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DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK

EFFECT OF DONOR FUNDED PROJECTS ON THE QUALITY OF MATERNAL HEALTHCARE: A CASE OF WAJIR COUNTY.

BY

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C50/77751/2012

A RESEARCH PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF ARTS IN SOCIOLOY (RURAL SOCIOLOGY AND COMMUNITY DEVELOPMENT), UNIVERSITY OF NAIROBI

October, 2016

ABSTRACT

This study focused on the effect of donor funded projects on the quality of maternal healthcare with a special focus on Wajir County. The objectives of the study were to establish the effect of recruitment of personnel and capacity building on quality of maternal health in Wajir County; to determine the influence of access to maternal health services on the quality of maternal health in Wajir County; and, to find out whether the availability of antenatal care influence the quality of maternal health in Wajir County. The methodology that was employed in this study was a descriptive design; systematic random sampling was used to identify the respondents for the study. It is concluded the availability of donor funding enabled recruitment and capacity building. The study recommends that given that in the event of emergency the findings revealed that patients are referred to secondary clinics and that the only two percent indicated attendance by a doctor, the study recommends that more doctors should be hired by the primary facilities to be able to attend to emergencies. The study further recommends that more facilities should be built to increase the accessibility of maternal services by the residents of the county.

CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

Devolution includes the exchange of duty or power inside formal political structures (Turner and Hulme, 2010). It includes the exchange of duty from a national government level of government to a lower level (Kincaid, 2009). The devolution of obligations is frequently lasting and surrenders all forces connected with the degenerated capacities, for example, political, authoritative, regulatory and financial duties (Kincaid, 2009). The primary distinction amongst devolution and designation to a huge degree includes the degree of exchange of obligation. It is essential to note that while assignment includes the exchange of duty from a focal government to another organization, the designation of forces is responsible to the focal government as opposed to an agent of the neighborhood group who is responsible to that group (Turner and Hulme, 2010). Different components influence the achievement or disappointment of regressed duties to region governments. Powerful conveyance of degenerated open administrations relies on upon the activities and procedures of the subsidiarity standard recommend that the direction and portion of merchandise and enterprises ought to be regressed to the most extreme conceivable degree predictable with the national enthusiasm, to advance openness and responsibility (Galligan& Fletcher, 1993, p. 16).

1.1.1 Maternal Health

As indicated by World Health Organization (WHO) (2012), 287, 000 ladies kicked the bucket of pregnancy and labor related confusions because of absence of access to sufficient social insurance in 2010. In addition, 99% of these were recorded in the creating nations: the greater part in the sub Saharan Africa and a third in South Asia (WHO, 2012).Majority of the maternal

passings are among ladies living in the provincial territories and in the poorer groups and they reflect disparities to access of wellbeing care(WHO, 2012).The Maternal Mortality Ratio (MMR) in creating nations is 240 for every 100, 000 live births contrasted with 16 for each 100,000 live births in the created nations (WHO, 2012). The maternal mortality proportion (MMR) in Kenya is 488 for every 100,000 live births, an expansion from 414 for every 100,000 in 2003 (KDHS, 2010). 43% of births in Kenya are office based conveyances; the rustic territories recorded 35.4% of office based conveyances contrasted with 74.7% in the urban zones. Home births happen more in country regions (63%) than urban zones (25%) (KDHS, 2010).The fourth antenatal scope rate in Kenya is 47%, a checked decline from 52% in 2003 (KDHS, 2010). 53% of ladies in Kenya don't get post-natal care (PNC) (KDHS, 2009).

The worldwide under five death rate as at 2010 was 57 for each 1000 live births (UNICEF, 2011). Seven (7.6) million Children under 5 years old passed on in 2010. Three million infants kick the bucket each year and an extra 2.6 million are still births (UNICEF, 2011). Half of the still beyond words the intra-partum period (WHO, 2012). Sub-Saharan Africa has the most elevated danger of tyke mortality, and one in each eight kids pass on before their fifth birthday (UNICEF, 2011). Kenya has under five death rate of 74 for each 1000 live births, newborn child death rate (IMR) of 52 for every 1000 live births, and neonatal mortality rate(NMR) of 31 for each 1000 live births (KDHS, 2010). The rustic zones in Kenya have more awful baby and under-five death rates of 58 and 86 for every 1000 live births separately (KDHS, 2010). The immunization scope rate is 77%, and just 32% of infants under 6 months' olds are only breastfed. 37% of under-fives living in the provincial ranges are hindered and 16% of every single under-five in Kenya are underweight (KDHS, 2010).

More than 80% of the passings coming about because of febrile sicknesses in newborn children and under-fives in Sub-Sahara Africa are of kids who did not have contact with an expert social insurance supplier since the start of the fever (Perez, Ba, Dastagire, &Altmann, 2009). All inclusive access to social insurance by all moms and youngsters is anticipated to diminish 33% of these passings watched as of now through the act of confirmation based financially savvy preventive and corrective wellbeing administrations (WHO, 2012). This is hampered by serious deficiency of HR for wellbeing, deficient aptitudes set and uneven land conveyance of the couple of accessible human services compel (WHO, 2012).

1.1.2 Wajir County

Formal wellbeing administrations in Kenya are given through national (parastatal) and district government, non-legislative associations (NGOs), neighborhood power, mission, and private wellbeing offices. The district governments run roughly 33% of these offices, 18.2% are controlled by the mission and NGO segment, 1.4% by neighborhood powers and 44.2% of offices had a place with the private part. Be that as it may, disappointment by the provinces government to meet the wellbeing area's set focus of being assigned 15% of aggregate government spending, has conveyed a ton of money related requirements to the Sector, diminishing nature of administration arrangement.

Wajir County is situated in the old North Eastern Province and constitutes six (6) supporters (Wajir East, Wajir West, Wajir North, Wajir South, Eldas and Tarbaj). The district has a populace of 661,941 individuals and a territory of 55,840.6 km². Wajir East, Wajir West, Wajir North, Wajir South, Buna, Eldas, Tarbaj and Habasweindistricts were mapped to this County.

The managerial base camp of the region is Wajir Town. It outskirts the provinces of Mandera toward the North and North East, the Republic of Somalia toward the East, Garissa toward the South and South West, Isiolo and Marsabit toward the West, and the Republic of Ethiopia toward the North West.

The principle monetary movement in Wajir County is pastrolism with some agro-pastrolism being drilled in the Northern part of the region. The County has mineral assets, for example, limestone and sand. It additionally has sunlight based and wind vitality potential. The County has 88 wellbeing offices: 4 District doctor's facilities, 2 Sub-District doctor's facilities, 2 dispensaries, 17 wellbeing focuses, 21 medicinal centers, and 2 nursing homes. It likewise has a specialist to populace proportion of 1:356,340, baby death rates of 98/1000 and under five death rates of 90/1000. The predominant ailments include: jungle fever, urinary tract contaminations, looseness of the bowels, and hunger.

In 2013/14 budgetary year, roughly Sh900 million was distributed to the wellbeing division and in 2014/15, Sh1.2 billion was put aside for the segment. Be that as it may, this has been insufficient as it speaks to under 30% of the County's wellbeing area needs. Furthermore, more than 90% of ladies in Wajir County don't get to talented conveyance administrations prompting to high maternal passing and tyke death rate. Inferable from this, benefactor associations have been extending and updating its wellbeing offices and administrations to guarantee the wretched wellbeing circumstance and setback in the County Government's subsidizing in wellbeing division is switched.

1.2 Research Problem

Women die from an extensive variety of intricacies in pregnancy, labor or the baby blues period. The greater part of the cases are preventable by great antenatal care (ANC) and care amid conveyance. The most well-known causes in Wajir County are hemorrhagic with 34%, coordinate causes with 34% (like deterred work, inconveniences anesthesia, C-area and ectopic pregnancy) and sepsis including HIV/AIDS, however low in the County at 16%. This is exacerbated by financial elements, for example, low work rate of ladies as just 1% in the age of 15-49 years are utilized; most minimal of all districts of Kenya.The maternal mortality proportion at Wajir is 289 per100,000 live births, the baby death rate of 52 for each 1000 live births, neonatal death rate of 44 for every 1000 live births and the under-five death rate of 72 for each 1000 live births (UNICEF, 2013). Fifty three percent (53.6%) of the conveyances are home conveyances. Forty seven percent (47.3%) of the conveyances were finished by incompetent wellbeing proficient and the risk natal scope (ANC) rate in Wajir is 35% (DHIS, 2014). (Half of the ladies don't have any post-natal checkups at Wajir and the inoculation scope rate is 71.6% (KDHS, 2010). The dreariness trouble among the under-fives is high with Acute Respiratory Infections (ARI) 12.5%, fever (35%), looseness of the bowels (27.5%), and underweight 28.5% (DHIS, 2014). These maternal, neonatal and youngster wellbeing pointers are still poor in spite of the area having conveyed group wellbeing volunteers (CHVs).

A few studies have been directed in the field of wellbeing area execution yet centered around perspectives other than the relationship between giver subsidizing and execution of state claimed endeavors; Ajwang (2009) considered the relationship between corporate culture and authoritative execution, an overview of Kenya state companies, while Ouma (2012) examined elements influencing the viable usage of contributor financed extends in Kenya. These studies

did not cover the relationship between giver subsidizing and maternal human services (maternal social insurance envelops the range of antenatal care, office conveyance, and postnatal scope as reverted capacity in Kenya).The motivation behind the study is to fill this gap in information by answering the following research question. What is effect of donor funded projects on the quality of maternal healthcare in Wajir County?

1.3 Research Questions

The study will answer the following research questions:

i. What is the effect of recruitment of personnel and capacity building on quality of maternal health in Wajir County?
ii. What is the influence of access to maternal health services on the quality of maternal health in Wajir County?
iii. Does the availability of antenatal care influence the quality of maternal health in Wajir County?

1.4 Objective of the Study

1.4.1 General Objective

To establish the effect of donor funded projects on the quality of maternal healthcare in Wajir County.

1.4.2 Specific Objectives

The specific objectives of the study will be:

i. To establish the effect of recruitment of personnel and capacity building on quality of maternal services in Wajir County

ii. To determine the influence of access to maternal health services on the quality of maternal health in Wajir County

iii. To find out whether the availability of antenatal care influence the quality of maternal health in Wajir County.

1.5 Justification of the Study

The country is right now working towards guaranteeing better maternal, neonatal and kid wellbeing (MNCH) for all with the Kenyan government having proclaimed free maternity benefits in every one of her doctor's facilities. This is to guarantee that maternal and youngster social insurance administrations are impartially open to every one of the ladies and kids living in Kenya. The CHVs were received as one of the systems to tackle the HR for wellbeing emergency that has been brought about by deficient supply of prepared human services experts. The study will highlight the potential increases made by the CHVs in enhancing access to MNCH benefits in provincial groups and give significant experiences to human services strategy producers to create and bolster group based medicinal services conveyance frameworks that are proficient and ready to viably address the issue of disparity in social insurance. The discoveries will be utilized to improve the regenerative wellbeing group wellbeing procedure and MNCH approaches sought after by the Kenyan government. It will likewise set the pace for more studies, by researchers and professionals, into the issues encompassing maternal and neonatal results. This study is in this manner a vital attempt as it looks to archive confirmation and experiences on maternal, neonatal and tyke wellbeing results after execution of the group wellbeing technique which will be critical in the wellbeing division and the general public on the loose.

1.6 Scope of the Study

The study sought to assess the effect of donor funding on quality of maternal healthcare in Wajir County. The study thus, looked at how donor funding affects accessibility to formal maternal health services, maternal deaths, skilled maternal health workers, and antenatal care coverage. The study targeted persons that seek maternal health care from donor funded clinics in Wajir County totalling to 480 persons. Thus, the geographical locale of the study was Wajir County.

1.7 Limitations and Delimitations of the Study

Various restrictions were confronted by the study. There was trouble in accessing the examined respondents in Wajir County. The limitation was overcome by supplementing the polls with up close and personal meetings where pertinent, to achieve the imminent respondents and requesting consent from the County Government and common organization in order to get presentation letter and imperative authorization for gathering information.

The traditionalist way of a few enterprises and vows of mystery managed on their wellbeing office representatives in regards to data divulgence may render information accumulation troublesome. Additionally, there would be trouble in gaging the objectivity of the respondents in reacting to the exploration instruments particularly inferable from the data to be looked for by the study. This restriction will be overcome by acquiring official agree to complete the study from County Government and commonplace organization and guaranteeing the respondents that classification would be kept up and the data utilized for scholastic purposes as it were.

The impediments of this study is incorporated into the strategy; that is, the technique that would build up inward and outer legitimacy of discoveries. This incorporates: the blunder making spellbinding or inferential inferences from test information about a bigger gathering. Information drawn from a really illustrative specimen permits a scientist to make speculations expecting the example is sufficiently vast and arbitrarily chosen. The study directed a pilot trial of the exploration instruments to gauge its dependability. Assessment of the boss and other expert on the topic will be looked to discover the legitimacy.

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter presents literature review. Literature review is examining already existing studies and using them to improve on the study being undertaken. It focuses on the theories and literature and empirical works on the concept of donor funded projects on the quality of maternal healthcare.

2.2 Literature Review

2.2.1 Quality of Maternal Health Services in Kenya

Kenya's general wellbeing enhancements have extensive been stricken by encounters of manhandle, abuse, and carelessness of sufferers by the hands of workers, an impediment more grounded by method for poor supervision and understaffing. Sufferers likewise report that the overall population wellbeing technique simply isn't socially touchy, neglecting to adjust to neighborhood events reminiscent of societies which oblige ladies to be gone to by utilizing female experts (Arthur, 2012). Wellbeing specialists are moreover inadequately instructed. The world budgetary foundation's most recent archive on Kenyan prosperity administrations, for instance, established that lone 58% of open prosperity suppliers would precisely analyze as a base 4 of the 5 most normal conditions sufferers give, and best 44.6% skillfully oversaw maternal/neonatal intricacies (Dixon, 2013).

Kenya has since quite a while ago experienced over the top maternal grimness and death rates. The latest assessments set the maternal mortality cost at 488 passings for each one hundred,000 live births, well over the MDG focus of 147 for each a hundred,000 with the guide of 2015.1 for each young lady who kicks the bucket in labor in Kenya, it's evaluated that an additional 20-30

females persevere through extreme damage or inadequacy as a consequence of issues amid pregnancy or supply. These unreasonable charges have continued in spite of improvements in various prosperity cautioning signs amid the keep going quite a while (The Guardian, 2013).

The emergency is pushed, as a base incompletely, by means of absence of section to lovely maternal prosperity offerings, including stake natal, conveyance, and submit-natal offerings. Regardless of the way that wellbeing part foundation has become over the previous decade (KNCHR, 2012), numerous ladies in any case live at a gigantic separation from prosperity comforts, are not ready to discover the cash at to pay costs for maternal offerings, or potentially confront distinctive limits to accessing extraordinary care. Passage to gifted supply is a predetermined venture. Generally, handiest forty four% of births in Kenya are conveyed underneath the supervision of a talented starting orderly, great under the objective of 90% of conveyances by 2015. Normal conveyance orderlies keep on guiding with 28% of births, relatives and partners with 21%, and in 7% of births, moms get no assistance by any stretch of the imagination (KNBS, 2009).

Expanding the weight on prosperity specialists without satisfactory brings up in pay as well as staffing debilitates to build this systemic circumstance extra. As attendants contend, no more extended most straightforward is it unattainable to promptly oversee more than 20 moms in a ward quickly (as some have been doing when you consider that the start of the product), it is burdening to work extra minutes consistently time and improves effectively exhibit assurance issues (KDHS, 2009). The negative brilliant of supplier in administrations can be celebrated among skill sufferers and goes about as a colossal obstruction to alluring with the overall

population wellbeing framework. Unquestionably, women in North eastern noticed the terrible decent of administration (17.Three%) and absence of female sellers (9.Zero%) as a portion of the key limits preventing them from providing in prosperity offices, more so than rate of supply (four.9%) (KDHS, 2009).

2.2.2 Causes of Maternal Mortality

While absence of section to minimal effort, agreeable supply offerings is a noteworthy motivation behind maternal mortality, it's not the one. Really, in accordance with specialists, one of the urgent prime components of maternal mortality are helpful to forestall and treat ailments like jungle fever, contamination from germs, and looseness of the bowels right on time in pregnancy. An absence of enough essential health mind and antenatal care keeps these and distinctive aptitude issues from being distinguished and treated therefore. Various Counties in Kenya, for example, the regions in Western and Nyanza, report low utilization of restorative experts, and more than one fourth of females in North japanese don't get any antenatal care in any regard. These issues are underlay with the guide of more extensive training, socio-fiscal fame, and sexual orientation disparities.

Maternal mortality and minimal one mortality charges have a tendency to be outright best in ranges with negative prosperity cautioning signs add up to and greater destitution stages. Huge deferrals are additionally brought on when groups aren't aware of the pointers of ways of life undermining issues or potentially when ladies are postponed in making the determination to pursuit offerings, recommending the significance of offering understanding and sharpening groups to bolster wellbeing looking for conduct (KDHS, 2009). Maternal prosperity in Kenya is extra controlled by method for females' absence of decision making force and assets for

searching for medicinal services, helpless arranging power in sexual and regenerative wellbeing matters, substantial real workloads even over the span of pregnancy, and presentation to sexual savagery (KDHS, 2005).

2.2.3 Barriers to Maternal Health Care in Kenya

Maternal health care encompasses the spectrum of antenatal care, facility delivery, and postnatal coverage. While women navigate access and utilization of maternal health services in various regions of Kenya, research studies are building to indicate that questions of access and utilization are somewhat dependent on the quality of maternal health care.

Antenatal Care

The Kenya National Reproductive Health strategy suggests at least four antenatal visits for each customer. Notwithstanding, 2010 information demonstrates that exclusive 57% of hopeful moms registrants went by ANC at least four times amid pregnancy, uncovering a diminishing from 78% in 2008 (Mbaruka, 2010). Discoveries uncover that despite the fact that antenatal wellbeing administrations are rendered gratis, riches still has an impact on the utilization of ANC administration, uncovering that ladies in higher riches quintiles more prone to make more ANC visits than those in the least riches quintiles (Arthur, 2012). Encourage, a lady's kind of work had no relationship with the quantity of times ladies went to ANC, however was connected with the planning of ANC visits, demonstrating utilized ladies will probably go to ANC in the principal trimester of pregnancy than the unemployed (Dixon, 2013).

Despite the fact that Kenya's exempts pregnant ladies from premium installments, there are numerous focuses in pregnancy where the "free" enrolment might be deflected or deferred by different impediments (Pell et al., 2013). These incorporate acknowledgment of pregnancy, cost

of go to a facility, finishing a pregnancy test, go to the NHIS office to start and finish paper work with the specialist, which may take different visits. The final product is the receipt of a brief enrolment card. In this manner, when a lady gets her MEP enrolment it might be well past her first trimester. Further, extra variables, for example, instruction, where less taught ladies, particularly in rustic focuses are less inclined to use ANC to the full limit. The age of the hopeful mother, number of living kids and medical coverage status impact the utilization of ANC, whereby more seasoned ladies will probably utilize more ANC contrasted with more youthful ladies (Dixon et al., 2013).

Facility Delivery with Skilled Attendant

Kenyan open wellbeing pleasantries have since quite a while ago experienced deficient framework, gear and staffing. Late overview information watched that best 36% of open prosperity administrations providing supply offerings had the whole broad conveyance room framework and mechanical assembly required, with country territories and decrease arrange enhancements absolutely unequipped. The Kenya prosperity Sector Strategic and subsidizing Plan (2012-2018) also appraises that present staff stages meet just 17% of negligible details required for powerful operation of the prosperity framework. Kenya has just 7 medical attendants for each four,000 occupants, half of the amount (14 for every 4,000) pushed by the field monetary foundation. These prosperity staff are furthermore unevenly assigned the nation over, with specific holes inside the North eastern and northern Rift areas (Bonfiace, 2013).

These issues had been least difficult extra more appropriate by utilizing the start of free maternal wellbeing offerings. Healing facilities have expressed enhanced congestion in maternity wards, with a few moms constrained to leave the doctor's facility right on time to make space for others

and even give on the floor as a consequence of absence of beds. Medical attendants have furthermore maintained being overburdened because of the fresh out of the box new scope, with near all working additional time and as few as three medical attendants helping 20 mothers at once (KNBS, 2009). Despite the fact that the government of Kenya has devoted money to extend staffing, with regards to Dr. John On'gech (Head of Reproductive prosperity at Kenyatta countrywide clinic) the guaranteed 30 new medical attendants for every electorate is however "a drop in the sea," as there is a shortage of somewhere in the range of 90 attendants at his wellbeing office without anyone else's input (Bonfiace, 2013).

Medicinal specialists in the writing see wellbeing offices and healing facilities as the best, most secure area for conveyance (Starrs, 1997; WHO/UNFPA/UNICEF/World Bank, 1999; WHO, 1996). In any case, because of geographic variations in access to wellbeing offices and predetermined number of wellbeing experts, ladies in the Wajir County are regularly not able to convey with a talented wellbeing proficient. The KHS gauges that just a single out of each five (22%) ladies of the County conveyed in an office (Mbaruka, 2010).

Stark contrasts exist between ladies' salary and conveyance with a gifted birth chaperon (Graham, 2009), uncovering a positive connection between's talented conveyance and riches quintile (KDHS, 2009), with a 3.2 crease increment in use of talented birth specialists between ladies in the poorest (24%) and wealthiest (93%) financial gatherings (WHO, 2009; KDHS, 2009). For the most part, ladies in the most elevated riches quintile and those with an optional training were the to the least extent liable to report having a significant issue getting to wellbeing offices (KDHS, 2009). Instructive achievements of the ladies was found to fundamentally

influence conveying at an office as ladies with essential, auxiliary training or above will probably convey in an office contrasted with their uneducated partners (De Allegri et al., 2011; Mrisho et al., 2007).

Geographic Barriers: Urban-Rural, North-South Disparities

Inconsistencies in wellbeing access exist both between the rustic and urban territories in Kenya, and between the northern and southern portion of the nation. Examines show ladies in rustic and urban territories encounter limitless disparities in the area and participation of birth, uncovering urban ladies are twice as liable to convey with a wellbeing proficient at an office than a ladies in a country range (KDHS, 2008; KDHS, 2009) with just 30% of provincial births went to by a talented expert (WHO, 2009; KDHS, 2009). Also, cesarean segments are more normal in urban territories (11%) than provincial regions (5%) (KDHS, 2009) likely connected with more noteworthy access to specialists in urban zones (KDHS, 2009). Prophylactic utilize additionally shifts significantly as 19% of ladies in urban zones use advanced contraceptives contrasted with their country partners (WHO, 2009).

Areas in the North Eastern Kenya encounters noteworthy deficiencies in wellbeing staff and wellbeing offices contrasted with fundamentally higher fixations in the south, because of higher rates of industrialization and urbanization (Dovlo, 1998). Rates of talented conveyance are essentially lower in the northern locales, where just 14% of ladies get mind from a specialist contrasted with 47% in the south (KDHS, 2009). Usage of talented birth specialists traverse from 47% in the Wajir County to 85% in the Nairobi zone, highlighting a very nearly twofold contrast in use illustrative of awesome difference inside the nation (WHO, 2009). Further, vast information crevices exist in regards to difficulties of pregnancy. Examines show just 26% of

ladies in the north get learning encompassing pregnancy confusions contrasted with 85% of ladies in the south (KDHS, 2009).

Accessibility of formal maternal services

Presumably the most essential limits to maternal prosperity mind in Kenya on a nation wide scale is the lack of physical section to pleasantries, as a consequence of the inadequate amount of luxuries, separation to enhancements, and deficient transportation foundation. Indeed, in answers to Kenya's 2008-2009 Demographic and prosperity Survey, the greatest rate (42%) of ladies who conveyed outside a wellbeing office did as such in light of the fact that the capacity used to be excessively far away or there was no vehicle to the office, contrasted with best 17% who alluded to the cost of conveyance as the key boundary. Cost of health courtesies positioned as an angle over 30% just for women in Nairobi, with provincial females a ways all the more prone to record that they didn't give in a therapeutic foundation given that it used to be too some separation or they needed transport. In North jap, where just a single maternity wing is in a matter of seconds operational, 68.Eight% of women had been prevented on record that of separation, absence of transport, or given that the capacity used to be do not open anymore, versus best 4.9% who refered to rate as the key boundary to master conveyance (KDHS, 2009).

The free maternity programming is hence destined to have the most profound result in Nairobi, a locale which as of now has the most flawlessly awesome charge of births conveyed under clinical specialists at 89%, contrasted with 32% in North jap and 26% in Western (KDHS, 2009). If not joined by method for more extensive ventures to expand the quantity of wellbeing offices in country regions and outfit transportation foundation to hyperlink females to those administrations, the application can have the impact of best additional improving regenerative disparities between Kenya's zones and districts.

2.2.4 Donor Funding Projects on Maternal health function

Inside the substance of proceeded with over the top quantities of preventable maternal passings, Donors have completed various strategies interested around a couple of occasions: expanding interest for care through group activation and birth arranging; developing passage to mind through transportation and obstetric bearer extensions; enhancing the top notch of administer to wellbeing representatives and ensuring drug give; tantamount to making upgrades to wellbeing records and maternal downfall reviews. Also, a basic segment of the MDG procedure is to widen the amount, limit, and preparing of master starting specialists (SBAs), particularly in need global areas worried with high maternal mortality (KDHS, 2009).

In general, the contributor applications added to a decrease in maternal mortality in 5 need areas in Kenya at a customary of 5% every year, which is turbo than the worldwide conventional. Participation during childbirth by utilizing a gifted provider expanded from 26.9% in 1990 to half in 2012(Cox and Goldratt, 2006). Wonderful region overhauls include Kisumu, Kirinyaga, Kiambu, Kajiado, Embu, which have every last discernible 41% to sixty six% decays. Generally speaking, the giver programs added to a decrease in maternal mortality in 5 need districts in Kenya at a normal of 5% every year, which is speedier than the worldwide normal. Participation during childbirth by a gifted supplier expanded from 26.9% in 1990 to half in 2012(Cox and Goldratt, 2006). Eminent region upgrades incorporate Kisumu, Kirinyaga, Kiambu, Kajiado, Embu, which have each observed 41% to 66% decays.

USAID's two lead MNCH bundles are the Maternal and adolescent wellbeing coordinated program (MCHIP) and the Saving mothers, Giving life (SMGL) activity. Propelled in 2008,

MCHIP represents considerable authority in lessening maternal, neonatal and youth mortality, quickening development towards achieving MDGs 4 and 5, and forcing bundles at scale for manageable upgrades in MNCH. SMGL, on the other hand, is a 5-12 months open individual association activity intended for quickening reserve funds in maternal and new tyke mortality in Sub-Saharan Africa. Propelled in 2012, its strategy makes a claim to fame of the "three postponements" connected to maternal and infant passings: 1) searching for right care, 2) accomplishing care in a convenient way; and 3) accepting high-charming consideration at a prosperity office (Cox and Goldratt, 2006).

DFID, the United Kingdom's honest to goodness official bolster organization, has taken a complete procedure to handling the difficulties of conceptive, maternal and infant prosperity by method for its vital prioritization of halting unintended pregnancies and guaranteeing solid pregnancy and labor for moms and kids in the setting up world. In this vein, DFID has swore to accomplish 4 basic result by utilizing 2015: (1) store the lives of as a base 50,000 ladies amid being pregnant and labor and 250,000 new tyke babies; (2) allow no less than 10 million additional females to utilize advanced techniques for family unit arranging; (three) block more than five million unintended pregnancies; (4) help no less than 2 million dependable conveyances, ensuring durable changes in top notch maternity administrations, most importantly for the poorest 40 percent. To accomplish these closures, DFID has actualized a few result headquartered activities and expanded concentrate on several center cautioning signs to keep tabs on its development, including: (1) maternal mortality premiums; (2) neonatal death toll rates; (three) preventative frequency cost for ladies of conceptive age (characterized as a while 15 to

forty nine); (four) the quantity of unintended pregnancies maintained a strategic distance from; and (5) the amount and percent of reliable conveyances.

2.3 Theoretical Framework

2.3.1 Overview

This study is introduced on social exchange and Systems theory, According to social exchange theory, the results of an association's conduct will be founded on the responsive conduct of alternate members inside the relationship (Son et al. 2000). Social exchange theory has been utilized to research distinctive predecessors of interorganizational connections through a perspective of non-monetary angles that impact the development of connections, for example, power, trust and interdependency. Frameworks theory takes a gander at the world as a framework made out of littler subsystems for instance, Moving from the present combination of autonomous elements toward a "framework" will require that each taking part accomplice perceive its reliance and impact on every single other partner.

2.3.2 Social Exchange Theory

As expressed by Premkumar and Ramamurthy (1995), "social exchange theory gives the establishment to the investigation of connections between associations". As per social exchange theory, the results of an association's conduct will be founded on the responsive conduct of alternate members inside the relationship (Son et al. 2000). The primary accentuation of this point of view is that the relationship between associations does not really should be specifically identified with any monetary results (Hallen et al. 1991, Humphreys et al. 2001).

Social exchange theory has been utilized by scientists as the hypothetical foundation to examine diverse precursors of interorganizational connections through a perspective of non-monetary angles that impact the development of connections, for example, control, trust, interdependency, and so forth (Prekumar and Ramamurthy 1995). Humphreys et al. (2001) place that social exchange theory lays an appropriate base for considering non-benefit making interorganizational exchanges. Along these lines, it is conceivable to use the social exchange theory to examine the social parts of benefactor subsidizing between advancement accomplices.

Trust and power are the two most ordinarily considered parts of social exchange theory. Trust has been recognized as a central component for effective interorganizational frameworks (Hart and Saunders 1997, Karahannas and Jones 1999, Williams 1997). Examine proposes that trust prompts to correspondence openness and data sharing, duty amongst associations and hence expands participation (Bakos and Brynjolfson 1993, Kumar 1996, Ratnasingham and Kumar 2000). Trust-based connections can give priceless advantages paying little mind to the relationship structure between the exchanging accomplices (Geyskens et al. 1996). Seen advantages, for example, exchanging accomplices' fulfillment, data sharing, long haul speculations, and building the notoriety of exchanging accomplices create from trust. Kumar (1996) states that exchanging accomplices that trust each other can create more prominent benefits, serve clients better, and can be more adaptable.

Social exchange theory will be appropriate to the study for it will help in giving a comprehension on the part of contributors on enrollment of work force. This is on the grounds that giver stores accompanies preparing of work force, with this been an exchange of data amongst givers and staff. This exchange of data is further confirm in the administration relationship between staff at

the wellbeing office and ladies looking for maternal wellbeing administrations at the wellbeing offices. Despite the fact that aberrant the part that contributor play is significant in supporting and helping the way of relationship amongst staff and the ladies looking for maternal administrations.

2.3.3 Systems Theory

Systems theory shows up on the world as a framework made out of littler subsystems. Systems as a representation of ways of life marvels are utilized by mankind as a part of everyday life to portray the working of those wonders. Systems theory can be utilized to normally and briefly acknowledge prosperity mind structures, strategies and results techniques and their communications inside a wellbeing care strategy. Systems thought can be used as a structure to clarify the frill of techniques and the connections between these extras, the limits of the methodology, the goals of the framework, and strategy's capacity to differ and adjust as per inside and outside strengths (Miller, 2007). Methods thought and considering can bolster us understand how prosperity mind organizations and procedures act and it makes it feasible for us to obviously examine, picture, dissect and perceive the structure, methodologies, and input circles that make up the association. This legitimate and get making sense of the gathering as a methodology is a need to have the capacity to control organizations easily and effectively and to accomplish gathering's aspirations (Miller, 2007).

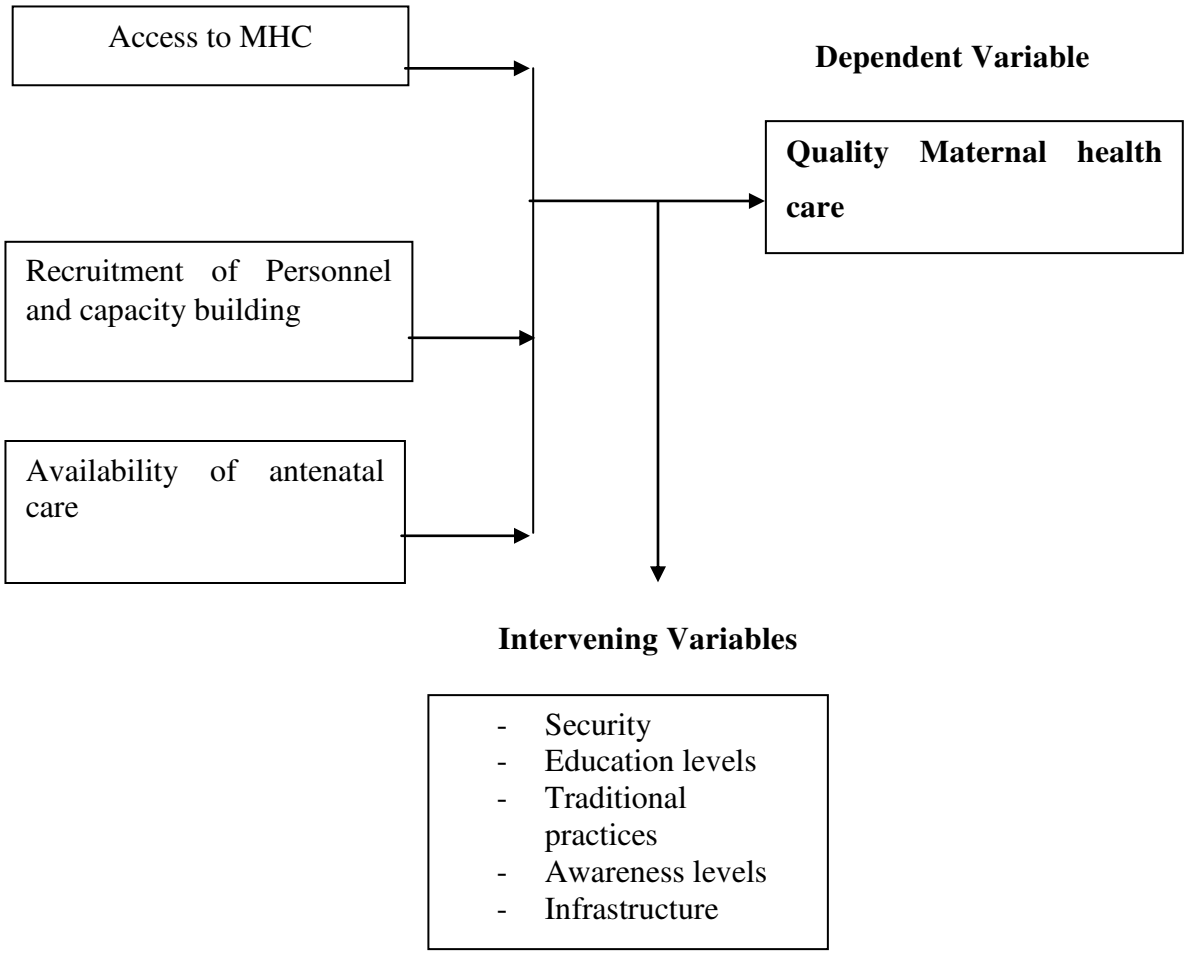
Moving from the present aggregation of free substances toward a "framework" will require that each taking part accomplice perceive its reliance and impact on every single other partner. Every partner must accomplish superior as well as perceive the basic of joining with different accomplices to advance the execution of the framework in general. Additionally, every

accomplice must perceive his or her reliance and impact on different accomplices (IOM, 2003). These are the hidden states of mind that bolster a systems way to deal with taking care of issues. A wellbeing framework that is viewed as keen when it is widely inclusive. The discoveries in Wajir County uncover that the group has distinctive maternal wellbeing alternatives including, conventional wellbeing laborers, prepared birth chaperons in administrative offices and those from NGO financed centers. All these maternal wellbeing offices fill in as a wellbeing framework to the event of the group. Be that as it may, the enthusiasm of this study was NGO financed clinics. As a framework, the conventional birth chaperons can gain from the mastery of the NGO center staff. As indicated by the flow of systems theory, individuals learn in and about complex element systems, and along these lines is an input procedure in which the choices of moms who might have generally got administrations from untalented birth chaperons would look for the administrations from either the center itself or from the customary birth specialists that have procured some expertise level. As indicated by the working of the systems theory, this change of conduct is educated by input got from the NGO supported center that adjusts the conduct of the ladies, and subsequently enhance the maternal wellbeing administrations they get. The idea of learning is vital to savvy systems, which might be proposed to be elements intended for the insightful and intelligent administration of advantages and objectives, fit for self-reconfiguration (or possibly of effectively initiated reconfiguration) so as to perform persevering conduct equipped for fulfilling the majority of the included members in time.

2.4 Conceptual framework

Figure 2.1: Conceptual Framework

Independent Variable



The above conceptual framework will be used in this study; the independent variables are availability of antenatal care, recruitment of personnel and access to MHCthat may influence quality maternal healthcare. Availability of antenatal care are thought to influence the quality of maternal health care, when women are able to get antenatal care then it is believed that the quality of the services she receives are better as opposed to getting the same from traditional women ; recruitment of qualified personnel will ensure that the services they offer are standard and as such the quality will be above board, access to MHC will be made possible if the donor funds are used to avail clinics that are accessible by the community women, how does the quality

of maternal healthcare for people accessing maternal health care compare to those not accessing maternal healthcare.

Quality maternal healthcare is the dependent variable in this study, how does the quality of maternal health care vary based on the independent variables. Infrastructure, security, level of awareness, and traditional practices which deals with the overall maternal health care and hence influencing quality are the intervening variable. Regardless of the variance of the independent variables, the intervening variable's influence is constant.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the methodology of the study; it describes the research design, target population, sample and sampling technique, data collection instruments, data analysis and presentation and research ethics.

3.2 Site Description

The study was conducted in Wajir County. Wajir County is located in former North Eastern Kenya, it borders the following counties; Mandera to the North and North East, The Republic of Somalia to the East, Garissa to the South and South West, Isiolo and Marsabit to the West, and the Republic of Ethiopia to the North West.The main economic activity in the County is pastoralism. The County has 88 health facilities: 4 District hospitals, 2 Sub-District hospitals, 2 dispensaries, 17 health centers, 21 medical clinics, and 2 nursing homes. It also has a doctor to population ratio of 1:356,340, infant mortality rates of 98/1000 and under five mortality rates of 90/1000. The prevalent diseases include: malaria, urinary tract infections, diarrhea, and malnutrition.

Women utilizing public MCH services are often of lower social cadre who are mainly victims of high maternal morbidity and mortality burden owing to interaction of social and economic factors.

3.3 Research design

This study used a descriptive research design. Donald and Pamela (2003), explicate that a descriptive study aimed at determining the what, when and how of a phenomenon studied. It is an appropriate means of gathering information when goals call for qualitative and quantitative data (Pollard, 2005). This enabled the researcher to understand better the effect of donor funded projects on the quality of maternal healthcare as a devolved function in Wajir County. The method chosen allowed collection of comprehensive, intensive data and provides an in-depth study on donor funded projects and how they affect the quality of maternal healthcare. The researcher used both primary and secondary data. Primary data was obtained by using questionnaire, key informant interviews and focus group discussions while secondary data were found using journals, textbooks and internet.

3.4 Unit of analysis and Unit of Observation

3.4.1 Unit of analysis

Units of analysis are units that are designed for purposes of aggregating their characteristics in order to describe some larger group or abstract phenomenon (Mugenda and Mugenda, 2003). Nachmias and Nachmias (1996) describe the units of analysis as the most elementary part of the phenomenon to be studied. To Singleton et.al (1988; 69) they are "what or whom to be analyzed". In this study the unit of analysis was to understand the effect of donor funding on quality of maternal healthcare.

3.4.2 Unit of Observation

The unit of observation in this study were heads of donor projects, MCH departmental heads, sub-county hospital heads, health workers, and mothers that seek maternal services.

3.5 Target Population

Target population in a research is the total number of individuals, elements or groups to be studied (Orodho, 2009). The target population in this study constituted beneficiaries (those seeking services from the facility) of donor funded implemented projects. Due to the large numbers of people, it is impractical to survey the whole population in terms of time and financial requirements. Kothari (2004) suggests the researcher must decide to select a sample design which he defines as a definite plan determined before any data is actually collected for obtaining a sample from a given population. As a result, a representative sample was selected to represent the population. The total target population for this study was as broken down in Table 3.1 below.

Table 3.1:Target population

Sub- County	**Women Beneficiary population**	**Frequency (n)**	**Percentage%**
Wajir East	97	19	20.2
Wajir North	51	10	10.6
Wajir West	46	9	9.6
Wajir South	56	11	11.7
Habaswein	78	16	16.3
Eldas	49	10	10.2

Buna	50	10	10.0
Tarbaj	53	11	11.0
TOTAL	**480**	**96**	**100.0**

3.6. Sample Size and Sampling Procedures

3.6.1 Sample Size

Mugenda and Mugenda (1999) suggest that a good sample is about 10% - 40% of the accessible population. From each stratum the study used systematic random sampling to select respondents totalling to 96 which is 20% of the target population. In addition to this Eight (8) key informants were also included in the study. According to Cooper and Schindler (2003), random sampling frequently minimizes the sampling error in the population. This in turn increases the precision of any estimation methods used.

3.6.2 Sampling Procedures

Ngechu (2004) underscores the importance of selecting a representative sample through making a sampling frame. A population frame is a systematic list of subjects, elements, traits, firms or objects to be studied. The study used a population frame to identify the beneficiaries that were included in the study. A population frame is the source material or device from which a sample is drawn. It is also known a list of all those within a population who can be sampled. From the population frame the required number of subjects, respondents, elements, and firms was selected in order to make a sample. Systematic random sampling technique was used to select the sample. Each sub-County had one donor funded clinic, the respondents in this study were picked while

visiting the donor funded facility. The researcher identified a starting point through random sampling, thereafter every 5th person that visited the facility. According to Kerry and Bland (1998) the technique produce estimates of overall population parameters with greater precision and ensures a more representative sample is derived from a relatively homogeneous population. Stratification aims to reduce standard error by providing some control over variance. The study used sub-Counties in Wajir as stratus for the study.

3.7 Methods of Data Collection

This study collected both qualitative and quantitative data. Quantitative data were collected using the survey method while Qualitative data were obtained through Key informants interview guide and focused group discussions. In the following section, I discuss each of this methods in detail.

3.7.1 Collection of Quantitative Data

Survey Method

The survey method entails the use of a questionnaire.

Questionnaire was used because it allowed for collection of data from many respondents within the shortest time. Questionnaire was developed based on the study objectives with section I focussing on recruitment personnel, section II focussing on access to maternal health and section III focussing on availability of antenatal care. In this study, the questionnaire was administered to the sample of women from the target population.

3.7.2 Collection of Qualitative Data

Key informant interviews

Key informant was administered by the researcher directly to the informants. The key informants included MCH departmental heads, NGO senior staff and local administration.

In total eight key informants were interviewed. Key informants were used to collect data from persons with important information on study objectives.

Focus group discussions (FGDs)

A focus group discussion is a form of qualitative research in which groups of people are asked about their attitudes towards a certain concept. Fifteen focus group discussions were held during the study. Five FGDs were held in each sampled Sub-County. Each Sub-County had a separate focus group discussion for women.

3.8 Ethical Considerations

The purpose of research ethics is to protect the welfare of the research participants. Research ethics also involves not only the welfare of the interviewees but extend to areas such as scientific misconduct and plagiarism (Blanche et al, 2009).

The researcher obtained a research permit from the National Council of Science which together with a letter from the University of Nairobi was attached to the interview guide.

During the course of data collection, the participants were well informed on the aims and the purposes of the study. Participation in the research remained voluntary. Informed consent was sought from all the participants and confidentiality and anonymity was maintained during this research.

3.9 Data analysis

The analysis of data brings order, structure and meaning to the mass of data collected (De Vos 1998). Interpretation on the other hand involved making sense or creating meaning from the data collected. In this study, the data collected was then edited and coded. Descriptive statistics was

used to analyse data into easily understood information by measuring central tendency such as mean, frequency and standard deviation by help of the statistical package for social science (SPSS) program. The data has been presented in tables, charts and graphs. The qualitative data was analysed using content analysis. Qualitative data from open-ended questions was analysed on the basis of common themes and presented in a prose form.

CHAPTER FOUR: DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

This chapter presents findings on the effect of donor funded projects on the quality of maternal healthcare as a devolved function in Wajir County. This section talks about the translation and presentation of the discoveries got from the field. The part encourage presents the foundation data of the respondents, discoveries of the investigation in light of the destinations of the study. The enlightening insights have been utilized to examine the discoveries of the study

4.2 Response Rate

The study targeted a sample size of 96 respondents from which 87 filled in and returned the questionnaires making a response rate of 90.6%. This response rate was satisfactory to make conclusions for the study. The response rate was representative. According to Mugenda and Mugenda (1999), a response rate of 50% is adequate for analysis and reporting while a rate of 60% is good and a response rate of 70% and over is excellent. Based on the assertion, the response rate was considered to be excellent.

4.3 Social and Demographic Information

4.3.1 Distribution by Age

Table 4.1 below is a presentation of the distribution of the respondents by age

Table 4. 1: Distribution by Age

Age	Frequency (n)	Percentage (%)
25 years and below	23	26.4
26-30 years	25	28.7
31-35 years	20	23.2
36-40 years	13	14.9
41-45 years	6	6.8
Total	**87**	**100.0**

Majority (28.7%) of the respondents were in the age brackets of 26-30 years; this was followed by those in the category of 25 years and below at 26.4%. The findings further revealed that those between 31-35 years were 23.2% of the respondents while those in the age bracket of 36-46 years were 14.9%. Only 6.8% of the respondents were between 41 - 45 years and above. The findings imply that most of those who visited the donor funded clinics were between ages 25 and 35 years which is the most productive age groups who need quality maternal health services as compared to the other age groups. These results are presented in table 4.1 above

4.3.2 Distribution by level of formal education

The study sought to establish the levels of education of the respondents, Table 4.2 below is a presentation of the findings. The findings revealed that (42.5%) of the respondents had no formal

education, this was followed by 31.0% had primary level and 16.1% Secondary level. Only 6.8% and 3.4% had college and university level of education respectively. The findings can be inferred to mean that donor funding helped provide for quality maternal care because most of the respondents have either low level of education or none at all and as such would not have sought for alternative maternal care.

Table 4. 2: Distribution by Level of Education

Level	Frequency (n)	Percentage (%)
University	3	3.4
College	6	6.8
Secondary	14	16.1
Primary	27	31.0
None	37	42.5
Total	**87**	**100.0**

4.4 Staff recruitment and Capacity building

4.4.1 Facility Equipment Status

The study sought to establish if the facilities were well equipped, the findings revealed that 59% of the respondents were of the opinion that the facilities were well equipped. Only 41% of the respondents felt that the facilities were not well equipped. The findings were corroborated by the views from the key informants, in an interview, a discussant was of the opinion that the NGO funded hospitals were well equipped, the discussant said,

> *"this facility (NGO funded) is such a blessing to us, we no longer have to worry where o seek maternal health services, their equipment's are so up to date*."

The findings are presented in figure 4.1 below

Figure 4. 1: Facility equipment status

4.4.2 Medication to prevent postpartum haemorrhage

The study sought to establish whether the respondents received oxytocin to prevent haemorrhage. It was revealed that respondents who experience haemorrhage, 75.9% received oxytocin to prevent haemorrhage and 24.1% did not received oxytocin. This findings were supported by the views expressed by key informant interview, a discussant said, yes, in case of haemorrhage, we provide medication.

Table 4. 3: Medication to prevent postpartum haemorrhage

Received medication	**Frequency(n)**	**Percentage (%)**
Yes	66	75.9
No	21	24.1
TOTAL	**87**	**100**

4.4.3 Average time for delivery after admission

The study further sought to establish the hours respondents take before delivery after admission. The findings revealed that majority of the respondents (41.4%) took between 1-2 hours, while 29.9% take 3-4 hours, 19.5% between 5-6 hours and 9.2% take more than 6 hours before delivery. The findings are presented in Table 4.4 below.

Table 4. 4: Hours before delivery after admission

Hours	**Frequency (n)**	**Percentage (%)**
1 – 2 Hours	36	41.4
3 – 4 Hours	26	29.9
5 – 6 Hours	17	19.5
Over six hours	8	9.2
Total	**87**	**100.0**

4.4.4 Mode of delivery

The study sought to establish the mode of delivery of the respondents, the findings revealed that the mode of delivery for most of the respondents (85.1%) was through a normal process while only 14.9% deliver through the Caesarean section (c-section). The findings are presented in table 4.5 below

Table 4. 5: Mode of delivery

Mode	**Frequency(n)**	**Percentage (%)**
Normal	74	85.1
C-section	13	14.9
Total	**87**	**100.0**

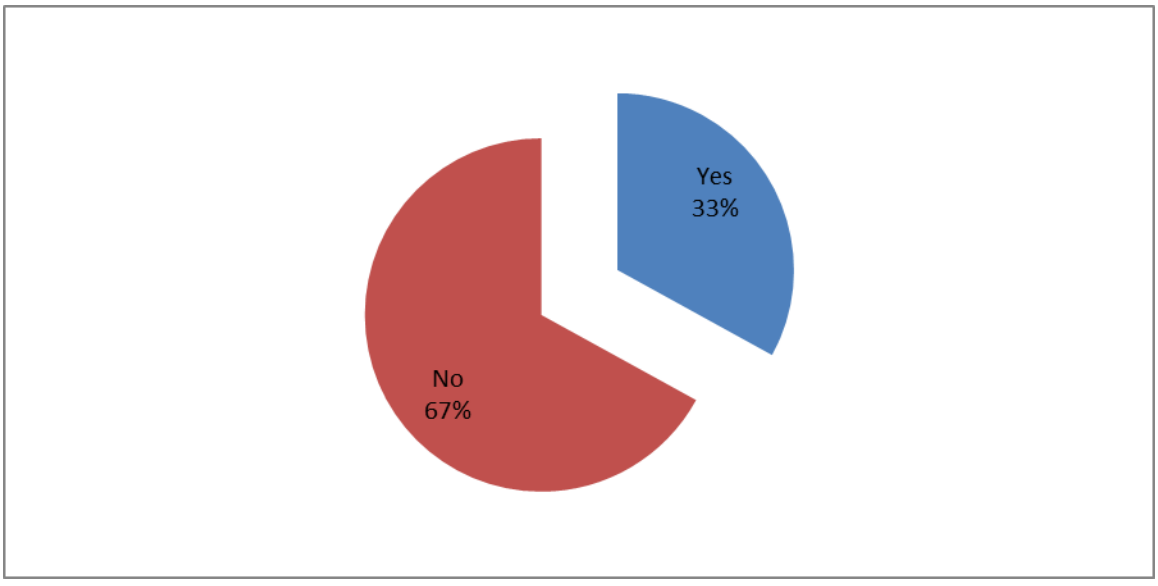
4.4.5 Why choose C-section

The study further sought to find out the reasons the respondents went for C-section delivery. It was revealed that all the respondents who underwent C-section were forced by complication that they developed during delivery. None of them underwent the process by choice. This findings are corroborated by sentiments by a program implementer who opined that he had never witnessed a case where the beneficiaries opted for C-section over normal delivery.

4.4.6 Emergency care at the primary clinic

The study sought to establish whether the primary facility provided emergency care. The findings revealed that only 33% of the respondents felt that the facility provided emergence health care. Majority (67%) of the respondents felt that there was no emergency care provision at the facility. The findings are presented in figure 4.2 below

Figure 4. 2 Emergence care provided by primary clinic



The findings of the study revealed that majority (67%) of the respondents were of the opinion that the primary facility did not provide emergency care. It was also revealed that 33% of the

respondents were of the opinion that the primary clinic provided emergency care. These findings are corroborated by the assertions from the key informant interviews where it was pointed that the primary clinics do not provide emergency care.

4.4.7 Reasons for not receiving emergency care at the primary clinic

A further probe for not receiving emergency care revealed that 12.6% of the respondents were of the opinion that the primary clinics did not provide emergency care due to lack of skilled birth attendants, 77% of the respondents were of the opinion that the clinics did not provide emergency services because they lacked necessary medical supplies/equipment, 4.7% cited lack of necessary drugs as a reason for the clinics not providing emergency care and 5.7% said there were no transport to secondary hospital. A further control for all factors, revealed that the respondents who felt that the facility was not well equipped were the most educated and therefore opted for alternative facilities. The findings however, were corroborated by the revelations from key informant interviews who indicated that the facilities were not well equipped and do not provide emergency care. The findings can be deduced to mean that social class played a role in the opinions of the respondents.

Table 4. 6: Reasons for not receiving emergency care at the primary clinic

Reason	**Frequency(n)**	**Percentage(%)**
No skilled birth attendant	11	12.6
Necessary drugs unavailable	4	4.7
Necessary medical supplies/equipment unavailable	67	77
No transport to secondary hospital	5	5.7

Total	**87**	**100.0**

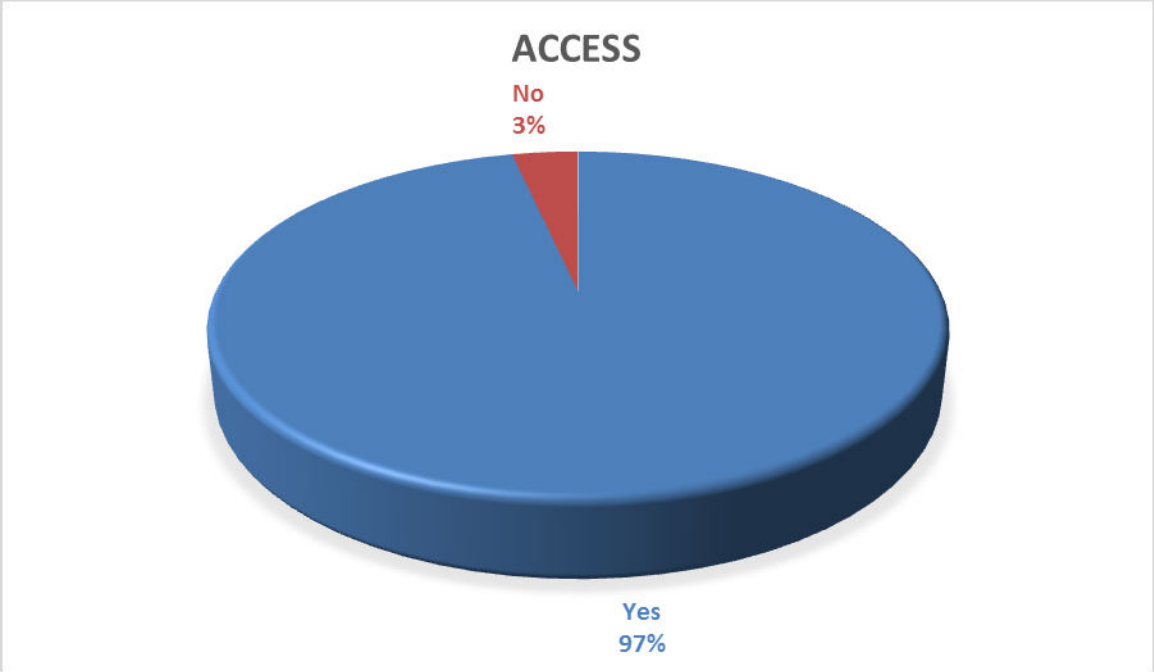
4.5 Access to maternal health services

The section presents findings on the access to maternal health services

4.5.1 Accessibility of Medical facility

The study also sought to establish the accessibility to maternal health services to the respondents and the results revealed that most of the respondents (97%) were of the view that those services were accessible. Only 3% of the respondents felt that maternal health services were not accessible. The findings are presented in figure 4.3 below.

Figure 4. 3: Medical facilities accessible



The study sought to establish whether medical facilities in Wajir are accessible. The findings revealed that majority (97%) of the respondents were of the opinion that hospitals are accessible. Only three percent felt that hospitals are inaccessible.

4.5.2 Distribution by time taken to reach NGO funded clinic/hospital

The study sought to establish the amount of time taken for respondents to reach NGO funded clinic/ hospital. The findings revealed that to reach NGO funded hospital/ clinic, 29.9% took 1 hour to 1.5 hours, 19.5% took 30 minutes to 1 hour, 18.4% took 1.5 to 2 hours, 16.1% took more than 2 hours while 14.9% took less than 30 minutes to reach an NGO funded hospital/clinic. The findings can be deduced to mean that the NGO funded hospitals are not situated close to the people. However, it can also be said that the residents of Wajir County love the services as this is demonstrated by the many minutes they take walking to the facility.

> *"The NGO funded facility is not readily accessible because of the sparse distribution of household in this county, I guess it was not easy for the NGO to get a central place that take the interest of all Wajir County residents. Majority would take an average of one and half hours to get to the facility" said a discussant in the FGDs*.

The findings are in agreement with views shared with a Key informant who opined that getting a central location to a pastoralist community is not an easy task.

> *"Our facility is placed at the most optimum point that was suggested by the community leaders*" she said.

The findings are presented in table 4.7 below.

Table 4. 7: Time taken to reach an NGO funded hospital

Period	**Frequency(n)**	**Percentage (%)**
Less than 30 mins	14	16.1
30 mins to 1 hour	17	19.5
1 hour to 1.5 hours	26	29.9
1.5 hours to 2 hours	16	18.4
More than 2 hours	14	16.1
Total	**87**	**100.0**

4.5.3 Mode of transport to the NGO funded hospital

The study sought to establish the mode of transport used by respondents to reach the NGO funded hospital. The findings revealed that the majority of the respondents (71.3%) used public transportation, 2.3% of the respondents used private cars and 26.4% walked to the hospital. These findings mean that notwithstanding the distance of the clinic, there is public transport that the residents can use to access the facility. The findings are presented in table 4.8 below.

Table 4. 8: Mode of transport to the NGO funded hospital

Mode	**Frequency (n)**	**Percentage(%)**
(Private car	2	2.3
Walking	23	26.4
Bicycle	0	0
Public transport	62	71.3
Total	**87**	**100.0**

4.6 Antenatal Care

This section presents the findings on antenatal care received by the respondents.

4.6.1 Facility Visit during pregnancy

The study sought to establish if the respondents visited a medical facility during pregnancy. The findings as presented in table 4.10 below revealed that 93% of the respondents visited a medical facility during pregnancy. Only 7% did not visit a medical facility during pregnancy. The findings are corroborated by revelations from key informant interviews that revealed women in the county visit medical facilities during pregnancy.

Table 4. 9: Visit facility during pregnancy

Visit	Frequency(n)	Percentage (%)
Yes	81	93.1
No	6	6.9
Total	87	100.0

4.6.2 Reason for not using government clinic/hospital

The study sought to establish the reasons that might have led to the respondents not attending government clinics. It was noted that some respondents never went to the government clinics because they were not satisfied by the services offered in the clinics. In a focused group discussion one discussant said

> *"the services we receive from those clinics are very poor, the last time I visited the nurses were not concerned, they just looked at me while I was hurting. I wonder if they have a heart".*

The waiting period was also said to be long, discussants complained that the service providers take long before serving the patients. It was also noted that doctors were not available in the public clinics. Lack of good medical infrastructure was also cited as a reason for not using government clinics; in an FGD a discussant said

> "*the government clinics do not have good machines compared to the NGO funded clinics, I would rather walk long distance but get better services".*

4.6.4 Frequency of visiting clinic

The study sought to establish how frequent the respondents visited the clinic. The findings revealed that 74% of the respondents visited the clinic more than 3 times while only 26% went for less than 3 visits. The findings may be deduced that for those who went to the clinics during pregnancy, they may have gone sufficient times, this is illustrated by a big percentage attending for more than three times. The findings are presented in table 4.10 below.

Table 4. 10: Frequency of visiting clinic

Visits	**Frequency(n)**	**Percentage (%)**
1-3 Times	23	26.4
More than 3 times	64	73.6
Total	87	100.0

4.6.5 Services received from the clinic

The study sought to establish the services the respondents received when they visited clinics. From the findings, 100% of the respondents received blood test, tetanus vaccine and HIV/STD testing services from the clinics. 91% went for physical examination from the clinics, only 36.8% and 3% of the respondents received nutritional supplements and ultrasound services from the clinics. A discussant in the focused group discussion said,

> "*I love the fact that whenever I visit the clinic for the first time in every pregnancy, the facility normally runs HIV/AIDS test on me, this I think is a very good measure in protecting the unborn baby.*"

Another discussant said

"*the facility should have a resident gynaecologist, the last time I wanted one I have to be referred to a secondary hospital*."

The findings are presented in table 4.11 below

Table 4. 11: Services received from the clinic (N=87)

Service	Frequency (n)	Percentage (%)
Physical examination	80	91.9
Gynaecological examination	14	16.1
Ultrasound	3	3.4
HIV/STD testing	87	100.0
Blood tests	87	100.0
Nutritional supplements	32	36.1
Tetanus vaccine	87	100.0

4.6.6 Complications detected during pregnancy

The study sought to establish whether any complication was detected during pregnancy for any of the respondents. The findings revealed that majority (85%) of the respondents did not have any complications during pregnancy while only 15% had complications during pregnancy. Key informant interviews supported these findings, in one interview a discussant said,

> *"most cases during pregnancy are usually smooth and we thank God, however, we have a few complications".*

The findings can be deduced to mean that not many complications are witnessed during pregnancy in the County. As such the primary clinics are able to provide sufficiently the services sought for during pregnancy. The finding are presented in table 4.12 below.

Table 4. 12: Response whether Complications were detected during pregnancy

Detection	Frequency(n)	Percentage (%)
Yes	13	14.9
No	74	85.1
Total	**87**	**100.0**

4.6.7 Reference to secondary hospital for treatment

The study sought to establish, whether any of the respondents had been referred to secondary hospitals for treatment. The study revealed that only 39% of the respondents were referred to a secondary hospital for treatment while 61% were not referred to a secondary hospital for treatment. These findings are supported by those from the key informants who suggested that since the clinics were funded by donors, incidents of referral have considerably reduced. This can be deduced to mean that the services offered by the clinics are adequate. The findings are presented in table 4.13 below

Table 4. 13: Reference to secondary hospital for treatment

	Frequency(n)	Percentage (%)
Yes	34	39.1
No	53	60.9
Total	**87**	**100.0**

4.6.8 Skilled birth attendant

The study sought to establish whether the women were attended to by a skilled birth attendant (doctor, nurse, or midwife). The study revealed that 86.2% of the respondents were attended to by skilled birth attendants while only 13.8% were not attended to by a skilled birth attendant. This means that the facilities have skilled birth attendants. The NGO funding therefore has enabled the clinics to hire skilled personnel to attend to those that seek services from the facilities. Table 4.14 below presents the findings

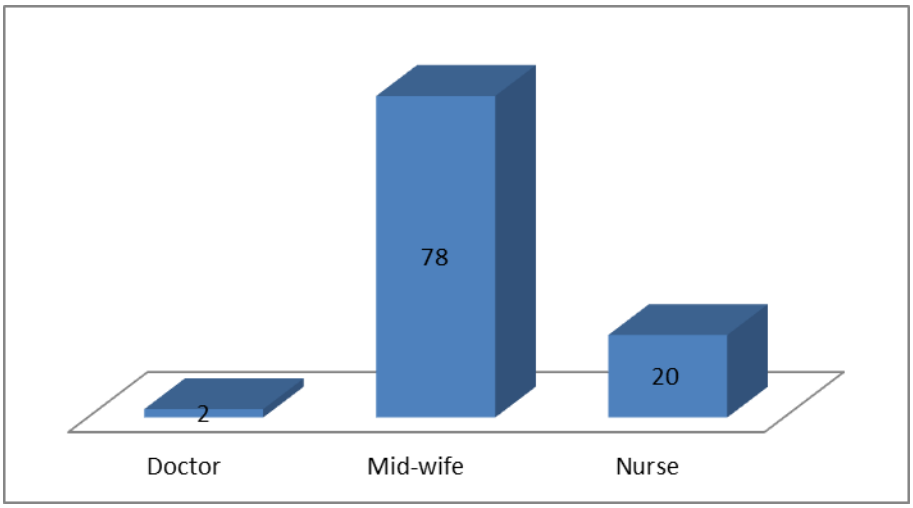
Table 4. 14: Skilled birth attendant

	Frequency(n)	**Percentage (%)**
Yes	75	86.2
No	12	13.8
Total	**87**	**100.0**

4.6.9 Type of birth attendant

The study sought to find out which skilled birth attendant (doctor, mid-wife, nurse) attended to the respondents. The findings revealed that 78%of the respondents were attended to by a mid-wife, 20% were attended to by nurses and only 2% of the respondents were attended to by doctors. This means that whereas the facilities have skilled labourers, the number of doctors was very small. The findings are corroborated by the revelations from the FGDs; in the FGDs, it was noted that majority of this hospitals do not have medical doctors, a factor that was said to contribute to referral to a secondary facility in case of emergency during pregnancy. The findings are presented in figure 4.5 below.

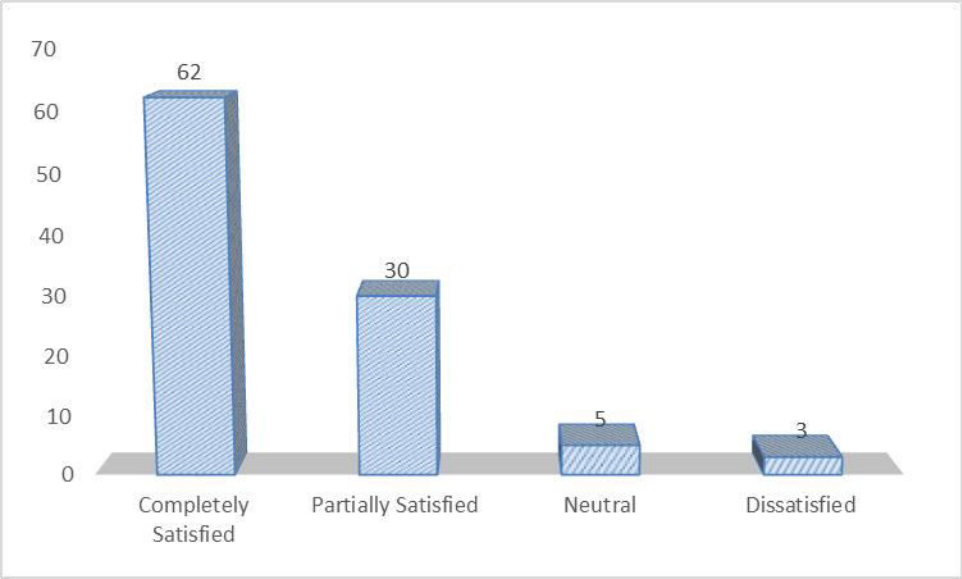
Figure 4. 4 Type of birth attendant during child birth



4.6.10 Level of satisfaction

The study sought to establish how satisfied the respondents were by the services received. The findings revealed that majority of the respondents 62% were completely satisfied followed by 30% of the respondents who were partially satisfied, 5% were neither dissatisfied nor satisfied (neutral) while only 3% were dissatisfied with the services received. The findings infer that the services offered by the NGO funded clinics were satisfactory since over eighty percent of the respondents were satisfied by the services. The findings are presented in figure 4.6 below.

Figure 4. 5: Level of satisfaction



4.6.11 Type of antenatal care

The study sought to establish the type of antenatal care received during antenatal care by the respondents. The results were as presented in *Table 4.16.* Most of the respondents (87.4%) agreed to have received adequate information about prenatal tests and procedures. Another 64.4% cited to have been given honest answers to their questions. Further 56.3% believed that prenatal care information was adequately shared to everyone involved in their prenatal care. Majority of the respondents (50.6%) believed to have been screened adequately for potential problems that can arise during pregnancy and 56.3% agreed that the results of the tests were effectively explained to them in a way they could understand. In addition 57.4% of the respondents cited that the prenatal care providers gave straightforward answers to their questions. Further, 60.9% of the respondents believed that they were given adequate information to be able to make decisions for themselves. The findings also revealed that more than half of the respondents (57.4%) believed their prenatal information were kept confidential while 41.4% cited to have fully understood the reasons for blood work and other tests done on them.

Table 4. 15: Distribution by type of Antenatal care (N=87)

Type of care	Frequency	Percentage
I was given adequate information about prenatal tests and procedures	76	87.4
I was always given honest answers to my questions	56	64.4
Everyone involved in my prenatal care received the important information about me	49	56.3
I was screened adequately for potential problems with my pregnancy	44	50.6
The results of tests were explained to me in a way I could understand	49	56.3
My prenatal care provider(s) gave straightforward answers to my questions	50	57.4
My prenatal care provider(s) gave me enough information to make decisions for myself	53	60.9
My prenatal care provider(s) kept my information confidential	50	57.4
I fully understood the reasons for blood work and other tests my prenatal care provider(s) ordered for me	36	41.4

4.6.12 Anticipatory Guidance

Expectant direction is the idea that spotlights on ladies being sufficiently given data to settle on choices about their pre-birth care and how their pre-birth mind suppliers get ready and give ladies alternatives for their introduction to the world experience. The study tried to build up the expectant direction accommodated the respondents. The study discoveries demonstrated that lone 17.2% of the respondents were given alternatives for birth understanding. It was likewise uncovered that 63.2% were given sufficient data to meet their bosom bolstering needs. More than

three-quarter (79.3%) of the respondents accepted to have been adequately arranged by their pre-birth look after their introduction to the world experience. Not very many of the respondents 0.08% each refered to that their pre-birth mind suppliers did not invested energy with them to give them data in regards to their work and conveyance desires and wellbeing of direct practice amid pregnancy. The discoveries likewise uncovered that 81.6% of the respondents got sufficient data with respect to their eating methodologies amid pregnancy. Not very many respondents (0.05%) felt that their pre-birth mind suppliers were occupied with how their pregnancies influenced their lives, while none of the respondents were connected to any group programs that were useful to them. Promote just 0.07% and 0.03% were given sufficient data about impacts of liquor abuse and despondency separately amid pregnancy. Likewise, just 21.8% felt that their pre-birth mind suppliers set aside opportunity to ask the things that were critical to the mothers. The findings are presented in table 4.16 below

Table 4. 16: Distribution of Respondent by type of Anticipatory Guidance (N=87)

Type of Guidance	**Frequency**	**Percentage**
My pre-birth mind provider(s) gave me choices for my introduction to the world experience.	15	17.2
I was sufficiently given data to address my issues about bosom bolstering.	55	63.2
My pre-birth mind provider(s) set me up for my introduction to the world experience.	69	79.3
My pre-birth mind provider(s) invested energy conversing with me about my desires for work and conveyance.	7	8.0
I was sufficiently given data about the security of direct practice	7	8.0

amid pregnancy		
I received adequate information about my diet during pregnancy	71	81.6
My prenatal care provider(s) was interested in how my pregnancy was affecting my life	4	4.6
I was linked to programs in the community that were helpful to me	0	0
I received adequate information about alcohol use during pregnancy	6	6.9
I was given adequate information about depression in pregnancy	3	3.4
My prenatal care provider(s) took time to ask about things that were important to me	19	21.8

4.6.13 Sufficient time rendered during prenatal visits

The study looked to build up whether the respondents got plentiful time with the antenatal care suppliers. The discoveries uncovered that exclusive (11.5%) of the respondents were of the sentiment that their pre-birth suppliers did not have much time for them. 70% of the respondents felt that their pre-birth mind suppliers had time for them. Sixty two percent felt that they had as much time as they required with their pre-birth mind suppliers. The study deduce that the NGO subsidized centers offered quality time to the recipients. The findings are presented in table 4.17 below

Table 4. 17: Response whether Sufficient Time was given by the antenatal care providers (N=87)

Type of response and time given	**Frequency**	**Percentage**
I had as much time with my pre-birth mind provider(s) as I required	54	62.1
	10	11.5
My pre-birth mind provider(s) was surged	34	39.1

	61	70.1
My pre-birth mind provider(s) dependably had sufficient energy to answer my inquiries	30	34.5

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Introduction

This chapter presents the discussion of key data findings, conclusion drawn from the findings highlighted and recommendation. The conclusions and recommendations drawn were focused on addressing the objectives of the study. The researcher had intended to establish the effect of donor funded projects on the quality of maternal healthcare as a devolved function in Wajir County. The study was guided by three objectives; to establish the effect of recruitment of personnel and capacity building on quality of maternal services in Wajir County; to determine the influence of access to maternal health services on the quality of maternal health in Wajir County; and to find out whether the availability of antenatal care influence the quality of maternal mortality in Wajir County.

5.2 Summary of the findings

The study established that the availability of donor funding, enables the clinics to recruit qualified personnel. The study found that eighty six percent of the respondents were attended to by skilled birth attendants. The quality personnel then would provide quality maternal services to the clients.

The study established that the NGO funded clinics were accessible with majority of the respondents taking less than one and half hours to access the facilities. While at the facility, the study revealed that majority of the respondents waited for less than thirty minutes to see medical staff.

The study revealed that at the donor funded hospital, sufficient information on birth experience was provided. Information was readily availed as such the expectant mothers felt that they were well prepared for the birth experience at the facility. Equally, it was revealed that sufficient information was provided regarding their diets during pregnancy. The study found that over sixty percent of the respondents were satisfied with the services they received from the clinics.

5.3 Conclusion of the study

From the findings, the study concludes that the availability of donor funding enabled recruitment and capacity building. This in turn resulted in the clinics having well trained personnel to handle maternal issues. By extension, the facilities were able to offer better maternal services as opposed to before when there were no well trained personnel. Provision of services near beneficiaries also meant that the community was able to access clinics from where they could get good maternal care. Accessibility of the services therefore contributed in availing good maternal care to the residents. Availability of skilled maternal attendants meant that maternal mortality rate reduced. Mothers' survival chances during pregnancy and birth was increased. This was demonstrated by a very negligible percentage of emergency cases; because of the services expectant mothers got from the qualified staff, there was very minimal emergency during birth. Where the personnel could not handle the complications that arose during birth, patients were referred to secondary clinics. This demonstrated that the staff were skilled enough to know their abilities and not just to risk with the lives of their clients.

5.4 Recommendations

From the findings of the study, the following recommendations are made:

1. Given that in the event of emergency the findings revealed that patients are referred to secondary clinics and that the only two percent indicated attendance by a doctor, the study recommends that more doctors should be hired by the primary facilities to be able to attend to emergencies.
2. The findings have revealed that the primary facilities did not have gynaecologists; the study recommends that the facilities should hire this kind of personnel to help provide the necessary services required by the community.
3. The findings indicated that the residents take long to access the facilities; to address this, the study recommends that more facilities should be built to increase the accessibility of maternal services by the residents of the county.

5.5 Suggestions for further study

1. The researcher suggests that further research should be conducted to investigate the factors that may contribute to non-attendance to postnatal care.
2. This study was conducted in Wajir only. It is possible that each and every County in Kenya has distinct features. The researcher suggests that a survey of other Counties should be explored to provide more robust insights on the topic.