. Women with higher levels of education are more likely to use trained delivery attendants, recognize warning indicators, and seek prenatal care. It should be mentioned that educated women are knowledgeable, which enables them to advocate for their care and make wise health decisions.

A systematic review by Teshale, (2025) revealed that maternal mortality is strongly associated with social determinants such as low education, limited household autonomy, and harmful cultural practices. The review synthesized both qualitative and DHS-based quantitative studies from several East African countries. Findings indicated that across communities, patriarchal norms and economic deprivation delayed health-seeking behaviors, leading to preventable deaths. However, because the study was a synthesis, it did not provide the contextual details specific to individual districts such as Babati. This highlights the importance of localized research that can unpack the nuances of socio-cultural factors within smaller populations.

According to Batist (2019), who exposed the reality of early marriage and adolescent pregnancy, despite the risks to young women, the number of pregnant women is

rising, demonstrating the impact of social factors on reproductive health among women in developing nations, especially in Africa. Many ethnic communities also have social pressure to have children at an early age, which pushes young women to get pregnant even when they are not yet ready to be mothers. Therefore, the high risk and complications of early pregnancy are social factors that lead to young women becoming mothers too soon.

Takaeb (2020), building on the social factors that have been identified as influencing maternal mortality rates, pointed out that nutrition plays a crucial role. When a pregnant woman has limited access to nutrition, it leads to malnutrition, which significantly raises the risk of complications. Postpartum hemorrhage and anemia are two possible complications. Furthermore, because of the unequal distribution of food in households, women from marginalized populations are more prone to experience malnutrition.

Borovečki (2023) noted that it is impossible to overestimate the importance of financial resources during pregnancy. A lack of financial resources hampered transportation to medical institutions, adequate nutrition, and high-quality treatment. Pregnancy and delivery risks are increased for women in underprivileged areas because they are less likely to be able to pay for prenatal care and trained birth attendants.

Furthermore, Okwan and Kovács (2019) pointed out that pregnancy and labor are not regarded as serious health concerns in many cultures due to a lack of family and community support, which results in insufficient assistance for the medical needs of

mothers. Strong social conventions that still see pregnancy as a female problem contribute to the stigma associated with reproductive health disorders, which eventually discourages women from seeking prompt medical attention.

Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS, 2022) reported that women with low education, low household wealth, and limited autonomy are significantly less likely to use antenatal care and skilled birth attendance, resulting in higher maternal mortality risks. This nationally representative survey included thousands of women of reproductive age and employed cross-sectional methods. While the findings provide valuable national-level patterns, they lack the qualitative depth to explain why women in particular communities make certain maternal health decisions. Therefore, a district-specific study in Babati is needed to bridge this knowledge gap by exploring the social realities underlying these national patterns.

Additionally, Shewiyo, 2021) conducted a community-based cross-sectional survey with 372 women in Babati Rural District. The study found that while antenatal care attendance was relatively high, knowledge of obstetric danger signs was poor, and preparedness for birth was inadequate, both of which compromised timely healthcare-seeking. Similarly, Felisian et al. (2023) used qualitative interviews with 12 pastoralist women in Manyara Region and discovered several socio-cultural practices, including reliance on herbal remedies, heavy maternal workloads, and preference for home delivery that elevated maternal risks. While these studies provide valuable district-level insights, they are either quantitatively limited to knowledge and service utilization or qualitatively constrained by small samples. The

current Babati study will integrate both methods to assess the prevalence of social determinants and explain how they contribute to maternal mortality within the district.

2.4.2 The Cultural Factors Influencing Maternal Mortality Rate

Cultural factors are recognized as central determinants of maternal mortality. The World Health Organization (WHO, 2021) and related global syntheses indicate that cultural beliefs and norms such as preference for home delivery, reliance on traditional birth attendants (TBAs), and gender norms restricting women's autonomy contribute significantly to delays in seeking care and increase maternal deaths. These findings are based on systematic reviews of qualitative and quantitative studies across multiple countries, using both survey data and ethnographic research. While they provide a broad overview of cultural influences, global analyses often lack the granularity to show how specific cultural practices operate within individual districts, leaving a critical knowledge gap that this study will address.

Women's autonomy and access to healthcare are often limited in many countries, especially in developing nations, by gender norms and cultural traditions that restrict their freedom to make their own decisions, even when those decisions affect their lives. The spouse or elders make decisions on the delivery procedure because pregnant women lack autonomy. Cultural conventions may force pregnant women to be cared for by traditional delivery attendants, who might not be prepared to deal with challenges. Furthermore, rather than using qualified medical professionals, some communities still use traditional birth techniques and rely on untrained traditional birth attendants (TBAs). Maternal mortality may rise because of

improperly handled complications. Some cultures in South Asia and Sub-Saharan Africa have "delivery at home" customs that deter women from seeking hospital medical attention during childbirth (UNICEF, 2023).

The study conducted by Chinn and Kramer (2020) reported that mistrust of the healthcare system, influenced by historical marginalization and cultural experiences of care, contributes to delayed or avoided maternal care among minority women. The study synthesized data from national surveys and qualitative interviews with 250 women in urban and rural areas. Although the research highlights how cultural perceptions affect maternal health-seeking behavior, its findings are context-specific to high-income urban populations and cannot be directly applied to rural Tanzanian settings, creating the need for locally contextualized studies like in Babati.

Based on the study conducted by McLachlan et al. (2023) found that perceptions of culturally unsafe health facilities, traditional birthing practices, and community-specific postpartum rituals contributed to maternal complications and underutilization of services. The study included 150 Indigenous mothers and 20 healthcare workers, using mixed-methods surveys and focus groups. While informative, these findings are limited to the Australian Indigenous context; they cannot capture the specific socio-cultural practices of pastoralist and agrarian communities in Babati, which is the focus of the present study.

Teshale, et al., (2025) synthesized East African studies and found that cultural norms, including decision-making hierarchies, preference for home births, and traditional postpartum practices, contribute significantly to maternal mortality. The

review included qualitative interviews and DHS data from Kenya, Uganda, and Tanzania, with sample sizes ranging from 50 to 500 participants per study. Although the review highlights regional trends, it does not provide district-level specificity or explore localized variations in cultural beliefs, which the Babati study will do.

Pregnancy before marriage is still illegal in several societies and ethnic groups. When a woman becomes pregnant, she is discouraged from seeking maternal health care because of the stigma, cultural customs, and fear of being judged. From this vantage point, it may be claimed that the methods to challenge existing cultural and harmful behaviors should be used in tandem with the efforts to boost pregnant women's accessibility to healthcare facilities (Crear-Perry et al., 2021).

Cultural expectations around high fertility and large family sizes can expose women to repeated pregnancies, increasing the risk of complications and cumulative health strain. Limited use of contraceptives, cultural influence, and religious opposition also contribute to high-risk pregnancies and subsequent maternal mortality. Furthermore, in many cultures, women would instead give birth in settings that are seen as culturally safe, such as their homes or under the supervision of TBAs. This preference frequently results in poor handling of issues like obstructed labor or bleeding (Hamal et al., 2020; Crear-Perry et al., 2021).

The study conducted by Kaaya, (2021) reported that Tanzanian women often adhere to cultural practices such as home deliveries, use of herbal remedies, and male-dominated decision-making regarding healthcare, which influence maternal mortality. The study used a cross-sectional survey with 1,200 women of reproductive

age and focus group discussions with community leaders. While it captures some national trends, it does not examine district-specific cultural nuances or their direct impact on maternal outcomes, leaving a critical knowledge gap based on cultural social cultural determinants on the maternal mortality rate.

Similarly; Felisian et al. (2023) conducted qualitative interviews with 12 indigenous pastoralist women and identified socio-cultural practices such as heavy maternal workloads, preference for home deliveries, and herbal remedies that potentially increase maternal risk. Similarly, Shewiyo et al. (2021) surveyed 372 women and found low birth preparedness and poor recognition of danger signs, partly influenced by local cultural norms. While these studies provide important insights, they are limited either in quantitative scope or qualitative depth. The current study will bridge this gap by combining household-level surveys with focus group discussions and in-depth interviews, quantifying cultural practices while exploring their mechanisms in maternal mortality.

2.4.3 The Perception of Pregnant Women on Maternal Mortality Rates

Pregnant women's perception of maternal mortality has been shown to influence health-seeking behaviors and maternal outcomes. Alemu et al. (2022) conducted a cross-sectional survey among 600 pregnant women in Ethiopia and found that nearly 55% of respondents underestimated the risks associated with childbirth complications. The study used structured questionnaires and logistic regression to identify associations between perception and socio-demographic factors. Women with limited awareness were more likely to delay antenatal care visits and facility-based deliveries. While this study provides valuable evidence on the link between

perception and care-seeking, it remains region-specific, and the cultural and contextual mechanisms shaping perception may differ in other LMICs such as Tanzania. These bridge the gap by investigating on the understanding how local cultural beliefs, social norms, and information access shape women's perceptions of maternal mortality at the community level.

In the USA, maternal mortality and severe morbidity are serious problems that necessitate focused solutions. Experts from various disciplines discussed these issues in April and May 2019 at the Eunice Kennedy Shriver National Institute of Child Health and Human Development. Access to healthcare, racial inequities, regional differences, maternity practices, social networks, environmental influences, and systematic racism were the main topics of discussion. Despite obstacles like inconsistent data and complicated healthcare, cooperation amongst stakeholders is essential for comprehending and preventing maternal health issues. Community engagement greatly aids research activities, as seen by projects in Washington, DC (Chinn, et al, 2020).

Furthermore, research, mainly conducted in Indonesia, has illuminated the social-cultural factors that contribute to maternal mortality, which continues to be a critical issue throughout the Asian continent. Maternal mortality rates in Indonesia are greatly influenced by sociocultural factors, according to a comprehensive analysis of 37 studies. A subset of these articles from 2005 to 2015 identified two main themes: Cultural Barriers and Vulnerable Populations. Similarly, in India, maternal health service utilization and mortality rates are significantly influenced by structural factors like caste/ethnicity, education, gender, religion, and culture. The health

system has a critical role as an intermediary, influencing maternal health outcomes through intermediate factors such as maternal age, location of residence, parity, media exposure, and health messaging. (Hamaln et all2020).

A study employing the Three Delay Model Approach was also conducted in Pakistan. Key informant interviews, focus groups, and case studies were among the qualitative techniques used, and the data was thematically reported. The results showed that low social status, nutritional deficiencies, lack of knowledge about maternal healthcare, limited mobility, lack of decision-making authority in family planning and healthcare, dependence on traditional birth attendants, and early marriages all increased maternal mortality, which was further exacerbated by delays in healthcare access. To alleviate maternal mortality in the area, government, and non-governmental organizations must implement women-focused programs focusing on socioeconomic empowerment and decision-making autonomy (Omer, 2019).

The results of a community-based cross-sectional study, which involved 233 participants from three rural districts in the Greater Accra Region and used a mixed-method approach, highlight the significance of dispelling myths about the causes of maternal mortality, especially in rural areas, through extensive community education initiatives. Data were gathered with informed consent and analyzed using basic statistics, Fisher's Exact Test, and crude odds ratio for quantitative data. At the same time, focus group discussions (FGDs) were recorded, transcribed, and thematically examined. Continuous efforts are required to achieve significant interventions to lower maternal mortality rates and promote long-lasting behavioral change (Yarney, 2019).

Africa has the most excellent maternal mortality rate globally, with Sub-Saharan Africa (SSA) contributing significantly. According to the UNDP's 2018 report, 53% of all maternal deaths globally happened in 2017. Girum and Wasie (2017) looked at health data for 82 developing countries between 2008 and 2016, highlighting the urgent need to address maternal mortality. The study highlighted the importance of national income levels, adult literacy rates, skilled birth attendance, access to clean water and sanitation, and prenatal care coverage in lowering maternal deaths by finding a significant correlation between the maternal mortality ratio and several socioeconomic and health-related indicators.

Sociocultural factors are proven to have the most significant impact on healthcare outcomes in Sub-Saharan Africa (SSA), especially when it comes to maternal mortality. Although medical and health-related issues are essential, socioeconomic determinants also have a significant impact. Maternal mortality rates are impacted by sociocultural factors both directly and indirectly, underscoring the necessity of coordinated intervention strategies. Maternal death rates in the Sub-Saharan region could be successfully decreased by addressing issues such as poor health behaviors, religious beliefs, education, unintended pregnancies, and maternal age through comprehensive measures (Okwan & Kovács, 2019).

Contrary to popular opinion, many urban Tanzanian women are unaware of pregnancy difficulties, according to a mixed-method study done in northern Tanzania with 192 participants, including expectant mothers, pregnant women, and healthcare practitioners. Although they are aware of symptoms like vaginal bleeding and stomach pain, they frequently overlook more significant ones like swollen hands,

feet, and face, blurred vision, an intense headache, and trouble peeing, which can be signals of pre-eclampsia, one of the leading causes of maternal death. Because of this ignorance, women only seek treatment when their disease worsens, which restricts the alternatives available to medical professionals. Many lives could be saved by increasing awareness of these signs (Kaaya & Luhanga, 2021).

2. 5 Research Gap

Many studies, particularly global syntheses (Wang et al., 2020; Teshale et al., 2025), have identified social and cultural determinants of maternal mortality. However, these studies often examine maternal mortality at macro-levels, providing broad generalizations without unpacking local mechanisms. For example, while global research highlights poverty, gender inequality, and education as social determinants (Wang et al., 2020), it does not explore how specific cultural practices, household decision-making, or local beliefs influence maternal mortality in rural communities. Similarly, local studies in Manyara and Babati (Felisian et al., 2023; Shewiyo et al., 2021) provide initial insights into cultural norms and knowledge of danger signs but do not link these perceptions directly to maternal mortality outcomes. Therefore, a contextual gap exists in understanding how pregnant women's social and cultural environment shapes their health-seeking behaviors and maternal outcomes.

Much of the existing literature focuses either on national-level data in Tanzania (TDHS-MIS, 2022) or other East African regions (Mekie et al., 2024; Teshale et al., 2025). While these studies provide important patterns, they mask sub-district and community-specific variations. Rural districts like Babati have unique demographic, socio-economic, and cultural characteristics, including pastoralist populations,

household decision hierarchies, and specific traditional practices. As a result, findings from other regions or national aggregates cannot be fully generalized to Babati. The geographical gap highlights the need for district-level research that captures local socio-cultural and social determinants of maternal mortality.

Most existing studies emphasize either social determinants (education, income, autonomy) or cultural practices (home delivery, herbal remedies, postpartum rituals) in isolation. Few studies integrate both aspects or explore women's perceptions and experiences related to maternal mortality. For instance, global reviews (WHO, 2021; Alemu et al., 2022) examine knowledge and perception but rarely link them with cultural practices at the community level. Similarly, local studies in Babati (Felisian et al., 2023; Shewiyo et al., 2021) focus on either knowledge or cultural practices but lack a comprehensive approach that considers social, cultural, and perceptual determinants collectively. This creates a content gap, which the current study will address by integrating these dimensions in one mixed-methods framework.

Most studies on maternal mortality use either quantitative surveys (TDHS-MIS, 2022; Mekie et al., 2024) or qualitative approaches (Felisian et al., 2023; Marabele et al., 2020). Quantitative studies provide prevalence and statistical associations but fail to explore local perceptions, beliefs, and practices in depth. Conversely, qualitative studies provide rich descriptions but often involve small samples that limit generalizability. There is a methodological gap in combining both approaches to understand not only the extent of social and cultural influences but also the mechanisms through which they affect maternal mortality. The proposed study in Babati District will use a mixed-methods design, integrating surveys of pregnant

women with in-depth interviews and focus group discussions, enabling both quantification and contextual exploration of social-cultural determinants.

2.6 Conceptual Framework

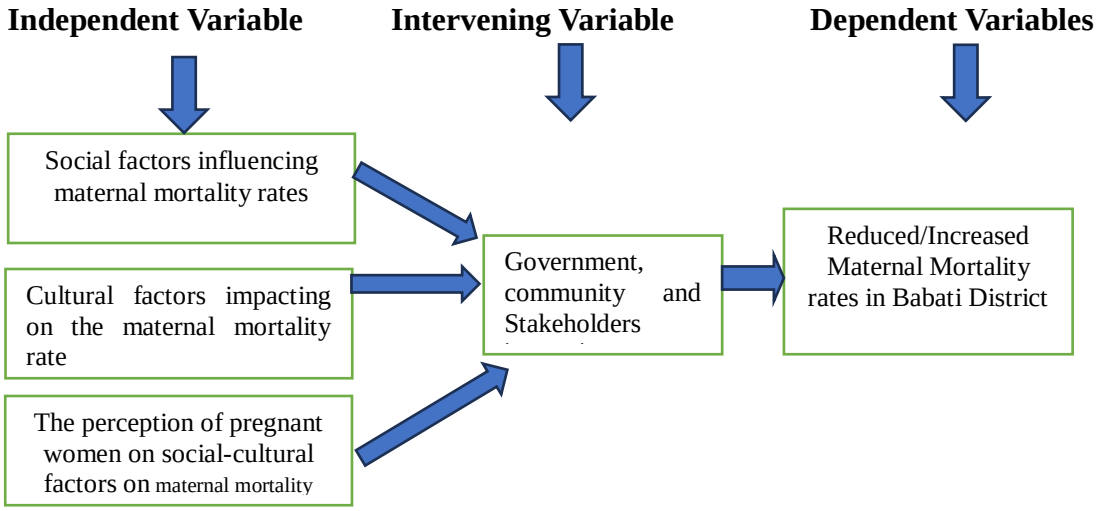

Figure 2.1: Conceptual Framework

Source: Guided by the Social Determinants of Health Theory

With the guidance of Social Determinants of Health (SDH) theory, the conceptual framework is informed by three independent variables, namely the social factors influencing maternal mortality rates, the cultural factors impacting on the maternal mortality rates and the perception of pregnant women on socio-cultural factors. These three variables when confronted with government policies and program, by involving community members and interested stakeholders on maternal mortality rate would reduce the problem of mortality rate in Babati district.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Chapter Overview

This chapter presents the research methods used to conduct the study. It covers the study area, target population, sample size and procedure, research philosophy, research design, research approach, data collection techniques, and data collection tools. This chapter also discusses ethical dilemmas and data analysis.

3.2 Research Philosophy

According to pragmatism, a mixture of many perspectives may yield a more comprehensive understanding of the phenomenon under investigation, which holds that there are numerous ways to perceive the world and conduct research to study reality (Cresswel, 2017): reference and pragmatism. Pragmatic researchers can conduct research in novel and dynamic ways to solve research problems because their research designs incorporate operational decisions based on "what will work best" in answering the investigated questions (Weick, 2002). This indicates that qualitative and quantitative methodologies were used in this study's data collection and presentation procedure.

Any research work with varying specific objectives, such as the identification of the social factors influencing maternal mortality rates, the cultural factors impacting the maternal mortality rate, and the exploration of the perception of pregnant women regarding the impact of social-cultural factors on maternal mortality rates, have to be interrogated with multiple methods, it is from this understanding, the pragmatic research philosophy was employed in this study.

3.2.1 Research Design

According to Groenland and Dana (2020), research design gathers, evaluates, interprets, and summarizes data for investigations. As such, it serves as a guide for achieving goals and responding to inquiries. The persistence of the maternal death rate among pregnant women in Babati, Tanzania, was thoroughly investigated in this study using a thorough evaluation of sociocultural factors influencing or affecting the rate. This study used a cross-sectional design in which the target group was surveyed once to gather field data or information. This type of design was used to learn more about the social and cultural elements that affect maternal mortality rates and how pregnant women perceive the effects of sociocultural factors.

3.2.2 Research Approach

The study employed a variety of data collection techniques. A mixed approach collects and analyzes data that blends quantitative and qualitative research methodologies in a single study to thoroughly understand a research subject. A hybrid approach provides more comprehensive evidence for analyzing a research problem and has benefits that exceed the limitations of both qualitative and quantitative research (Kuusio et al., 2021).

Key Informant Interviews (KIIs) were used in a qualitative methodology. The KIIs were suitable for gathering data and information from social welfare officers at the Babati hospital and expectant ladies seeking prenatal healthcare treatments. Health professionals, expectant mothers, and social welfare officers employed at the Babati hospital were the subjects of the quantitative methods that used structured questionnaires as data-gathering instruments.

3.3 Study Area

United Republic of Tanzania (URT, 2012) noted that the Manyara region is occupied by tribes such as Iraq, Hadzabe, Akie, Maasai, and Datooga. The main economic activities in Manyara include livestock keeping, hunting, and farming. In this region, indigenous people keep their distinct culture, including language. People from the Manyara community are believed to survive entirely on hunting, traditional features, and customs. As a result, this region's community members strongly believe in their traditions, customs, cultural practices, and beliefs.

Further, as highlighted by URT (2022) using the Tanzania Demographic and Health Survey and Malaria Indicator Survey 2022 Final Report, the Manyara region leads with 5.8% maternal mortality rates among the other three regions in the central zone, with Dodoma and Singida scoring below five percent, respectively. Hence, Babati Hospital was chosen as it receives all the referral cases related to prenatal care among pregnant women in the region.

3.4. Population of the Study

The population of this study comprised pregnant women residing in Babati District, Manyara Region, Tanzania, estimated at 18,022 women of reproductive age according to district health reports (Babati District Council, 2022). This group was chosen because maternal mortality directly affects women during pregnancy, childbirth, and the postpartum period, and their experiences provide critical insights into the social and cultural determinants influencing maternal health outcomes. Pregnant women are also considered a vulnerable population due to their heightened risk of morbidity and mortality, particularly in rural areas with limited access to

quality healthcare services. In addition to pregnant women, the study considered key informants such as traditional birth attendants, health workers, and community leaders, whose perceptions and practices significantly influence maternal health-seeking behavior. Focusing on this population aligns with previous maternal health studies in Tanzania (TDHS-MIS, 2022; Shewiyo, et al., 2021), which emphasize the importance of understanding both individual and community-level determinants of maternal mortality

3.5. Sampling Procedure

A researcher used systematic sampling to select pregnant women who informed this study.

3.5.1 Systematic Sampling Procedure

The systematic sampling procedure is one type of probability sampling that allows each member to be included and given an equal chance of being selected by the researcher (Singh, 2020). Starting at random, researchers choose participants at regular intervals, where every nth person in the population (Cresswell, 2018). The population size is then divided by the intended sample size to determine the sampling interval. With a total population size of 18,022, the determined sample size is 400. From the obtained sample size, the interval is 45. Since all pregnant women who access prenatal services at Babati Hospital have details kept in the hospital system, obtaining a sample size of 400 respondents using an interval of 45 was ideal.

3.5.2 Sample Size

This study employed Yeman formula to calculate the samples with the population of 18022 populations with margin error (e) of 0.05.

Formula: $n = N/ 1+ Ne^2$

3.5.1.1 Sample Size

The study was informed by four categories of respondents as indicated at table 3.1

Table 3.1: Distribution of Respondents

S/N	Categories	Data Collection Tools	Total
1	Pregnant Women	Semi structured Questionneire	370
2	Social Welfare officers		10
3	Physicians	Structured Questionneires	10
4	Nurses		10
	Total		400

Source: Field Data, 2025

3.6. Inclusion and Exclusion Criteria

The study recruited only women in the reproductive age group of 20 to 44 who were pregnant during data collection. Further, the focus was on women residing around Babata township council. Babata Referral Hospital was the only one considered to select study respondents. The recruitment of physicians, social welfare officers, and nurses was also informed. At least one had to have worked at BabatI Hospital for at least two years. This time was assumed to have given them the code on the sociocultural factors related to the maternal mortality rate in the study area.

3.7. Source of Data

This study was guided by both primary and secondary data sources. As indicates

3.7.1. Secondary Data Source

On the other hand, secondary data are those previously gathered by another party and have undergone statistical analysis (Kothari, 2004). The researcher used

information from both published and unpublished sources. Books, medication reports, and medical reports were also included in the review. All of these allowed for a change of pace and a fresh perspective on the research challenge. Researchers can conceptualize a framework using secondary data and determine where they differ from other researchers. Additionally, it makes it possible to comprehend the sociocultural customs around the maternal mortality rate among expectant mothers in Babati District.

3.7.2 Primary Source of Data

Primary data are new and unique because they are gathered for the first time (Kothari, 2004). Primary data collection gathers new information about the sociocultural factors among pregnant women. Using this source, the researcher chose to employ semi-structured questionnaires.

3.8. Data Collection Methods

Data collection methods refer to the systematic approaches used to gather information for research purposes. The choice of method depends on the research objectives, the nature of the data required, and the study design (Creswell & Creswell, 2018). Data can be quantitative, qualitative, or mixed depending on whether numerical measurements, subjective experiences, or both are needed. This study employed Semi-structured Questionnaire as the methods of data collection

3.8.1 Semi-Structured Questionnaire

A semi-structured questionnaire containing structured and non-structured questions is one versatile instrument that simultaneously gathers quantitative and qualitative

data (Lim, 2024). To ensure the instrument was filled out correctly, the researcher and assistant gave it to social welfare officers, doctors, nurses, and pregnant mothers. Twenty pregnant women and five social welfare officers who worked only at Babati Hospital were given qualitative questions, and the researcher and assistant were required to record and document their answers.

3.9 Reliability and Validity of Data

This study applied several strategies to ensure the acceptability and trustworthiness of the methods and tools.

3.9.1 Reliability of Data

The consistency and dependability of a measurement, which guarantees that equivalent outcomes are attained under comparable circumstances, is referred to as reliability. It evaluates the accuracy, consistency, and reliability of study results. The equivalency of items within the same test and the stability of measures given to the same individuals at various times are used to assess reliability. High dependability improves the precision of findings and raises the possibility that study findings will be sound (Kumar, 2018). Before conducting the study, the researcher conducted a pilot test to find and fix any possible issues with the research tools before distributing them to a larger sample.

3.9.2 Validity of Data

The ability to measure a particular concept effectively, efficiently, and precisely is called validity. In summary, validity assesses how well the research findings correspond with the research questions by determining whether the conclusions

reached are accurate from the participants' viewpoint (Abutabenjeh & Jaradat, 2018). A pre-test of all semi-structured questionnaires was conducted to find and fix any inconsistencies to improve the study's validity. The questions that the research subject did not fully understand were modified accordingly.

3.10 Qualitative Data Rigor or Trustworthiness

Ensuring Rigor and Quality in Qualitative Research Design: This study followed the guidelines of Johnson et al. (2020) regarding the principles of rigor and quality in qualitative research design. As demonstrated in the semi-structured interview, the researchers noted credibility, reliability, and conformance as they developed and conducted every interview. Presenting findings to the principal investigator for validation and comment will be part of the member-checking process, ensuring correctness.

3.10.1 Dependability

Janis (2022) states that thorough research log maintenance and precise documentation of all methodological decisions, data collection techniques, and analytical processes are strategies for building dependability to create consistency of findings within the study. This thorough documentation makes audit trails possible and makes it easier for other researchers to replicate the study. Throughout this investigation, the researcher kept a reflexive field journal. The researcher's personal experiences, prejudices, and presumptions that could affect the gathering and analysis of data were documented in this field journal.

3.10.2 Trustworthiness

According to Ghafouri (2016), the researcher examines the quantity, quality, and

variety of data and everything he has experienced, heard, and seen to have credibility during the study. He also asks himself if the data and findings are appropriate for his claim to the research. After conducting semi-structured questionnaires, the researcher used member checking to discuss significant findings and interpretations with a subset of respondents to guarantee that the findings were valid, credible, and reliable. Participants were able to confirm the researcher's comprehension and spot any possible misunderstandings as a result.

3.10.3 Confirmability

According to Ghafouri (2016), supervisors and colleagues utilize the study's validity, an overview of contradictory situations, precise explanation of facts, and confirmability of research findings to enhance the qualitative research review process. By using reflexivity, where the researcher critically examined their own biases and prejudices, confirmability was improved, and the data remained participant-driven. The thorough documentation of the study process produced a thorough audit trail. Data analysis methods, coding schemes, questionnaires, and interview recordings (with participant consent) were all part of this trial. This makes it possible for outside reviewers to evaluate the research choices and how well they match the results.

3.10.4 Transferability

The degree to which research findings can be applied to different contexts or circumstances is known as transferability. To increase the possibility of transferability, qualitative researchers seek to provide detailed and complex descriptions of the study's setting, participants, and methods (Ahmed, 2024). The

researcher's thorough explanations enhanced the study's transferability, enabling readers to assess how relevant the results were to comparable circumstances.

3.11 Data Analysis and Presentation

The research technicalities used in the data analysis and presentation are explained to readers in this part.

3.11.1 Data Analysis

According to Huang (2019), data analysis turns unprocessed data into significant information. Thus, data processing entails gathering, recording, organizing, storing, and modifying or adjusting to convert the raw data into meaningful information. Since the study employed mixed research approache , Descriptive statics analysis was employed to analyze quantitative data collecte while SPSS Version 23 employed to evaluated and interpret quantitative data from objectives one, two, and three. In Qualitative data analysis thematic analysis was utilized to examine the qualitative data, and quotations were then used to identify and condense the main themes. Where information gathered organized and coded into themes that were useful in presenting the finding of this study

3.11.2 Data Presentation

Huang (2019) defines data presentation as the arranging and visualizing of processed data or relevant information to make it easier to read and comprehend. The Quantitative from this study were presented using textual, tabular, and graphical techniques While the qualitative data where presented using quotation and narrative paragraphs. Because these methods were compatible and efficacious in

communicating the intended meanings of the research findings to the readers, the researcher decided to utilize textual, tabular, and graphical methods to present and visualize the study's findings.

3.12 Research Ethical Consideration

According to Olaniran and Baruwa (2020), adult education researchers must adhere to a strict ethical framework when conducting research with adult learners. This framework should include informed Consent, confidentiality, anonymity, and the prevention of participant harm.

3.12.1 Research Clearance

The Open University of Tanzania conducted a thorough ethical review of the research proposal before data collecting started. Furthermore, the regional medical doctor and the regional commissioner granted the required approvals.

3.12.2 Confidentiality

To preserve the humanity and dignity of the participants, it is essential to protect subject privacy and personal data gathered during research investigations. All participant information should be handled with the highest confidentiality during the entire research process, according to Pietilä (2020). All identifying information was promptly eliminated from the data in this study to preserve participant privacy. Data was safely kept in a password-protected area only authorized staff could access. Participants will express their agreement if data sharing is required, and researchers will abide by all applicable data protection laws.

3.12.3 Anonymity

According to Favaretto, et al., (2020), the second most frequently reported criteria for conducting research were respected for the privacy of research participants and protection from potential identification, typically accomplished through anonymizing data. To maintain anonymity and confidentiality, no personally identifying information was collected during the data gathering and reporting.

3.12.4 Consent

When applicable, Consent is a necessary component of research operations. Researchers should be aware of their understanding, procedures, resources, obstacles, and solutions regarding Consent and assent. (Mead and Associates , 2023). Participants in this study were given informed consent forms; any incentives given to them should not affect their choice to join or jeopardize their autonomy, and they were free to leave the study at any time without facing any consequences.

3.12.5 Voluntary Participation

People must be aware of the type of data being collected when they have the opportunity to object and other details so they can give their informed permission (Favaretto, 2020). Participation in this study was voluntary, and each participant completed a consent form attesting to their Informed Consent. Participants' autonomy should not be compromised by any incentives to persuade them to join; they were free to leave the study without facing any consequences.

3.12.6 Do not Harm Principle

It is important to follow the ethical guidelines for research projects, which state that no harm should be caused. By adhering to ethical standards, you should avoid

making things worse for research subjects, institutions, and other stakeholders. Taylor (2021). Two social workers were hired for this study in order to assist female participants who were experiencing emotional and psychological difficulties related to the subject matter. Additionally, the researcher identified and reduced potential participant risks, such as psychological distress or social stigma, and maintained participant anonymity by not collecting personal data.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND DISCUSSION

4.1 Chapter Overview

Socioeconomic and demographic factors are very important in research studies, as Creswell and Creswell (2018) pointed out. They give essential background information and help us understand why results vary between population groups. Babbie (2020) revealed that age, gender, marital status, and level of education are some socioeconomic and demographic factors that help researchers divide and research study groups better. In health behavior studies, such as looking at the mortality rates among pregnant women, these traits help researchers find trends and differences. Further, this study's data was collected from four hundred (400) respondents.

Moreover, this research work entitled "Examine the Influence of Social-Cultural Determinants on Maternal Mortality Rate among Pregnant Women in Babati District – Tanzania" is guided by three specific objectives, namely to investigate the social factors influencing maternal mortality rates among pregnant women in Babati District, to examine the cultural factors impacting on the maternal mortality rate among Pregnant Women, and to explore the perception of pregnant women regarding the impact of social-cultural factors on maternal mortality. These specific objectives were interrogated in line with variables to establish the influence.

4.2 The Socioeconomic Demographic Information among Study Respondents

The socioeconomic demographic in this study was dealt with using the cross-tabulation of awareness of the influence of socioeconomic demographics against age,

marital status, sex, and education; more details are presented as follows,

4.2.1 The Cross Tabulation of Awareness of the Influence of Socioeconomic Demographic Characteristics against Marital Status, Age Cohort and Education Level

Pointing to Marital status, Table 4.1 shows that from the marital status, 50% of married women recognized the influence of sociocultural determinants on maternal mortality rate among pregnant women against 2% who did not realize it. Further, 25% among the divorced against 1%, and 15% of singles against 7% recognized the influence. This is to say, the majority of the respondents in this study, 90% against 10%, recognized the impact of socio-cultural determinants on maternal mortality rate among pregnant women.

Table 4.1: Socio-Economic Demographic Information of the Study Respondents

Influence of Social-Cultural Determinants on Maternal Mortality Rate among Pregnant Women	Singl e	Married	Divorced	Percent (%)
		Marital Status		
Recognise Influence	15	50	25	90%
No Influence	7	2	1	10%
Total	30	8	62	100%
		Age Cohort		
21 - 30	10	40	15	65%
31 - 40	2	15	10	27%
41- 50	1	3	0	4%
51 Above	1	3	0	4%
Total	14	61	25	100%
		Education Levels		
Primary Level	8	38	3	49%
Secondary Level	3	10	6	19%
College Certificate	1	3	1	5%
Diploma Level	1	4	1	6%
Bachelor's and above	6	8	7	21%
Total	19	63	18	100%

Source: Field Data, 2025.

Pointing to Education Levels, Table 4.1 shows that 38% of married respondents had a primary education level, 10% were secondary school leavers, and the rest were below 10%. Further, from the singles, 8% had primary school education, 6% were bachelor holders, and the rest were between 3% and 1%. Still, among divorced, 7% were bachelor holders, 6% were secondary school leavers, and the rest were between 1% and 3%, respectively. Pointing to Age Cohort, Table 4.1 shows that 40% of married women were from the age cohort of 21-30, while 15% were from the divorced and 10% were from the single, respectively. Other age cohorts, such as 31-40, 41- 50, and 51 and above, were relatively between 15% and 1% around all marital statuses (married, single, and divorced).

4.2.1.1 Discussion on the Cross Tabulation of Awareness of the Influence of Socio-Economic Demographic Characteristics against Marital Status, Age Cohort, and Education Level

The findings, presented in Table 4.1, show that maternal mortality is still a remarkable problem for public health, and sociocultural factors have a big impact on how well a pregnancy goes. Among these factors, marital status, level of schooling, and age have been studied extensively as ways to change maternal mortality rates. It is worth noting that being married can affect a mother's health by giving her mental, social, and financial support. Studies have shown that married women often have better access to health care, nutritional support, and mental health. This lowers the risk of mortality rate during childbirth.

However, teen or forced marriages raise the risk of complications because of early births and limited access to health care (Raj, et al., 2009). This is especially true in

low-income areas. Also, women who are not married may face discrimination, financial problems, and limited access to prenatal care, which raises the risk of maternal death (Say & Raine, 2007). Early marriage is linked to more problems and deaths in mothers because women are not fully developed physically and cannot make good decisions (Santhya et al., 2010).

Moreover, education has a significant effect on how mothers seek health care and what they know about the risks of pregnancy. Lower maternal mortality rates are linked to women with more education because they are more aware, have better income status, and have more control over their healthcare decisions (UNICEF, 2020). Because women with little or no schooling are less likely to get skilled birth attendants, complications like postpartum hemorrhage and labor that won't move are more likely to happen (Kumar et al., 2019). Women with more education can avoid getting pregnant too soon, use family planning, and get the care they need (Abuya et al., 2012). Studies have shown that maternal mortality is much lower in places where many women attend school (Goli & Moradhvaj, 2018).

At this point, age is one of the most important factors that affect a mother's health. Teenage girls and older women are more likely to have problems during pregnancy and childbirth. Teenage pregnancies are more likely to cause pre-eclampsia, eclampsia, and labor problems because the reproductive systems of teens are not fully formed yet (Blum & Gates, 2015). Teenage moms are also less likely to get skilled care because they are afraid of social stigma and need the money. Getting older during pregnancy raises the risk of high blood pressure, gestational diabetes, and problems like placenta previa and postpartum hemorrhage, which in turn raises

the risk of death for the mother (WHO, 2018)

4.3 The Social Factors Influencing Maternal Mortality Rates among Pregnant Women

The findings and discussion for the first specific objective of this study (The Social Factors Influencing Maternal Mortality Rates among Pregnant Women) are informed with the following sub-sections, namely**,** Identified Social Factors influencing Maternal Mortality Rates **(**MMR), Access to Prenatal and Maternal Healthcare Services influence MMR, The Influence of Income Levels, Employment, and Education on MMR, and the Influence of Cultural Norms, Traditions, and Practices during pregnancy and childbirth contribute to MMR.

4.3.1 Identified Social Factors influencing Maternal Mortality Rates

The maternal mortality rate (MMR) is affected by several social factors that make it harder for women to get and use health care services for mothers. Some of these social factors are education level, income, cultural views, marital status, and the ability to get medical care

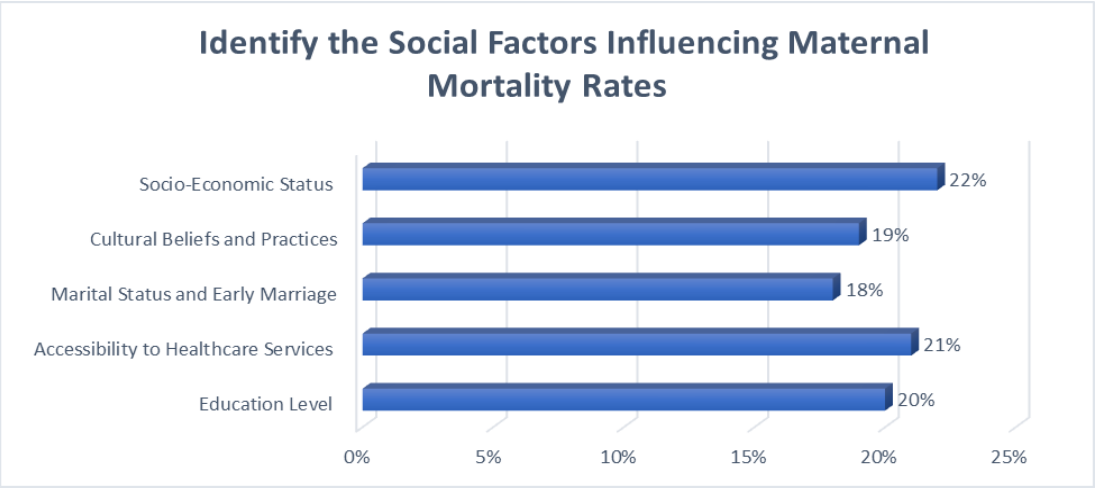

Figure 4.1: Identified Social Factors Influences MMR

The study identified the following social factors influencing MMR in the Babati area: education level, accessibility to healthcare services, marital status and early marriage, cultural Beliefs, and socioeconomic status. As per Figure 4.2, the findings show no significant differences among them, ranging from 22% (socioeconomic status), which is the highest, to 18% (marital status and early marriage), which is the lowest. The finding implies that all the identified factors influence the MMR in the Babati area equally and must be treated equally when addressing them. These findings were supported as follows,

4.3.1.1 Discussion on the Identified Social Factors Influencing Maternal Mortality Rates (MMR)

Her level of education influences a pregnant woman's health as Abuya, et al., (2012) noted that women with more education are more likely to get prenatal care, use skilled birth attendants, and follow other good parenting habits. Lack of schooling makes it harder to learn about the risks to mothers and less likely for them to use health care. Because they do not seek medical help as often, women with less schooling are more likely to die during pregnancy (Goli & Moradhvaj, 2018). Getting educated also gives women the power to make smart choices about birth control, time between births, and health care access (WHO, 2021).

Moreover, being poor makes it harder for mothers to get medical care, eat healthy food, and live in a safe place (Filippi et al., 2016). Lack of money makes it harder for women to get skilled care, which raises the risk of home births and other problems during pregnancy. Research has shown that because low-income families have less access to health care, the death rate for mothers is higher in those homes (Ronsmans

et al., 2006). This means that differences in income make it harder for some people to get health care, especially in places with few resources (Khan et al., 2006).

Additionally, cultural norms and traditional behaviors affect how mothers get medical care. People in some cultures think that a problem during birth are typical and does not need medical help (Hogan et al., 2010). High rates of maternal mortality may be caused by cultural taboos that keep women from getting medical care (Bhandari et al., 2016). Still, in some African and South Asian cultures, women need approval from their husbands or in-laws to get medical care for themselves during pregnancy. This makes it take longer for them to get life-saving care (Moyer & Mustafa, 2013).

Further, the health of a mother is affected by her marital situation. Due to early pregnancies and lack of control over decisions, early and forced marriages raise the risk of maternal death. Teenage girls are more likely to have problems during pregnancy, such as labor being delayed and pre-eclampsia (Raj et al., 2009). Also, pregnant women who are not married may face social shame, which can make it harder for them to get medical care (Say & Raine, 2007).

Furthermore, one of the leading causes of maternal death is that women do not have easy access to healthcare services. In rural or remote areas, women often must drive long distances, do not have access to public transportation, and cannot get to healthcare facilities that are up to par. The death rate for mothers goes up when there are not enough trained birth attendants or good healthcare facilities (Campbell & Graham, 2006). Also, it is important to know that the "Three Delays Model"

explains how waiting too long to seek, reach, and receive proper care can lead to a mother's death (Thaddeus & Maine, 1994). How much education someone has, how easy it is to get medical care, whether they are married, their cultural beliefs and practices, and their socioeconomic status.

4.3.2 Access to Prenatal and Maternal Healthcare Services Influence MMR

The sub-section on the influence of accessibility and available prenatal and maternal healthcare services to MMR is informed by Health Insurance Coverage, Accessibility of Maternal Healthcare Facilities, Transportation and Infrastructure, and Quality of Maternal Healthcare Services, more details as per Figure 4.2

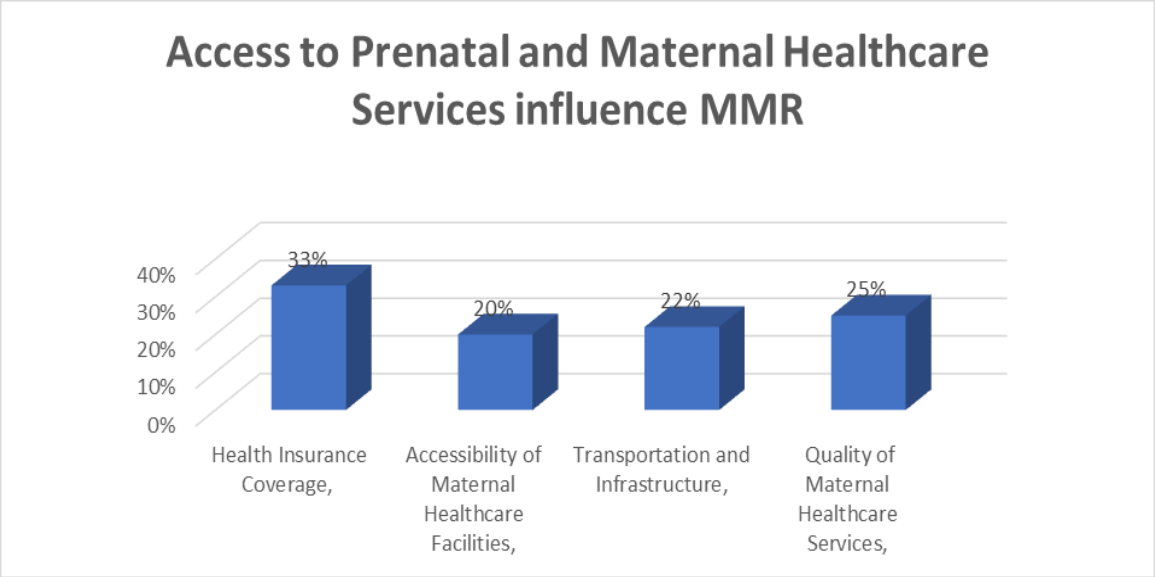

Figure 4.2: Access to Prenatal and Maternal Healthcare Services influence MMR

Figure4.2 is informed by four variables: health Insurance Coverage, Accessibility of Maternal Healthcare Facilities, Transportation and Infrastructure, and Quality of Maternal Healthcare Services. The highest score is observed for health insurance coverage, with 33%. Further, the quality of maternal healthcare services scored 25%; 22% was noted for transportation and infrastructure, and 20% for accessibility of

maternal healthcare facilities.

The findings imply that the four variables, such as Health Insurance Coverage, Accessibility of Maternal Healthcare Facilities, Transportation and Infrastructure, and Quality of Maternal Healthcare Services, as in Table 4.2, have very related scores. This can be related to the problem under study, meaning each variable is significant. These findings were reflected in the works of Ng'anjo Phiri et al. (2021), Yaya et al. (2018), Macha et al. (2012), Donabedian (1988), Kruk et al. (2010), Bohren et al. (2015), Essendi et al., (2011). Moyer et al. (2013) Gabrysch & Campbell (2009), WHO (2021), more details as provided,

4.3.1.1 Discussion on the Accessibility to Prenatal and Maternal Healthcare Services Influence MMR

It is worth noting that it is essential for the government to make it easier for mothers to get medical care by offering free or low-cost care (Yaya et al., 2018). Access to maternal care has been improved by health insurance programs like NHIF in Tanzania, but it is still hard to reach people in rural areas (Macha et al., 2012). Ng'anjo Phiri et al. (2021) say that countries with free maternal healthcare policies have seen more women get prenatal care and fewer mothers die during pregnancy.

On the same note, the level of maternal healthcare services affects women's choices about whether to get care (Donabedian, 1988). Women do not go to health centers as often as they should because they are not well-equipped, do not have enough staff, do not have enough important drugs, and are dirty (Kruk et al., 2010). Women who are pregnant may not go back for prenatal visits if they have bad experiences with

healthcare workers, such as being mistreated or discriminated against (Bohren, et al., 2015).

Further, women, especially those living in rural areas, have difficulty getting to healthcare facilities on time for prenatal visits or emergency care because they do not have many transport choices, and the roads are not well maintained (Essendi et al., 2011). High transportation fees and a lack of ambulances make women less likely to go to prenatal and delivery care (Koblinsky et al., 2006). In developing countries, bad roads make it take longer to get to medical services, which can lead to maternal deaths (Moyer et al., 2013).

Moreover, maternal healthcare access, how close healthcare facilities are, and how many trained healthcare providers are available are critical (Thaddeus & Maine, 1994). There are not as many healthcare facilities as possible in rural and remote places, so women have to travel a long way to get care for their babies, which makes them wait longer to get help (Gabrysch & Campbell, 2009). Not having enough trained midwives, doctors, and medical equipment can make it hard to get good prenatal and emergency obstetric care (WHO, 2021).

4.3.2 The Influence of Income Levels and Education on MMR

This subsection was dealt with using key informants, from pregnant women and social welfare officers; the following were their narrations,

> *"Pregnant women from poor families, without a source of income, cannot afford to have quality healthy care, nor can have access to nutrition and decent living home" (A Pregnant Women)*

The narrations presented by a pregnant woman were supported by a social welfare officer, who added that,

> *"Pregnant women, due to low income, are more likely to be exposed to malnutrition and anemia" (Social Welfare Officer).*

As presented in the narration, these findings directly connect to income's influence on MMR. Further, as presented, other qualitative data were collected from medical practitioners, who focused their narration on the influence of education on MMR.

> *"Women who have achieved a better education, have a better chance to decide on the size of family and the means for birth control" (Medical Doctor)*

In agreement with the narration, a nurse noted that,

> *"Education helps women to have informed choices when it comes to health of a women and nutrition during pregnancy time" (a Nurse)*

The presented assertions indicated the importance of education when deciding on the birth control methods, health, and nutrition needed during pregnancy.

4.3.3.1 Discussion on the Influence of Income Levels and Education on MMR

Income and education level have a significant effect on maternal mortality rates because they affect access to health care, nutrition, and health knowledge. Getting rid of differences in these areas through programs that help people get out of poverty, better job policies, and investments in women's education can lower the number of deaths of mothers. A woman's income directly affects her ability to pay for food, medical care, and a safe place to live, all of which are very important for lowering the death rate among mothers. Higher-income levels are linked to more women using maternity healthcare services like trained birth attendants and emergency obstetric

care (Kruk, et al., 2010). Women with low incomes are more likely to be malnourished, anemic, and have other problems during pregnancy, which raises the chance of death for the mother (Filippi, et al., 2016). Women with higher incomes are more likely to have health insurance, making it easier for them to get maternal health care without worrying about money (Yaya, et al., 2018). According to Ronsmans, et al. (2006), women in the lowest income quintile are five times more likely to die during childbirth than women in the highest income quintile. To put it another way, in Tanzania, insufficient money was seen as a big reason poor women did not use healthcare services as much as other women (Macha, et al., 2012).

Education is one of the most important factors that affects a mother's health because it affects how she plans her family, goes to the doctor, and knows about the risks she faces. Educated women are more likely to notice warning signs during pregnancy and get medical help immediately (Abuya, et al., 2012). More prenatal care, hospital deliveries, and postnatal care services are used by women with higher levels of education (Goli & Moradhvaj, 2018). Women with more education tend to have fewer children and space their births farther apart, which lowers the chance of problems during pregnancy (Cleland, et al., 2012).

Moreover, a study in Kenya found that women with a college education had a much lower rate of maternal mortality than women who had never been to school (Wirth et al., 2008). More educated women are more likely to use birth control and have fewer unplanned pregnancies, which lowers the chance of maternal deaths (Bongaarts, 2014). Further, in Nigeria, the death rate for mothers was much higher for women who had not gone to school than for women who had at least a basic education

(Fagbamigbe & Idemudia, 2016).

4.3.3 The Influence of Cultural Norms, Traditions, and Practices during Pregnancy and Childbirth Contribute to MMR

This sub-section is on the Influence of Cultural Norms, Traditions, and Practices during pregnancy and childbirth contribute to MMR the following features namely a preference for home births, traditional birth attendants, decision-making is still men's work, Dietary practices, and the use of traditional medicine were used to inform it, as follows,

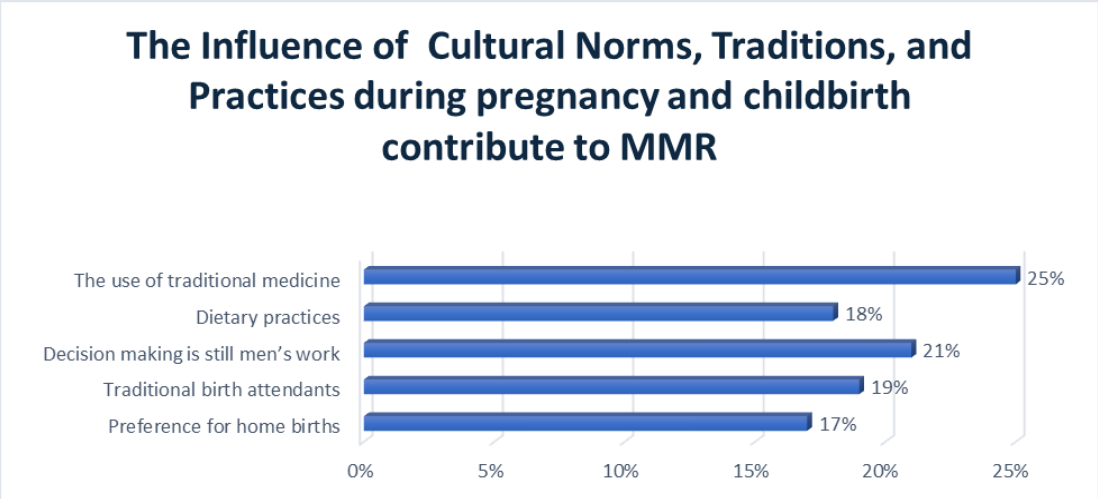

Figure 4.3: The Influence of Cultural Norms, Traditions, and Practices during pregnancy and childbirth contribute to MMR

The table shows that the uses of traditional medicine recorded by 25%; 21% recorded decisions still in the hands of men, 19% noted Traditional birth attendants, 18% pointed to Dietary practices, and 17% pointed at a preference for home births. The findings reveal that all the identified features are equally significant in influencing the well-being of pregnant women in the study area.

4.3.4.1 Discussion on the Influence of Cultural Norms, Traditions and Practices during Pregnancy and Childbirth contribute to MMR

In many places, especially rural ones, giving birth is seen as a normal process that does not need any medical help. Because of this, women may want traditional birth attendants (TBAs) to help them give birth at home instead of skilled medical professionals (Moyer & Mustafa, 2013). In many patriarchal countries, men or older people make the main decisions about women's health care (Say & Raine, 2007). During pregnancy or childbirth, women may need permission from their husbands or other family members before going to the doctor.

Some cultural views and practices about nutrition and care after giving birth can be bad for a mother's health. If pregnant women cannot eat certain foods, they might not get enough nutrition, which raises the chance of anemia and birth problems (Abrahams & Jewkes, 2012). Postpartum seclusion practices in some countries keep women from going to the doctor, even when they have life-threatening problems like postpartum infections (Filippi et al., 2016). Some ancient practices, like binding the abdomen, may lead to problems after giving birth (Osubor et al., 2006).

Some damaging cultural practices, like female genital mutilation (FGM) and child marriage, make the chance of a mother dying much higher. Women who have had FGM are more likely to have obstructed labor, delayed bleeding, and obstetric fistula, all of which can lead to death during labor (WHO, 2018). Child marriage leads to early pregnancy, which is linked to higher rates of maternal mortality because of higher risks of eclampsia, labor problems, and bleeding after giving birth (UNICEF, 2019). Because their bodies are not fully formed for childbirth yet,

teenage girls are more likely to have problems during pregnancy (Raj et al., 2009).

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4.4 The Cultural Factors Impacting on the Maternal Mortality Rate

This is the second specific objective of the study, which was dealt with using the following variables,

4.3.1 Knowledge of the Cultural Factors Impacting on the Maternal Mortality Rate

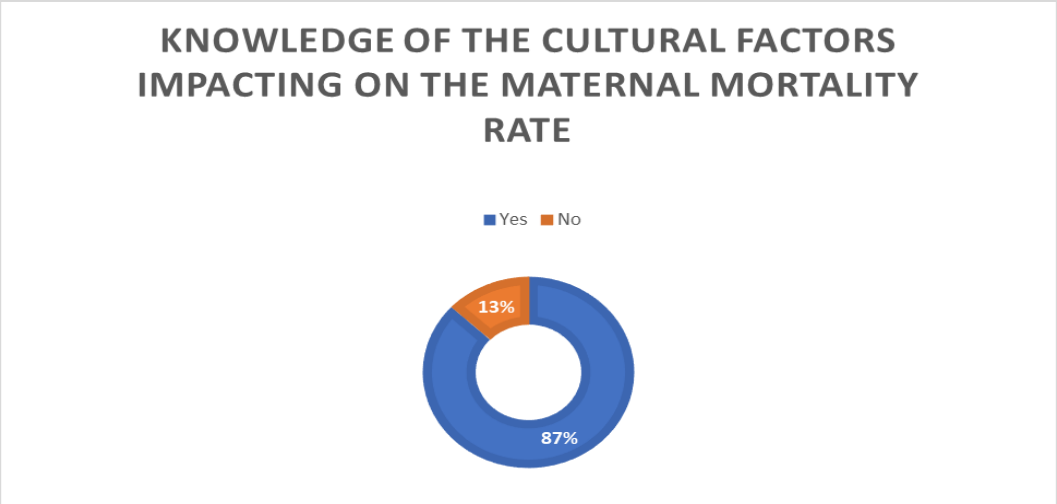

Figure 4.2: Knowledge of the Cultural Factors Impacting on the Maternal Mortality Rate

Figure 4.2 shows that the majority of the student respondents (87%) were informed and aware of MMR's social and cultural impact; only 13% indicated not to be aware. This group (13%) cannot be treated as insignificant, as the life of a single pregnant woman matters a lot. Measures to create awareness of the influence of social-cultural factors on MMR must be created from the grassroots level.

4.4.1 Discussion on Knowledge of the Cultural Factors Impacting on the Maternal Mortality Rate

Campbell & Gabrysch (2009). Women may or may not get prenatal care (ANC), skilled birth attendants, or postnatal care, depending on their cultural norms and traditional views. Some groups see pregnancy and childbirth as natural processes that do not need medical help, which makes people wait longer to get help. Cultural factors affect maternal mortality in two ways: directly and indirectly. They do this by affecting birth habits, decision-making, and access to health care. Reducing these cultural barriers through healthcare laws, education, and community involvement can help lower MMR.

4.4.2 Beliefs and Preference for Giving Birth at Home

Maternal mortality rates (MMR) are affected by cultural factors that affect how people seek medical care, follow traditional practices, and how often they do so. Using Key informants (Nurses and pregnant women), the following narration was presented,

> ***"****It is a normal practice in some society, including residents of Babati, to prefer giving birth at home, being assisted by the old women even though they have no competencies required to handle this work*" (a Nurse-Key Informant).

The presented narration shows the preference among pregnant women in Babati to seek health services and support from traditional healers and older women. This preference is enforced with some rituals that must be undertaken during birth and sometime after birth. On another note, pregnant women narrated,

> *"It a common practices that pregnant women belief that by going to seek modern healthcare, the unborn child can be born with some kind of deformity"* (One of the pregnant women).

The MMR issues relate to misconceptions and social stigma related to women who visit modern health facilities during pregnancy.

4.4.2.1 Discussion on Beliefs and Preference for Giving Birth at Home

World Health Organisation (WHO, 2021) noted that cultural norms and traditional practices affect how mothers look for health care. Some cultures value home births with traditional birth attendants (TBAs) more than births with skilled medical workers, which can make the delivery more dangerous. Gabrysch and Campbell (2009) pointed out that cultural stigmas, religious views, and false ideas about modern healthcare can make it hard for pregnant women to get antenatal care (ANC), emergency obstetric services, or care after giving birth.

4.4.3 Relationship between Cultural Factors and Maternal Mortality Rate

Maternal mortality rates (MMR) are affected by cultural factors that affect how people seek medical care, follow traditional practices, and how often they do so. These things can help you understand the relationship:

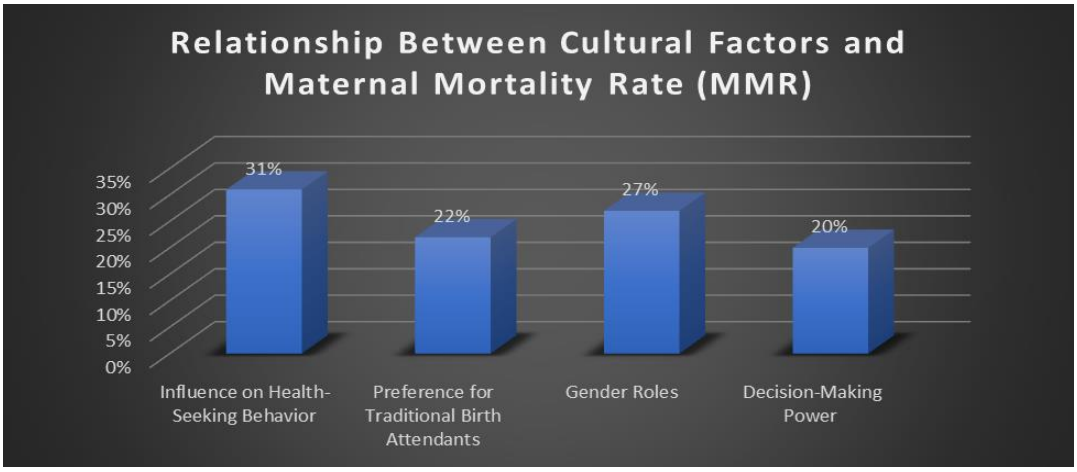

Figure 4.3: Relationship between Cultural Factors and Maternal Mortality Rate

Figure 4.3 is informed with three variables, such as influence on health-seeking behavior, preference for traditional birth attendants, and gender roles and decision-making power, where the findings show that the scores ranged between 31% (Influence on health-seeking behavior) as the highest, and the lowest (20%) noted at decision-making power. Other variables, such as preference for traditional birth attendants, were recorded at 22%, while 27% was observed at gender roles. The finding implies that the four factors are interrelated and directly related to MMR in the study area. Each of them influences MMR among pregnant women.

4.4.3.1 Discussion on Relationship between Cultural Factors and Maternal Mortality Rate (MMR)

Gabrysch and Campbell (2009) found that cultural norms and traditional views affect women's decisions about whether to get prenatal care (ANC), skilled birth attendance and care after giving birth. Some groups see pregnancy and childbirth as natural processes that do not need medical help, which makes people wait longer to get help. Thaddeus and Maine (1994) said that in patriarchal societies, men in the

family often make choices about women's health care, which can make it take longer for them to get emergency obstetric care. Not being able to choose how to get skilled medical care raises the risk of issues like bleeding, labor problems, and infections. WHO (2021) says that many cultures use traditional birth attendants (TBAs) instead of trained medical professionals because they trust them, can pay them, or have religious beliefs about them. However, TBAs do not always know how to deal with problems like eclampsia or postpartum hemorrhage, which raises the death rate for mothers.

4.5 The Perception of Pregnant Women regarding the Impact of Social-Cultural Factors on MMR

This is the third specific objective of the study. It was dealt with qualitatively, and information was collected from pregnant women, nurses, social workers, and physicians. Specific qualitative questions were asked guided by health-seeking behaviors, traditional beliefs, gender roles, decision-making power at the family level, socioeconomic challenges, and accessibility to healthcare. The following narration was captured during the key informants' interview and focus group discussion,

4.5.1 Seeking of Healthcare Services and Beliefs

The qualitative information on seeking healthcare services and beliefs was collected from nurses and social workers. The quotation was used to summarise these findings as follows,

> *"The community members, particularly the elders still prefer the practice of using the traditional birth attendants than medical practitioners"* (A Nurse during Key Informants)

A Social worker, in agreement with the narration of the Nurse, noted,

> *"The elders and pregnant women still believe and trust in the powers of traditional birth attendants; however, they are not informed of the limitation of healthcare-related services in case of emergency*" (A Social Worker during Key Informant Interview).

The findings from the nurses and social workers show that in Babati, there are still strong traditional beliefs related to pregnancy and giving birth, which perpetuate the possibility of pregnant women or women, in general, accessing healthcare services from the health facilities.

4.5.1.1 Discussion on Seeking Healthcare Services and Beliefs

The nurses and social workers found that there are still strong traditional beliefs in Babati about pregnancy and giving birth. These beliefs make it harder for pregnant women and women in general to get medical care at health facilities. These findings were echoed by Gabrysch & Campbell (2009), who noted that the way pregnant women think about maternal health care is affected by cultural norms, traditional beliefs, and local knowledge systems. Some communities believe conventional birth attendants (TBAs) are more than skilled healthcare providers, so they prefer home births with TBAs instead of skilled healthcare providers. This makes it take longer for people to get emergency obstetric care.

4.5.2 Gender Imbalances and Choices

The question on the perception of gender imbalances and choices was exposed to pregnant women during the focus group discussion; they narrated the following,

> *"Customarily and traditionally, a woman does not have power or autonomy to make own decision; when it happen she is considered as*

> *repealing against the family and the clan norms*" (One of the pregnant women during FGD).

Another pregnant woman cemented on the power imbalance noted

> *"The decision related to health is left in the hands of the male, who is free to consult his family members or elders; a woman is simply waiting to be told the decision made for implementation*" (Another pregnant woman during FGD).

Considering the power of finances, another pregnant woman narrated,

> *"Though a woman is at the forefront in contributing to socioeconomic accumulation of the household assets, it is a common practice that a male partner can allow a woman to know or consult on how the same can be spent. Without financial power no one can make a valid decision*" (another pregnant woman during the FGD).

The presented qualitative information on the perception of the gender imbalances and choices, which were collected during the focus group discussion, shows the impact of lack of gender roles imbalances and choices, which denies pregnant women access to make their own decisions on their health-seeking choices.

4.5.2.1 The Discussion on the Gender Imbalances and Choices

The focus group discussion yielded rich qualitative data on people's feelings about gender roles and choices. This data shows how the lack of gender roles and choices affects pregnant women's ability to make their own decisions about their health care. These results were backed up by Ganle et al. (2015), who said that in many countries, women do not have much freedom to make health decisions because their male partners or extended family members make the financial and healthcare decisions. Lack of decision-making power can make it take longer for women to get the health services they need, which raises the MMR.

4.5.3 Socioeconomic Challenges and Accessibility to Healthcare

To collect qualitative information on the perception related to Socioeconomic Challenges and Accessibility to Healthcare, this question was directed to Physicians, Pregnant women, and social workers; the following was the captured narration during key informants, In an area which is mountainous such as Babati, homestands typically are located remotely, which makes it harder to have reliable transport; this was narrated by a physician who noted that,

> *"Due to transport problem which is accelerated with the nature of Babati being mountainous area, it increases the chances of pregnant women not to access medical attention from the medical practitioners who are located in health facilities which demands extra costs, which come along with poor roads"* (a Physicians during key informant interviews).

Supporting the challenges related to transport in Babati, added by highlighting poverty at the household level as another factor increasing the vulnerability of pregnant women to access healthcare services,

> *"Women in Babati are very significant in numerous socioeconomic activities; however, they do not have access to the benefits of their rewards, as men own it; hence, when it comes to their economic status, women are inferior. They cannot afford health care services which demand any contribution, without a man's decision to give them money*" (Pregnant Women and Social Worker during key informants' interviews).

Further, another pregnant woman noted,

> *"Due to poverty level among pregnant women, it is tough to decide on the option for the site for deliveries as it depends on financial powers"* (A pregnant woman during Key Informants Interview)

The findings from the social workers, pregnant women, and physicians, as collected during the key informants, highlighted the socioeconomic challenges affecting pregnant women in Babati; they also pointed out the challenges facing pregnant

women when accessing affordable and quality healthcare services.

4.5.3.1 Discussion on the Socioeconomic Challenges and Accessibility to Healthcare

The information gathered from social workers, pregnant women, and doctors showed that pregnant women in Babati face social and economic problems. It also highlighted the difficulties they encounter in getting affordable and quality healthcare. The results agree with Say & Raine (2007), who noted that economic factors like poverty, transportation, and healthcare costs significantly impact how much maternal healthcare is used. Women from low-income backgrounds may think that healthcare services are too pricey or hard to reach. As a result, they might choose to give birth at home or wait to get care, which increases the risk of maternal mortality.

4.6 Relevancy of Social Determinants of Health Theory to this Work

The Social Determinants of Health (SDH) theory helps us understand how social and cultural factors affect the number of mothers who die during pregnancy or childbirth. The SDH framework shows how social, economic, and environmental factors, including maternal mortality, affect health results. On socioeconomic status affecting pregnant women on their healthcare accessibility, Marmot et al. (2008) pointed out that the Social Determinants of Health (SDH) theory shows that factors like poverty, education, and job status affect how well women can receive good maternal healthcare. Women with low incomes struggle with money, which results in bad health for mothers. Poor women often wait too long to get help from trained birthing professionals, have poor nutrition, and do not receive enough prenatal care, which

raises the chances of dying during childbirth.

Pointing to cultural beliefs and health-seeking behavior, Bohren, et al., (2014) revealed that the SDH theory highlights the role of cultural norms, traditions, and gender roles in shaping health choices. In many societies, people choose traditional birth attendants (TBAs) instead of trained health workers because of their cultural beliefs. These practices can cause delays in getting emergency care for childbirth, which can lead to more problems during delivery.

Braveman et al. (2014) pointed out that health system barriers and social inequities are essential for understanding Social Determinants of Health (SDH) theory. They explain how problems in healthcare systems, like poor infrastructure, unfair treatment, and unhelpful healthcare workers, can negatively affect maternal health outcomes. Women from disadvantaged areas struggle to access emergency childbirth care, qualified birth attendants, and proper maternity services, which results in higher death rates. The SDH theory, therefore, helps us understand how social, economic, cultural, and healthcare system issues lead to maternal deaths. By tackling these social factors, we can lower maternal mortality rates and enhance the health of mothers.

CHAPTER FIVE

SUMMARY, CONCLUSION, AND RECOMMENDATION

5.1 Chapter Overview

This chapter presents the summary, conclusion, and recommendation for the study. It is guided by the title and the three specific objectives. Details as presented,

5.2 Summary

The study entitled “The Influence of Social-Cultural Factors on Maternal Mortality Rate Among Pregnant Women in Tanzania” is guided by three specific objectives, namely, to assess the social factors influencing maternal mortality rates in Babati District, to examine the cultural factors impacting the maternal mortality rate, and to explore the perception of pregnant women regarding the impact of social-cultural factors on maternal mortality rates in Babati - Tanzania.

Moreover, considering the nature of the specific objectives, the study was guided by the Social Determinants of Health (SDH) theory in investigating the Influence of Social-Cultural Factors on the Maternal Mortality Rate Among Pregnant Women in Babati. The identified objectives guided the literature review while referencing other regions such as North and South America, the Caribbean, Europe, Australia, and the Pacific Islands. Further, other locations such as Asia, Sub-Saharan Africa, the Southern African Development Community, and the East Africa Community regions were interrogated about different areas.

It is worth noting that this study employed the pragmatic philosophy and a cross-sectional study design to interrogate the identified variable. Moreover, the sample

size of four hundred (400) research subjects (both participants and respondents) participated in this study. Data was collected from Babati Regional Hospital from pregnant women, nurses, physicians, and social workers.

5.2.1 The Social Factors Influencing Maternal Mortality Rates among Pregnant Women

The study found that social factors affecting MMR in the Babati area include education, access to healthcare, marital status, early marriage, cultural beliefs, and economic position. Figure 4.2 shows that there are no significant changes among the groups. The highest is socioeconomic status at 22%, and the lowest is marital status and early marriage at 18%. On the access to prenatal and maternal healthcare services affecting MMR, the study found Health Insurance Coverage, Accessibility of Maternal Healthcare Facilities, Transportation and Infrastructure, and Quality of Maternal Healthcare Services. The best score is from health insurance coverage, which is 33%. The level of maternal healthcare services was rated at 25%. Transportation and infrastructure received a score of 22%, and the accessibility of maternal healthcare facilities was rated at 20%.

5.2.2 The Cultural Factors Impacting on the Maternal Mortality Rate

A study on cultural factors affecting maternal mortality rates found that most respondents (87%) were aware of how social and cultural issues impact this rate, while only 13% were not aware. This group (13%) is essential because the life of one pregnant woman is very valuable. We must learn how social and cultural factors affect MMR from the community level. Additionally, the study found that many pregnant women in Babati prefer to give birth at home and seek help from traditional

doctors and older women. This choice is followed by a ritual that must be done during and shortly after birth. MMR problems are connected to misunderstandings and negative social attitudes towards women who go to modern health centers for care during pregnancy.

5.2.3 The Perception of Pregnant Women regarding the Impact of Social-Cultural Factors on MMR

The qualitative information related to seeking healthcare services and beliefs noted strong traditional beliefs related to pregnancy and giving birth, which perpetuate the possibility of pregnant women or women, in general, receiving healthcare services from the health facilities. The presented qualitative data on how people felt about gender roles and choices, which came from the focus group talk, shows how not having gender roles and choices can make it hard for pregnant women to make their own decisions about their health care, on the social and economic difficulties and access to healthcare. The information gathered from social workers, pregnant women, and doctors showed that pregnant women in Babati face social and financial problems. It also highlighted the difficulties they encounter in getting affordable and quality healthcare**.**

5.3 Conclusion

The entitled “Examine the Influence of Social-Cultural Factors on Maternal, Mortality Rate among Pregnant Women in Babati-Tanzania” is concluded by highlighting that social and cultural factors significantly affect the rates of women dying during pregnancy. The results show that traditional beliefs, gender roles, decision-making power, financial issues, and access to healthcare all influence the

way pregnant women seek healthcare and their health effects. Cultural beliefs often prevent people from using good maternal healthcare services. This causes delays in getting help during emergencies, which raises the chances of mothers dying. n worse.

This study has shown that maternal mortality in Babati District is influenced by a complex interaction of social and cultural determinants, alongside pregnant women's perceptions of maternal health risks. Social determinants such as low educational attainment, limited decision-making power within households, poverty, and restricted access to maternal health information were found to significantly affect maternal health outcomes. Women with lower socio-economic status were less likely to attend antenatal care regularly, utilize skilled birth attendants, or recognize warning signs during pregnancy, increasing their risk of maternal complications and mortality. These findings align with global and regional evidence highlighting the critical role of social structures in shaping maternal outcomes.

Cultural factors were equally influential in determining maternal mortality. Practices such as home deliveries, reliance on traditional birth attendants, postpartum rituals, and the use of herbal remedies were common in the study area. Moreover, household and community norms that prioritize male decision-making often limited women's ability to seek timely healthcare. These results confirm observations from previous studies in Tanzania and sub-Saharan Africa, which noted that harmful traditional practices and gendered decision-making hierarchies continue to exacerbate maternal mortality (Felisian, et al., 2023). The study also highlighted that pregnant women's perceptions of maternal mortality are critical determinants of health-seeking

behavior. Many women perceived maternal death as a matter of fate or spiritual influence, which contributed to delays in accessing healthcare services. These findings are consistent with evidence from Mekie et al. (2024) and Alemu et al. (2022), emphasizing that awareness and risk perception strongly influence maternal care utilization. The combination of quantitative data, which established the prevalence of risk factors, and qualitative insights, which explained the underlying mechanisms, provides a comprehensive understanding of the multifaceted causes of maternal mortality in Babati District.

Further, to lower maternal mortality rates (MMR), we need to put community programs in place that tackle damaging traditions, encourage education for mothers, and improve women's ability to make decisions. Improving healthcare facilities, ensuring trained birth attendants are more available, and supporting maternal health policies that respect different cultures are essential. Improving maternal health and lowering maternal death rates can be achieved by changing policies, running public health programs, and enhancing healthcare systems to tackle social and cultural factors. Future studies should look for new ways to combine traditional methods with modern maternal healthcare services to provide effective and culturally suitable care.

5.4 Recommendation

Based on the findings of this study, the following recommendations were proposed.

5.4.1 Recommendations to the Government

The government should think about starting a neighborhood program to educate

pregnant women, their families, and traditional birth attendants about maternal health. This can be done by reaching out to people in rural places with the help of local health workers and using radio broadcasts. It would clear misunderstandings and harmful cultural practices, making it harder to get skilled maternal care. The government should motivate men to join their partners in ANC visits and help make decisions about female health by offering rewards for couples who go to ANC together. This would help break down cultural barriers where men make healthcare decisions and manage funds. The government should address socioeconomic barriers to maternal healthcare by implementing financial support plans such as NHIF coverage for pregnant women. This can be done by working with local governments and non-profits to help lower the prices of maternal care.

Policy makers should prioritize women's education and empowerment, as higher educational attainment increases awareness and promotes proactive health-seeking behavior. Improving access to maternal health services through adequate staffing, medical supplies, and culturally sensitive care is also essential, particularly in rural communities. Community-based maternal health campaigns should be implemented to raise awareness about the preventable nature of maternal mortality and address harmful cultural practices.

Health practitioners are encouraged to adopt culturally competent approaches, respecting local beliefs while promoting safe maternal practices. Strengthening antenatal and postnatal counseling, with a focus on educating women and families about danger signs, birth preparedness, and the importance of skilled attendance, is critical. Collaboration with traditional birth attendants can also be an effective

strategy, as they are influential in local communities and can help bridge gaps between modern healthcare services and cultural practices.

5.4.2 Recommendations to Community Members and Male

With government support and various stakeholders, males should be involved in numerous activities related to MMR; by doing this, their awareness of women's right to health, nutrition, and decision-making related to reproductive health would increase. Efforts should be made to enhance awareness at the household and community levels, encouraging shared decision-making and the adoption of safe maternal practices. Communities should support women in accessing health facilities, while maintaining respect for cultural traditions that do not compromise maternal safety.

This study highlights the need for further longitudinal research to establish causal links between social-cultural determinants and maternal outcomes. Additionally, there is a need to evaluate the effectiveness of interventions aimed at reducing harmful cultural practices in rural Tanzanian communities and to develop culturally appropriate educational tools to improve maternal health literacy.

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APPENDICES

Appendix 1: Semi-Structured Questionnaire

Demographic Characteristic among the respondents for this study

1. The Sex of the respondents:
    1. Male
    2. Female
2. Age cohort among respondents.
    1. 21- 30
    2. 31- 40
    3. 41 – 50
    4. 51 +
3. Marital Status among respondents
    1. Single
    2. Married
    3. Divorced

4, Education level among respondents

1. Primary level
2. Secondary level
3. College certificate
4. Diploma
5. Bachelor

5, Identified Social Factors influencing Maternal Mortality Rates (MMR)

1. Education level,
2. Income,

3. Cultural views,
4. Marital status,
5. the ability to get medical care.

6, Access to Prenatal and Maternal Healthcare Services influence MMR

1. Health Insurance Coverage,
2. Accessibility of Maternal Healthcare Facilities,
3. Transportation and Infrastructure,
4. Quality of Maternal Healthcare Services

7, In your view would you tell me of the Influence of Income Levels, and Education on MMR

(Probe more for Poverty, better job policies, and investments in women's education)

8. What is the Influence of Cultural Norms, Traditions, and Practices during pregnancy and childbirth contribute to MMR

1. preference for home births,
2. Traditional birth attendants,
3. Decision making is still men’s work,
4. Dietary practices,
5. Use of traditional medicine

9. Do you know how Cultural Factors Impacting on the Maternal Mortality Rate
    1. Yes
    2. No
10. Would you please tell me about your views on beliefs and preference of giving birth at home
11. The relationship between cultural factors and maternal mortality rate

1. Health-seeking behaviour
2. Preference for traditional birth attendants
3. Gender roles
4. Decision-making power

12. Would you tell me about the Perception of Pregnant Women regarding the Impact of Social-Cultural Factors on MMR (Probe more for Seeking of Healthcare Services and Beliefs, Gender Imbalances and Choices, Socio-Economic Challenges and Accessibility to Healthcare)

Appendix ii: Clearance Letters

THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY

THE OPEN UNIVERSITY OF TANZANIA

Ref. No OUT/PG201902031 **1st February, 2025**

District Executive Director (DED),
Babati District Council
P.O. Box 400,
MANYARA.

Dear Director,

RE: RESEARCH CLEARANCE FOR MR. YUSUPH DAUDI KINAMBIKE, REG NO: PG201902031

2. The Open University of Tanzania was established by an Act of Parliament No. 17 of 1992, which became operational on the 1st March 1993 by public notice No.55 in the official Gazette. The Act was however replaced by the Open University of Tanzania Charter of 2005, which became operational on 1st January 2007.In line with the Charter, the Open University of Tanzania mission is to generate and apply knowledge through research.

3. To facilitate and to simplify research process therefore, the act empowers the Vice Chancellor of the Open University of Tanzania to issue research clearance, on behalf of the Government of Tanzania and Tanzania Commission for Science and Technology, to both its staff and students who are doing research in Tanzania. With this brief background, the purpose of this letter is to introduce to you **Mr. Yusuph Daudi Kinambike, Reg.No: PG201902031),** pursuing **Master of Social Work (MSW).** We here by grant this clearance to conduct a research titled **"Examine the Influence of Social-Cultural Determinants**

on Maternal Mortality Rate among Pregnant Women in Babati District - Tanzania" He will collect his data at your area from 4th February 2025 to 30th March 2025.

4. In case you need any further information, kindly do not hesitate to contact the Deputy Vice Chancellor (Academic) of the Open University of Tanzania, P.O.Box 23409, Dar es Salaam. Tel: 022-2-2668820.We lastly thank you in advance for your assumed cooperation and facilitation of this research academic activity.

Yours sincerely,

THE OPEN UNIVERSITY OF TANZANIA

Prof.Gwahula Raphael Kimamala

For: VICE CHANCELLOR

UNITED REPUBLIC OF TANZANIA
PRESIDENT'S OFFICE
REGIONAL ADMINISTRATION AND LOCAL GOVERNMENT
MANYARA REGION

BABATI TOWN COUNCIL
(All correspondences to be addressed to the Town Director)

In reply please quote;

Ref. No: BTC/A.40/16 VOL.VI/290 **Date:** 07/02/2025

Director,
Open University of Tanzania,
P. O. Box 271,
BABATI.

RE: RESEARCH FOR MR. YUSUPH DAUDI KINAMBIKE

Kindly refer to the subject matter above together with your letter Ref. No. OUT/PG201902031 dated 01ST February, 2025.

2. I would like to inform you that the request for research on **"Examination the Influence of Social – Cultural Determinants on Maternal Mortality Rate among Pregnant Women in Babati Town Council"** for Yusuph D. Kinambike has been accepted.

3. Please be informed that the Council will not incur any cost or payments for the student while conducting his research.

4. The student is required to report to Town HHSND at **Babati Town Council.**

Thanks for your cooperation.

Masinde V. Malima
For: TOWN DIRECTOR
BABATI

TOWN DIRECTOR
BABATI

Copy: Yusuph D. Kinambike,
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P. O. Box 271,
BABATI.

Town Director's Office, 1 Halmashauri Street, P. O. Box 383, 27103 Bagara, Manyara,
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