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Exploring the Existing Cultural Practices that Influence Maasai Women's Access to Social Security for Health in Kajiado West Sub-County

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Abstract: Even though culture is an important social regulator, it has become necessary to investigate the extent to which Maasai women's social security for health is influenced by cultural practices. The study's goal was to discover the link between social health security and Maasai cultural practises that include patriarchy, polygyny, early/child marriage, moral norms, religious practices, traditional medicine, and female genital mutilation. Feminist theory and systems theory served as the theoretical foundation for the research on how cultural practices influenced Maasai women's social security. The study employed a mixed-method sequential explanatory design and the intended respondents consisted of Maasai women of Kajiado West Sub County. According to Yamane formula, 398 women made up the sample size. Data collection methods included focus groups, questionnaires, and interview guides. Purposive sampling was used to select the respondents from the five wards in the Sub- County. Quantitative data was analysed using quantitative techniques with the help of SPSS V.22.0 to generate simple descriptive statistical results in the form of frequencies and percentages. Qualitative data was subjected to content analysis. The study discovered that cultural practices had an impact on the social health security of Maasai women. According to study findings, cultural practices impacted Maasai women's social health security in a variety of ways. Cultural shifts and continuity from a variety of perspectives would aid in the elimination of some of these harmful practices and the strengthening of new, beneficial ones. Cultural practices and women's social security for health in Kajiado West Sub-County have a statistically significant inverse relationship. Access to health care is a fundamental human right that deserves to be prioritized by government structures, and all women of all ages ought to have access to health care. Through its existing structures, the government should support feminist efforts to provide access to health care. The study ought to tackle issues affecting women's welfare such as health, decision-making, and economic empowerment, which will contribute to improving access to social health insurance. The research also sheds light on issues in family social work, gender interventions, and community health social work.

Keywords: *Culture, Cultural Practices, Maasai Women, Social Health Security*

1.1 Study background

The concept of culture is widely understood, and each society has given it a phenomenally different significance. What is considered acceptable in one culture may be viewed as detestable in another. This viewpoint stems from the fact that culture is an all-encompassing concept in terms of man. It includes every aspect of man's life and experience. This is possibly why the concept has elicited numerous definitions from various scholars, all of which revolve around a common meaning. We prefer Tylor (1958) and Malinowski's (1931) definitions for our purposes here. Tylor (1958) defines culture as a four-dimensional whole that includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society (Tylor,1958). According to Berhane et al. (2017) in order to promote social security for health, it is important to understand and respect cultural practices while also identifying and addressing harmful practices. This requires working with communities to develop culturally sensitive approaches that take into account the social and cultural context in which health behaviors and practices are embedded.

Promoting social security for health requires a multi-sectoral and culturally sensitive approach that recognizes and addresses the complex interplay between culture, social norms, and health behaviors. According to the literature, the Maasai are a pastoral community in Sub-Saharan Africa that practices livestock rearing and production. Mtey (2017) states that the pastoralists are predominantly polygynous. Similarly, nomadism is said to be a distinguishing feature of African pastoralists. The pastoralists have a structural patriarchy system in which men have power and dominate women (Graamans et al., 2019). Women have been restricted or disadvantaged socially and economically as a result of this structure (Onyima, 2019).

It is noted that various programs such as health insurance do not fully meet the importance of women's social health security (Habib et al., 2021). These factors limit the ability to improve the health of the greatest number of women in the most effective ways possible. The fact that the women's health agenda is almost entirely focused on women of childbearing age is discriminatory because it excludes women who do not have children and women who are no longer of reproductive age (Peters et al., 2016).

The Maasai community articulates itself with socially driven dimensions that rule life in common. This communitarian life bound them to adhere to the cultural, familial, religious, and community practices. These dimensions often restrain them from accessing mainstream provisions offered to citizens in common which include education, health, economic provisions, and political provisions (Esho, 2019). The restrained and restricted life of the Maasai community blocks their life advancement as per the equal-to-vision achievement of both SDGs and vision 2030 of Kenya. NHIF is one of the least expensive but common provisions given to Kenyan for health security with people's participation. Being a pastoral community driven by poor literacy rate, economic backwardness, poor housing existence of culturally and socially welcomed practices like polygamy, the Maasai population accessed to health security is not even half of the total (Kamau & MacNaughton, 2019).

1.2 Literature Review

The research provides a comprehensive picture of women's social articulation and social health security. It is important to note that cultural practices influence the behaviours of community members. The study also looked into the relationship between cultural practices and the social health security of Maasai women in Kajiado West sub-county. The research opens up new avenues for informing and developing social work theories, as well as deepening understanding of the cultural determinants that may influence social health security. Religious practices and beliefs can have various effects on access

to health insurance coverage, depending on the specific beliefs and the healthcare system in place. Some religious beliefs may prohibit the use of contraception, and therefore individuals who hold these beliefs may not want insurance coverage that includes contraception (Butkus et al., 2020).

Literature posits that religious beliefs can have a significant impact on an individual's access to health insurance coverage, and it is important for individuals to understand their options and any potential exemptions or limitations based on their beliefs. Religion and culture are so interconnected that one cannot be discussed without the other. African traditional religions prayed for the community's welfare because it was their most obvious manifestation. Additionally, they held that sacrifices and prayers were essential to their spirituality and were necessary to activate God's agents (Thomas, 2015).

Traditional religions, as reported in the literature, differ significantly from one ethnic group to the next and vary over time. Religion has always played an important role in society, and it is difficult to distinguish between culture and religion. The Maasai people are deeply traditional, conservative, and historically nomadic pastoralists who live in southern Kenya (Forster, 2019; Dasre et al., 2020). Beliefs in goddesses, a social hierarchical structure, families, social orientation, and patriarchies are examples of African cultural beliefs. Cultural religious beliefs were examined in the study to gain a better understanding of the Maasai Community's distinct cultural context (Darley& Blankson, 2020). Faiths in Africa are as diverse as the continent itself. Religion has an impact on every aspect of life in African civilisation, including birth and death, marriage, family relationships, food changes, and even health care, as seen in the Maasai community. Indigenous African religions forge deep connections between people's lives and the worlds of their forefathers. Humans can thus maintain ongoing and reciprocal relationships with their ancestors, who are said to be intensely interested and involved in their descendants' day-to-day affairs. The Maasai believe they are descended from spirits, gods, and ancestors and adhere to supernatural ancestral behavioural norms. Despite Christian assimilation, the Maasai maintain their traditional religious practices (Olupona, 2014).

African religion includes beliefs, rituals, ceremonies, and festivals, religious artefacts and sites, values and morals, and religious authorities or leaders. African religion is the result of the African ancestors' and mothers' thoughts and experiences. Religion has had a profound impact on African civilizations, and some groups still practice their traditional religious practices today. In the African context, traditional religion is seen as providing direction in life and a sense of stability. Furthermore, religion is perceived to provide solutions to man's problems across all socioeconomic contexts (Mbiti, 2015).

Medicine Men are traditional healers in many Indigenous cultures. They are often seen as the most knowledgeable and experienced members of the community when it comes to matters of health, well-being, and spiritual strength. Medicine Men are believed to possess the ability to diagnose and treat illnesses, both physical and psychological, through the use of traditional medicines, ceremonies, and rituals (Kpobi et al., 2019). Medicine Men have been around for many centuries, and their role in Indigenous cultures has remained largely unchanged. Until recently, however, there has been a lack of research on the efficacy of treatments provided by Medicine Men. As a result, their abilities and contributions to Indigenous communities have often been overlooked or dismissed (Adu-Gyamfi & Anderson, 2019) A review of the literature revealed evidence of the efficacy of traditional treatments provided by Medicine Men. It will also discuss the potential benefits of these treatments, and the importance of incorporating traditional medicine into modern healthcare systems. The first studies examining the effectiveness of traditional treatments provided by Medicine Men were conducted in the early 20th century. These studies found that the traditional treatments provided by Medicine Men had

positive effects on physical and psychological health, as well as spiritual and emotional well-being (Arrey et, al,.2016).

Since its inception, marriage has been a major theme in anthropology. In a marriage, relationships are everything. According to Marxist theory, marriage is a sign of social development and is associated with procreation. In societies where marriage is the only legal bond of procreation of off springs, marriage continues to be a significant and unique event in the life cycle of the individual as well as the basis of the family (Kamal, 2015; Elengemoke & Susuman, 2021; Cleuziou & MBrien, 2021). Child marriage, also known as early marriage by some scholars, is widely recognized as a harmful sociocultural practice that is both the cause and the result of human violations. Child marriage violates a girl's right to autonomy, a life free of violence and coercion, and an education. Child marriage has been practised in Sub-Saharan Africa for generations and is seen as a culturally legitimate way of protecting girls from pre-marital sex. Poverty, limited educational opportunities, women's subordination, and economic shocks from unemployment are all factors that contribute to child marriage (Maswikwa et al.,2015).

The slow pace of putting an end to child marriage is concerning. Women who marry as children have lower levels of knowledge than those who marry later in life. Three Sub-Saharan African countries (Kenya, Senegal, and Zambia) added to the body of evidence on child marriage. Gender norms and economic insecurity were mentioned as contributing factors to teen pregnancy and child marriage among poor girls. Another study discovered that the pressure to marry young was caused by women's limited educational and economic opportunities (Petroni et al., 2017).

Scholars attribute household factors related to early marriage may be driven by dowry, a cultural and economic factor. The amount of bride price paid by the groom to the bride's parents upon their marrying consent increases when the bride is younger. This creates an economic incentive to marry girls young to save and obtain wealth, especially for households in economic hardships (Delprato, Akyeampong & Dunne, 2017).

According to the literature, child marriages are most prevalent in rural areas and are primarily caused by poverty, cultural traditions, and values based on patriarchal norms. Girls are imprisoned in marriage against their will due to a combination of social customs, low levels of education, lower status for women, the perception that they are a financial burden, and other factors. According to reports, other notable effects of child marriage include freedom from unfavorable and strict parental rules, low authority for girls, and lack of decision-making power (Erulkar,2013; Delprato,2015; Budu et al., 2021).

Women's health and autonomy have reportedly suffered because of a number of negative factors, including girls' mobility, families' insufficient support for girls' education, limited access to health care, and few opportunities for social engagement or employment outside the home (Montazeri, 2016; Mathew, 2019; Budu et al., 2021). A review of the literature revealed that forced marriage, involves a process of spouse selection by the parents and other kin groups. They impose their preferences on those getting married without their consent. For many societies, having a child to marry off, particularly a daughter, is a valuable asset regardless of her own wishes. It is also stated that in many societies, entire kin groups are involved in marriage arrangements. It should also be noted that forced marriage has divisions based on different interests, opinions, and unequal power relations (Parkin,2021).

Poverty, outdated attitudes toward female children, traditional beliefs and practices like initiatory ceremonies, and genital mutilation are all blamed in literature for the persistence of forced marriages in contemporary pastoralist communities, which includes the Maasai (Mtey, 2017).
Child marriage violates fundamental human rights and jeopardizes access to education, healthcare, and employment. Child marriage is widely regarded as an infringement of a child's rights, affecting girls disproportionately around the world. The universal declaration of human rights, the convention on consent to marriage, the minimum age of marriage, and the convention on the rights of the child are among the international agreements that have led the debate on marriage age (Daher-Nashif & Bawadi, 2020).

Polygamy is defined as having more than one spouse at once, and is often seen as an alternative form of marriage (Kah & Lundt, 2020). Polygamy is not a recent development, as it has been practiced in some societies for centuries. There are many types of polygamy, including polygyny, where a man has multiple wives, and polyandry, where a woman has multiple husbands. Polygamy is also becoming increasingly popular, where individuals have multiple partners in a consensual, non-monogamous relationship (Leer-Salvesen, 2020).

Throughout history, polygamy was common in some societies, particularly in African and Middle Eastern cultures. Polygamy was also practiced by the early Mormons in the United States and is still practiced by some sects of the religion. In many polygamous societies, the husbands are expected to take care of all of the wives, which can be a difficult financial burden. Women in these societies are often seen as subordinate to the husband and do not have the same rights and privileges as men (Pearsall, 2019).

According to Hayes and Van Baak (2022) polygyny, can potentially affect health insurance coverage in a few different ways such as through dependents, legal status, cultural norms and gender inequality. If a man has multiple wives, it is possible that all of his wives and their children would be considered his dependents for health insurance purposes. This could potentially increase the cost of insurance, especially if the man has a large family. In some countries or states, polygyny is illegal or not recognized, which could impact the ability of multiple wives and their children to be covered under the same health insurance plan (Islam, 2021).

Morals are a part of culture, which is viewed as a guiding framework for community action. What distinguishes morality from culture is its inherent relationship to nominative norms of assessment, judgment, and comprehension of what is right and wrong, good or evil, worthy and unworthy, just and unjust. Morality is a social order that is based on organised social activities. Morality exists within humans as a set of norms that define, orient, and govern behaviour from within, as cultural understandings are acquired and absorbed through socialisation processes (Vandenberghe, 2017). Attitudes, ideas, behaviours, and actions that are desirable and acceptable standards of behaviour that all members of a society should uphold are referred to as values. However, values differ from person to person and civilisation to civilisation. This is because different social groups or human cultures have different ideas, attitudes, and standards that make up their value system. Value is defined in African culture as a cohesive collection of attitudes, behaviours, and actions that an individual, organisation, or community adopts and develops as a standard to govern their conduct and preferences in all situations (Awoniyi, 2015).

Female genital mutilation is a global issue, with an estimated 200 million girls and women have undergone the procedure and an additional three million girls at risk of being cut each year (United Nations Children Fund, 2016). Female genital mutilation is seen as a rite of passage and a guarantee of social status in the marital family and community in African culture. Even if mothers oppose the practice, they may still pressure their daughters to undergo FGM out of fear of social consequences. Women's access to marriage has been restricted by female genital mutilation. Some evidence supports feminist theories that daughters are less likely to undergo FGM when their mothers have higher levels of education (Grose et al., 2019).Female genital mutilation has been linked to entrenched cultural practices, including but not limited to cultural beliefs, as a rite of passage for girls into adulthood and an accepted part of marriage ceremonies in most Sub-Saharan African communities (Ahmed et al, 2018; World Health Organization 2016).

Nearly 89 percent of women in Maasai land have had female genital mutilation (FGM), which is a long-standing socio-cultural practice that is deeply ingrained in tradition (Hayashi, 2017). irrespective of the fact that female genital mutilation (FGM) is illegal in Kenya, a significant number of parents continue to subject their daughters to the practice in order to reduce the risk of their becoming pregnant as adolescents and to make them more marketable for marriage. Maasai girls are frequently circumcised between the ages of 11 and 13, after which they are quickly married off in exchange for animals to a man chosen by their father or older men of the community (Graamans et al., 2019). The effects of female genital mutilation (FGM) and getting married at a young age on girls are devastating. Girls who marry at a young age are frequently coerced into dropping out of school and having their educations cut short. It is quite unlikely that they will ever go back to school after getting married due to the fact that they will be too busy with housework, having children, and having many pregnancies (Vandekemp-McLellan, 2020). In addition, the parents of many pastoralists do not recognize the immediate benefits of their children receiving an education. Because of this, many people are not ready to wait for the almost twenty years it will take to receive returns on their investments in education, particularly given that dowries for girls bring instant rewards (Van Bavel, 2022).

1.3 Methodology

The research employed mixed methods sequential explanatory design to survey cultural practices that influence Maasai women's access to Social Security for health in Kajiado West Sub-County. The research included the collection and analysis of quantitative numeric data as well as qualitative data, which was collected and analysed sequentially and aided in the elaboration of the quantitative results obtained. The reason for this method is that quantitative data and results give a broad picture of the research problem. More analysis, especially collecting qualitative data, is needed to refine, extend, or explain the broad picture (Subedi, 2016). The study used both quantitative and qualitative research data collection tools to collect data. These were questionnaires interviews and focus group discussions in order to understand the social articulation aspects of social health security for health and other factors that may be affecting them in matters of women's social health security. Questionnaires double as one of the primary sources of collecting data employed in the collection of quantitative data. The method was used as the responses are easier to standardize; all responses were given in the same manner, as the questionnaire adopted the Linkert scale. The Linkert scale is considered a good method of carrying out research analysis and the study applied a five-point Likert scale ranging from 5 (strongly agree) to 1(strongly disagree) (De Winter & Dodou, 2010; Nickols, 2012; Chyung et al,.2017). Purposive sampling was used to select respondents who participated in the study. The study employed Yamane statistical formula to determine the sample size of 398 respondents from the total population of Maasai women of Kajiado West Sub-County (Mora & Kloet, 2010). A questionnaire was used to obtain

quantitative data from the 398 respondents. The researcher, as moderator, assisted with a community health officer used focused group discussion to obtain qualitative data from a group of 6 to 12 female participants. Field data from the structured questionnaire, focus group discussions, and in-depth interviews were verified and checked for accuracy. Quantitative data from the structured portions of the semi-structured questionnaire was analysed using SPSS 22.0 to generate simple descriptive statistical results in the form of frequencies, percentages, and crosstabs. Qualitative data from the structured questionnaire was subjected to content analysis and assigned codes by topic. Responses from focus group discussions, in-depth interviews, and unstructured parts of the questionnaire were replicated and used to elaborate on the analysed data.

1.4 Findings

The respondents indicated the extent to which they agree or disagree with the aspects of the cultural practices on a five-point Likert scale of Strongly Disagree, Disagree, Neutral, Agree, and Strongly Agree.

Cultural practices

Table 1: ***Statements on Cultural Practices***

Cultural practices	SD		D		N		A		SA		Total
	F	%	F	%	F	%	F	%	F	%	
Move for pasture	11	(3)	3	(0.8)	0	(0)	142	(38.9)	209	(57.3)	365
Abandoning culture brings curses	27	(7.4)	69	(18.9)	22	(6)	143	(39.2)	104	(28.5)	365
Believe in Spiritual powers for healing	23	(6.3)	64	(17.5)	53	(14.5)	179	(49)	46	(12.6)	365
Female children source of wealth	20	(5.5)	36	(9.9)	10	(2.7)	206	(56.4)	93	(25.5)	365
Participation in ceremonies	10	(2.7)	62	(17)	18	(4.9)	175	(47.9)	100	(27.4)	365

Source; Field data, 2023

Study results revealed that, the Maasai community moves from place to place to find pasture for animals. The Maasai community are nomadic pastoralists who depend on cattle for livelihood, and at times a challenge to be located for outreach services on matters of healthcare. Women suffer so much when it comes to accessing healthcare since men are the main breadwinners of the family's women, and most women don't have any source of income.

The findings show that the Maasai believe that abandoning cultural practices brings curses to the entire community. According to them, the guardian spirit causes misfortune and death to people who disobey Maasai culture and tradition but bestows immense blessings on those who follow them. The findings show that the majority of the respondents believe in spiritual powers for healing more than modern medicine. The community believes in the use of traditional healing and the intake of herbs for cure. This has contributed to poor health among women due to poor health-seeking behaviour. In the community female children are viewed as a source of wealth. The respondents participate in traditional ceremonies including, naming, initiation and tooth extraction. Polygamy is a significant obstacle that hinders women from accessing social health security in the community as only one wife is accommodated in the cover and the decision is also solely left to the husband to decide on whom to

include. In addition, early marriages denied young girls the chance to get education and instead are married off by their fathers.

There is a statistically significant negative relationship between cultural practices and women's social security for health, [r (365) =-.887, p=.000]. This demonstrates that the increase in cultural practices leads to a decrease in women's social health security. Taking all other independent variables at zero, a unit increase in cultural practice will lead to a 72.1% reduction in social security for health. The findings imply that the more the Maasai community continues with their cultural practices the more they limit women from accessing social health security. This has also been supported by WHO (2013) that traditional healing is a big part of the culture of the people and plays a unique role in the health care of people who live in remote areas.

The research study reveals inconsistencies between family and traditional practices and the health policies that govern citizens. The government must step up its efforts to address undermining factors associated with control and patriarchy, such as power disparities, gender equity, access to education, child marriage, and female genital mutilation.

Levels of Cultural Practices

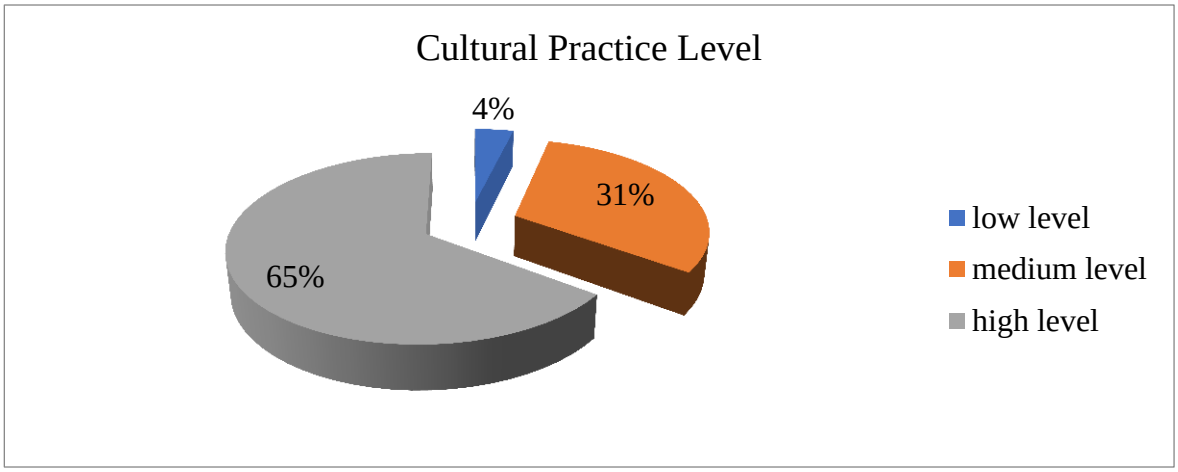

Figure 1: Level of Cultural Practices
Source; Field data, 2023

The figure shows that for 65% of the respondents, there was a high level of cultural practice, medium cultural practice for 31% of the respondents, and a low level for 4% of the respondents. This implies that there was a high level of cultural practice. The high level of cultural practice may have an influence on social security for health among the Maasai community. A focus group participant noted the following in support of the idea that there is a high level of cultural practices on women's social articulation:

> Women in my community are seen as having only two options: get married and start a family. Girls who marry later are perceived as having bad character, which is why they delayed getting married. Girls who don't get married before turning 18 are stigmatized, and the larger community acts negatively toward their families **(P 02).**

Table 2: Chi-Square Tests Between Marriage Position and Level of Cultural Practices

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	152.154[a]	8	.000
Likelihood Ratio	199.626	8	.000
Linear-by-Linear Association	84.507	1	.000
N of Valid Cases	365		

Source; Field data, 2023

The Chi-Square Tests results indicate that ɑ < ρ-value at a 95% level of confidence (ɑ=0.000, ρ-value = 0.05%, chi-square value = 152.154). Therefore, the study concluded that there is a significant association between marriage position and cultural practices level. Thus, a significant association exists between marriage position and cultural practices level. This means that the marriage position of the women affects the level of cultural practices.

1.5 Conclusion

The study revealed that there is a statistically significant negative relationship between cultural practices and women's social security for health, [r (365) =-.887, p=.000]. This demonstrates that the increase in cultural practices leads to a decrease in women's social security for health. Therefore, there is a statistically significant negative relationship between cultural practices and women's social security for health in Kajiado West Sub-County. The findings imply that the more the Maasai community continues with their cultural practices the more they limit women from accessing social health security. This has also been supported by WHO (2013) that traditional healing is a big part of the culture of the people and plays a unique role in the health care of people who live in remote areas.

1.6 Recommendations

Access to health care is a fundamental human right that deserves to be prioritized by government structures, and all women of reproductive age ought to have access to health care. The frameworks have been tested as part of the Linda Mama initiative, Mbuzi Moja, Kangata Care, and the most recent Nate Care; such approaches will make it easier for women to access quality, affordable, and appropriate health care; the County government can assist in this regard. Through its existing structures, the government should support feminist efforts. Such arms as FIDA are critical not only to the rights associated with self-determination but also to societal priorities. There is a significant need for understanding the various factors that comprehensively undermine efforts to obtain social security, a provision that the government strongly promotes and supports. The study only included 398 people; more research would be especially useful in pastoralist communities.

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