

**FACTORS INFLUENCING COMMUNITY PARTICIPATION IN
MATERNAL HEALTH CARE PROJECT IN KITUI COUNTY
KENYA**

BY

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DECLARATION

This research project report is my original work and has not been presented for an award of degree in any other institution.

Sign Date.....

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L50/85398/2016

This research project report has been submitted with my approval as the University Supervisor.

Sign Date.....

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DEDICATION

This project work is dedicated to my dear parents Agnes Joseph and late Joseph Muriithi, for laying a strong foundation of education in me, by giving me the basic education and providing for it, through their hard work, and encouraging me to take studies seriously. My mother always guided and advised me to always seek God's guidance in all my undertaking, the reason behind, this successful journey. I also dedicate Research to everybody who contributed positively to its development.

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ABBREVIATIONS AND ACRONYMS

AIDS	:	Acquired Immune Deficiency Syndrome
ANC	:	Anti natal Care
CHW	:	Community Health Worker
CU	:	Community Units
CWA	:	Child Welfare Association
CWSK	:	Child Welfare Society of Kenya
GBV	:	Gender Based Violence
HIV	:	Human Immune Virus
HW	:	Health Workers
MDGs	:	Millennium Development Goals ()
MOH	:	Ministry of Health
NGO	:	Non-Government Organizations
STDs	:	Sexually Transmitted Infections
UN	:	United Nations
UNCRC	:	United Nations Convection of Children’s Right
UNESCO	:	United Nations Organization for Education, Science and Culture
UNFPA	:	United Nation Population Fund
UNGA	:	United Nation General Assembly
UNICEF	:	United Nations International Children and Education Fund
WHO	:	World Health Organizations

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ABSTRACT

Community participation is a very important aspect on any project focused on a given community. Maternal health care is one of the basic health projects provisions of health sector in the country. Despite the government providing free maternal health, child mortality and related death have been prevalent in many counties especially in Kitui County. Various reasons have been pointed out as the main factors leading to this phenomenon. The purpose of the study was to investigate the factors influencing community participation on maternal health. This study was guided by four objectives; to establish how level of awareness influence community participation on maternal health, to assess how cultural factors influence community participation on maternal health, to examine how referral mechanism influence community participation on maternal health, and to determine how cost of health influence community participation on maternal health. The study was undertaken in Kitui County. A total of 300 respondents with 50 community units, 91 Maternal Health workers, and 91 community health extension workers with 68 Opinion Leaders were used in the study. The study design included developing a questionnaire that was administered after a population frame had been determined through cluster sampling method to get required sample size. The study used descriptive cross sectional. Data was collected using a structured questionnaire and was analyzed using computer data base Statistical Package for the Social Sciences SPSS and presented using tables. The results helped to find out the roles played by Maternal Health Workers, Community Health Volunteers, and opinion leaders in implementation of community based maternal health care indicating areas of success, failures, and challenges encountered. The study analyzed data, presented and interpreted the findings based on the respondents and this helped in the conclusions and recommendation and suggestion for further studies on community participation on maternity health care projects in Kitui County.

CHAPTER ONE

INTRODUCTION

1.1. Background of the study

In health, community participation is an essential element. A Local Agenda 21, of the 21st century, of WHO strategy for health for all. The Cities Health plan is founded on the values of both of these policies and community participation is hence essentially vital to attain health and maintainable growth at the local level, WHO (1989). According to Bell, (1994), community participation needs working outside consultation to allow people to develop an important part of the decision making and action procedure. This is not limited to an answer to creativities or programs agreed by officials and experts. It involves additional inputs by the people seeing the necessity and acting upon it as activists, pressure groups or self-help groups. John (2013) conquers that community participation attracts the vigor and passion that exists inside communities to describe what that community intents to do and the way it wants to function. Smout, (2000), argues that individuals cannot be enforced to get involved in projects which affect their own lives but should be given a chance when necessary. Beneficiary community participation, away from attracting cost-effectiveness for project execution and assets distribution to a broader coverage of weaker units of society, is a key strategy of safeguarding that accountability and benefits trickle to the recipients also, (Barasa & Jelagat, 2013). Communal involvement might take place throughout one of the following events according to Ahmed, wants evaluation – articulating sentiments about desirable progresses, ranking objectives and negotiation, forecasting – expressing purposes, fixing objectives, condemning policies, organizing – nurturing cognizance in a community around requirements, forming or backing up organizational arrangements inside the community, teaching – involvement in official management skills, executing – engaging in administrative events, operation, and management, monitoring and evaluation – contributing in the assessment of work done, distinguishing progresses that can be completed and redefining necessities, Ahmed, (2010)

Samuel, (2001), orates that there are many reasons that make community unwilling toward taking apart in community participation; an biased sharing of efforts or benefits between fellows of the community, an extremely peculiar society where there is minute or no sense of community, the feeling that the government or agency ought to offer the amenities, agency treatment of community members – when persons are treated like destitute they are further expected to behave as if they are.

Community participation may add seriously to the success and competence of a programme; adds, Kilpatrick S., (2009), the key issue in its achievement is the attitude of agency worker in the field. When staff don't treat persons with dignity or else are seen to favour certain persons or groups inside a community, this can have a greatly unhelpful outcome on involvement. Rifkin, (2000), argues that it is not easy for every member of a population to donate to a programme similarly however, efforts can be made to recognize crucial members and persons that can be vigorously involved. The shareholders could comprise of the affected people, native and agencies. The significance of community participation in maternal health is unconcealed, says UNICEF, (2013) 'involvement by individuals, communities and distinct groups in shaping their well-being should be followed as a foundation for positive programs and services to uphold and improve their health' Government agencies in Australia nationwide and at state level 4, have upheld a concern in community participation since it has some perceived benefits. Rural health service development community participation has remained to result in more reachable, significant, and suitable services. Moreover, it is often implied that community participation will result in greater community fulfilment with health services, and certainly improved health results, however, proof to support this statement is inadequate, (Wyart, & Tallon-Baudry, 2009).

(Wyart, & Tallon-Baudry, 2009), argues that rural and distant Australian populations support community participation and from time to time requests for it. There is an extended custom of community offerings to all types of health services including hospitals, general practice services and preventative health programs. Community participation, in assisting growth of these services and agendas, is repeatedly premised on the theory that the health of the community, its energy, and sustainability is endangered if health services and programs are inaccessible or unsuitable. In India, according to (Ravindran & Sunil, 2012) says that rates of maternal deaths decreased from 212 deaths per 100,000 live births in 2007 to 178 deaths in 2012. The progress is mainly owed to vital involvements by the government such as the (JSSK) Janani Shishu Suraksha Karyakaram system which includes free maternity services for women and children, a countrywide acceleration of emergency transfer systems and maternal death audits, and advances in the governance and management of health services at all levels. nonetheless, adolescent and uneducated mothers and those living in far to reach parts still have a much higher chance of dying in childbirth. Adolescent girls outside Indian cities are particularly exposed as teenage marriage and pregnancies are very high in rural and remote areas of the country. UNICEF India funds the Indian government at

national and regional levels to increase the standards and coverage of great impact maternal health services and to escalate community request for the services. Its emphasis is on efforts to bring to attention the essentials of adolescent mothers who are more at danger of problems during pregnancy and the delivery and post-delivery periods. Deprived females in remote areas are limited to adequate health care. This is particularly real for areas with small numbers of skilled health workers, such as sub-Saharan Africa and South Asia. Although, stages of antenatal care have improved worldwide in the past decade, only 46% of women in low-income republics gain from skilled care during childbirth. This means that many of births are not conducted by a skilled midwife, a doctor or a trained nurse, Braun, (2006)

According to (Iyaniwura & Yussuf, 2009) opines that quite a number of causes of maternal mortality have been revealed by many studies in Gambia. They comprise of limited access to emergency obstetric care, poor quality of referral care, hemorrhage and related conditions such as hypertension and anemia, and widespread diseases such as malaria during pregnancy. Several barriers to skilled birth attendance in The Gambia have also been revealed by recent survey, reviewing that the most commonly recounted obstacles to skilled births were inadequate time to travel (75%) besides, lack of transport (29%) . Further, likely obstacles include absence of trust in government facilities, high cost of healthcare, domestic workload, and cultural practices that include home delivery by traditional birth attendance. Further reviewed were known high maternal age, domestic wealth, education, low parity and urban residence as factors that predict the use of maternity services. Additionally, Crijns, (2012), argues that the risk factor of maternal death is the probability that an adolescence woman will eventually die from a maternal cause, which is 1 in 3800 in industrialized countries, against 1 in 150 in unindustrialized states. Majority of complications that account for 80% of all maternal mortality are: severe postpartum hemorrhage, sepsis or infections, hypertension and dangerous abortion. High maternal mortality ratio (MMR) endures in Kenya, despite serious commitment from the government to address the matter. Controls by WHO, UNICEF, UNFPA, and the World Bank, founded on existing national data for Kenya, demonstrate that maternal mortality declined slightly between 1990 and 2010, from 400 per 100,000 births to 360 (WHO 2012). Approximates by others are higher, such as an MMR of 560 per 100,000 between 1993-2010 calculated by Hill et al. (2007), and an maternal mortality ratio between 1998-2008 at 488 per 100,000 births, by Kenyan Demographic and Health Surveys (KNBS and ICF Macro, 2010).

On the other hand, Kenya adopted the Health21, initiative by WHO (2012), even though, delivery of service delivery is still inadequate. In 2014 the first lady initiated Beyond Zero Campaign tolerance mobile clinics to cap the many case of child mortality and death related due to maternal complications. Today even in Kitui county the mobile clinics are lying idle without health worker, nor equipment to run the mobile clinics. World Aids Day of 2013, in Kenya, unveiled a Strategic Framework initiative for the engagement of First Lady in HIV control and promotion of maternal, newborn and child health, in the 'Beyond Zero campaign. The framework focuses on five key areas: Fast-tracking HIV programmes, - Persuading investment in high impact actions to support maternal and child health and HIV control – encouraging male involvement as partners and game changers - Linking communities to speak about barriers in seeking HIV, maternal and child health services and providing guidance, accountability and acknowledgement to accelerate the attainment of HIV, maternal and child health targets, Izugbara, (2016). As evidence shows from various countries in this background, mortality rate is still an issue whose time has come to deal with, from the point of community participation. Izugbara, (2016) suggests that whereas funders provide required finance, it is vital for countries, communities and supporters team up to ensure that programmes are gainful and in line with national main concerns. This is why the study wished to focus on investigating the influence of community participation on maternal health project in Kutui County.

1.2 Statement of the Problem

It was reported by World Health organization's (2001) that in Sub-Saharan African many women deliver in their rural homes and out of every 10 children born, 6% die of birth complications or the mother dies in regards to child birth. Most of the children who make it develop other health related complication surmountable by lack of understanding. Children or mothers die lack the basic maternal health care that are provided by the health care institutions in many of the counties.

In Kenya, the national maternal health programs comprise: family planning, antenatal care, skilled birth, HIV testing and counseling, , emergency obstetric care, care after birth and being in line with national policies, Izugbara, (2016). In Kenya maternal health in public hospitals is required to be free of charge, and any child under the age of 5 is supposed to get free treatment. Despite the government providing free maternal health, child mortality and related death have been prevalent in many counties especially in Kitui county. The devolution of health care from the central

government to county government seems to have brought in its share of challenges too in maternal health care.

Maternal health Improvement is one of the eight Millennium Development Goals (MDGs) adopted by the international community in 2000. Under MDG5, countries dedicated to reducing maternal mortality by three quarters between 1990 and 2015. However, between 1990 and 2010, the global maternal mortality ratio (i.e. the number of maternal deaths per 100 000 live births) declined by only 3.1% per year.

This is far from the annual decline of 5.5% required to achieve MDG5, WHO, (2014). The United Nations Population Fund (UNFPA) estimated that 289,000 women died of pregnancy or childbirth related causes in 2015. These causes range from severe bleeding to obstructed labour, all of which have highly effective interventions. As women have gained access to family planning and skilled birth attendance with backup emergency obstetric care, the global maternal mortality ratio has fallen from 380 maternal deaths per 100,000 live births in 1990 to 210 deaths per 100,000 live births in 2015. This has resulted in many countries halving their maternal death rate, Izugbara, (2016). The community's perception of going to hospital is hampered by the view that hospitals are not meant for them since the traditional healers or mid-wives can do better, is an absurd phenomena at best since it lacks scientific prove and it feels like an assumption or an excuse to hide an underlying issues. Elimelech, (2014) observed however that in many Sub-Saharan Africa funded projects, local community members have failed to be involved in making critical decisions that directly affects their projects. This is raising concerns as to whether it is possible reasons as to why many projects have failed after the sponsor withdraw their support. This research therefore intended to establishing the factors influencing community participation on maternal health project in Kitui County basing its argument on the prevailing circumstances of Kitui.

1.3 Purpose of the Study

The intention of the study was to investigate the factors influencing community participation on maternal health project in Kitui County.

1.4. Research Objectives

The objectives of the study were:

1. To establish how levels of awareness influence maternal health care project in Kitui County.

2. To assess how cultural factors influence maternal health care project in Kitui County.
3. To examine how referral mechanism influence maternal health care project in Kitui County.
4. To determine how cost of health influence maternal health project in Kitui County.

1.5 Research Questions

The study aimed to answer the following questions;

1. How does level of awareness influence community participation on maternal health project in Kitui County?
2. How do cultural factors influence community participation on maternal health project in Kitui County?
3. How does referral mechanism influence community participation on maternal health project in Kitui County?
4. In what ways does cost of wellness influence community participation on maternal health project in Kitui County?

1.6 Significance of the Study

The research established influence by community participation on maternal health provision to Kitui County residents. In this particular research, the study intended to establish the contribution of community in carrying out awareness creation, addressing cultural factors, referral mechanism and how cost of health hinders maternal health provision. It was meant to help the researcher come up with policies and guidelines on proper maternal health care with regard to culture and cost of health. It was also to help in giving direction on achievement, success of the program and the challenges objectively especially in terms of reducing stigma and myths associated with maternal health care. I'm hoping that other researchers, those targeting to study maternal health care in other counties will find the research a beneficial.

1.7 Basic assumption of the Study

The assumption of the study were that, the community units were functional, there was to be enough time to carry out the study, analyses and present to the board of examiners. It was assumed the weather would be favorable during collection of data; there was enough capital and enough CHVS to sample from. Also assumed is that all CHV would possess

basic education and speaks English. It was assumed there was some data kept in the link facilities.

1.8 Limitations of the Study

One of the major limitation was concerned by the respondents especially institutions of health care, other respondents who could not give out proper response because of the fear of where this data would go too; however the researcher requested a letter from the University to show that this is for the purpose of education only.

The scope of questionnaire as the only research technique had limitations. For example the answers had to be recognized as ultimate and there is no chance to review outside the given answer or simplify vague answers. However, the use of elimination of ambiguity and unnecessary responses or biases helped to establish the required goal of the research. Lack of money may be constraint and poor command of English language among Community Health workers may be a challenge, however, the researcher used the available finances and had to go with an interpreter during the research questionnaire admission. Implementations of the study results may be challenging as some of the recommendation required finances; the researcher suggested getting finances from the world health organization or the World Bank to cater for this.

1.9 Delimitation of Study

Maternal health involves a number of services ranging from prenatal, postnatal, delivery and care of the baby. This study was delimited to Kitui County, as it is one of the counties with maternal health problems. It is also one of the counties where, focus is on community participation to improve on maternal health.

The study was delimited to target population living within the targeted county. The respondents of the study included; community units, maternal health workers, community health volunteers and opinion leaders. In respect to the study of this research, the variables included; Level of awareness, cultural factors, referral mechanism and cost of health which forms the basis of the research on factors influencing community participation on maternal health project in Kitui County.

1.10 Definition of significant terms

Awareness creation:- In this study, this refers to information, education and messages communicated to members of the public with the aim to bring about behavior change.

Community HealthWorker: - In this study, this refers to community own resources persons identified by the community and trained and supported by Community Health Extension Workers (CHEW).

Community participation: - process whereby people, both individually and in groups, exercise their right to play an active and direct role in the development of appropriate health services.

Awareness: - ability to distinguish, feel or to be of occasions.

Cultural factors: - This referred to beliefs, art, ethics, traditions and any other abilities and behaviours acquired by a member of the society.

Referral:- process of getting into contact with an individual professional or health institution about situation and how professionals and institutions communicate and work together to provide comprehensive support

Cost: - amount or equivalent paid or charged for something.

Maternal health:-health of women during pregnancy, child birth and postpartum period.

Training; referred to the knowledge and skills taught to the Community Health Volunteers, Community Health workers and Community Health Committees members.

1.11 Organization of the Study

The study is organized and arranged in the following main sections

Chapter one contains back ground of the study, statement of the problem, purpose of the study, research objectives, research questions,, significance of the study, basic assumption, limitation of the study, delimitation of the study, definition of significant terms and organization of the study.

Chapter two entails literature review, looking for factors influencing community participation on maternal health projects in Kitui County. In this chapter also, incorporated is the theme of first objective, second objective, third objective, fourth objective, theoretical framework, conceptual framework and summary of the literature review.

Chapter three covers method used, research design, target population, sample size and sampling techniques, research instruments, validity of the instrument, reliability of the instrument, data collection procedures, data analysis techniques, ethical considerations and operational definition of variables.

Chapter four deals with data analysis, presentation, interpretation and discussion of the findings on the factors influencing community participation on maternal health project in Kitui County.

Chapter Five presents and discusses briefly the summary and the findings of the study. It further makes conclusions and recommendations based on the findings of the study as well as suggestions for further studies.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This section contains a broad theoretical model, theoretical review, implication of health behaviour, limitations, conceptual framework, and empirical literature relevant to the problem under study. Also included in the chapter are; research gaps and the summary. The independent variables considered in this research include; Level of awareness, cultural factors, referral mechanism and cost of health care, dependent variable Community participation on maternal health project, the intervening variables will be ministry of health policy on community maternal health, poverty and level of community literacy. The moderating variable will be on CU/ CEHW knowledge of Maternal health care and level of education of opinion leaders on maternal health.

2.2 Level of Awareness and Community Participation

(Wyart, & Tallon-Baudry, 2009) defines awareness as the capacity to recognize and distinguish, to feel, or to be of occasions. Additionally, state or value of being mindful of something. Awareness offers raw material from which animals grow qualia or subjective ideas about their experience. Community participation in health programmes rationale has incorporated answering and responding better to communities' requirements, designing programmes that account for relative effects on well-being of society, such effects of local knowledge or traditional practices, growing public responsibility for health, and for it being needed in itself. Working with communities is believed to be key in cultivating health fairness, healthcare service delivery and uptake, this has remained suggested in international meetings and charters, (Wilcox, 2017). World Health Organization Study Group of 1991, well defined community participation in health as: "a process whereby people, both individually and in groups, exercise their right to play an active and direct role in the development of appropriate health services, in ensuring the conditions for sustained better health and in supporting the empowerment of community to help development. [Community involvement in health] actively promotes people's involvement and encourages them to take an interest in, to contribute to and take some responsibility for the provision of services to promote health" WHO's (1991) report.

According to Quiggin, *et al.*, (2010), adds that approaches to involvement can be agreed in relations of two broad categories; the first is effective, where involvement is a distinct, temporary

intervention and might include for example, “[using] community resources (land, labour and money) to offset the costs of providing services”). However, the method has been condemned for treating involvement as supplement on or input to healthcare programmes and for disregarding the fundamental perspective and procedures contributing to communities’ health differences.

Dialogue that develops over time among the community on maternal health awareness heightens the level of awareness in the community. It pays attention to absence of resources and social unfairness as reasons of poor health and perceives community participation as a means to allocate control more equally within and amid societies, healthcare specialists, and the state, while also developing individuals’ and groups’ own abilities to contribute in the process of change – cultivating their own health directly, or through community development activities. In other words, this ‘community development’ or ‘empowerment’ method realizes contribution as a longer-term method in which communities are vigorously involved in determining on and applying plans to change the socio-political, economic, and psychological conditions that shape their health, (Rabkin 2010),

Looking at participation as a vibrant practice rather than a separate involvement, suggests that as well as looking at outcomes, assessment must also account for fundamental complications such as the different forms. Participation can take in diverse settings, and the sustainability of participation over time – for example, is the impression of participation acknowledged inside the community, or is it temporarily accepted while donors provide money for interventions? (Quiggin, 2010). According to Samuel, (2001) mobilizing communities inspires developments and wellbeing of the communities by empowering its members– including powerful “doorkeepers” – to pinpoint, address and advocate for right to accessing quality health care. He adds that mobilizing communities, addresses awareness needs of maternal health among those communities by discussing issues together on a mutual understanding that the issue at hand are theirs and can only be addressed by themselves. Mobilization is quality helped by all stakeholders coming together and made aware of maternal health issues through facilitation by government agencies, NGOs and development conscious grouped like world bank, WHO among others. Randomized control judgements demonstrate the usefulness of the women’s groups approach learning how to adjust this to different local contexts. The groups develop their own plans, organize their own resources and

self-evaluate their work, especially health of mothers or the would be mothers. (Pavlou, P.A. and El Sawy, O.A., 2011).

Due to awareness levels by mobilization of community concerned on the matters of maternal health, can bring about policy awareness hence policy examination and support initiatives can influence those in positions of power to bring about changes that make an actual change to people's health and welfare. Many communities have no or low knowledge of awareness regarding maternal health of ANC in the countries of Sub Saharan Africa. This has created misconception in the way mothers hand ANC bringing about mortality rate high World Health Organization and UNICEF (2010). Capacity building of the community approach focuses on understanding the problems that hinder different groups of people, government organizations from recognizing their growth and development, while enhancing the abilities that allow them to achieve measurable and sustainable outcomes, (Moore, G. 2002). (Shirlow, & Murtagh, 2004), suggests that community capacity building often relates to strengthening the skills, competencies and abilities of people and communities in developing societies so that, they can overcome the reasons of their rejection and suffering. Moore, G. (2002). States Community capacity building at the societal level should support the establishment of a more "collaborative public administration that learns equally from its actions and from feedback it receives from the population at large." Community capacity building must be used to develop public administrators that are receptive and answerable. Among possible factors that are expected to promote communal involvement in improvement on the community driven approach include; material (benefits), growth interest, growth need, past development experience, giving back to society, project meets needs and peer pressure, (Maraga, 2010)

According (O'Meara, Chesters, & Han, 2004), who says that communities must be educated to identify and answer to obstetric emergencies, and the quality of health care offered to women must be improved. Moreover, communication must be improved between official and non-official health care systems, between communities and health care facilities, and between women and providers. Most partners in maternal health are uniquely placed to work with their communities to raise awareness about maternal health issues. They are aware of the traditional practices and misconceptions that prevent women from seeking care and have often experienced first-hand the dangers of giving birth at home and failing to seek antenatal and post-natal care for their children. This provides them with the credibility needed to address barriers to access to care and to educate

community members about safe motherhood practices, family planning, and the importance of giving birth in a health facility assisted by skilled medical personnel.

Research has demonstrated the usefulness of specific involvements to increase maternal health. Among the methods that have been adopted by many governments and organizations are: 1) access to good quality family planning (including medical and surgical abortion); 2) skilled care during childbirth; 3) access to emergency obstetrical care (EmOC) at the local hospital when complications arise; and 4) increasing knowledge and awareness of pregnancy and childbirth and skills to respond to danger signs (Marsh, 2002; Ahluwalia, 2003). In addition, it is important to increase awareness of the rights and needs of women, and this should be a part of any intervention. Society should improve quality of care, linkages and social support for women, men, families and communities (WHO, 2003).

Many governments and organizations have been working to identify the most effective and cost-efficient methodologies for reducing maternal deaths. Although advanced technology undoubtedly plays an important role in saving mothers' lives, the lessons of the past decade demonstrate this is not the only way to prevent maternal deaths. Even though many developing countries lack advanced obstetrical and neonatal technology, training can improve outcomes. For example, maternal and child problems can be reduced with health education as the following examples demonstrate. Diarrhea can be reduced if the mother boils drinking water and washes her hands before preparing and serving food. Tetanus can be prevented by vaccinating the mother and using sterile tools to cut the umbilical cord. Malnutrition could be reduced if parents understood how to incorporate nutritious foods already available in their villages (Williams, 1994). According to (Stuebe, & Schwarz, (2010), says that while safe motherhood programs take a broad-based approach incorporating health, social and economic factors, which many aren't aware of yet many policy makers think about the problems strictly in terms of available resources; "Problems can be solved once we have enough money to get adequate medical services." Some use this argument as a justification not to do anything until the resources are available based on the link between low Gross National Product (GNP) and high maternal mortality. The level of awareness on perinatal mortality is still low in the sub-saharan Africa. A large proportion of perinatal mortality is due to complications of childbirth (Troedsson, 2002). Perinatal and maternal mortality are closely linked and it has been estimated that there are ten perinatal deaths for every maternal death (Andersson,

2000). However, only recently has perinatal mortality has received global attention. The socio-economic and developmental impact on maternal mortality is most dramatically demonstrated by the fact that most of maternal deaths occur in developing countries which is equivalent to more than 99% of maternal deaths which occur in developing countries. Maternal Mortality represents the highest difference in health statistics between developing and developed countries (WHO, 2006). The MMR is 20 in developed regions, compared to 440 in developing regions. The gap is even larger between the most and least developed countries. For example, in 2000, the MMR was 11 in the United States but was 523 in Haiti (compared to a low of 1 in Sweden; 1,132 in the Central African Republic; and a high of 1,900 in Afghanistan (WHO, 2004). Access to appropriate medical care and treatment is the crucial to reducing maternal, perinatal deaths and morbidity when complications arise. Many factors such as health seeking behavior and utilization of appropriate care are dependent on individual and community recognition of illness and warning signals. Outcome of a study conducted in India showed that 54% of the maternal mortality cases were not referred to a hospital because family members were not aware of the severity of the symptoms (Kumar, 1995). Social stigma associated with seeking care and the lack of awareness about illnesses that need attention have been recognized as major problems (Dixon-Mueller, 1991). Complications can arise suddenly and cause immediate harm if there is no appropriate medical care and treatment. Therefore, understanding early warning signs and actions to take when complications occur are crucial steps to lowering mother and the unborn child morbidity and mortality.

The Health Behavioural Model suggest that health searching behaviour is a function of three sets of personal features - predisposing characteristics for example age, household size, education, number of previous pregnancies, - supporting characteristics, that is income, relationship with health workers, etc. and - need characteristics, that is perceived health status, and benefits expected from the treatment. Awareness through facilitation and mobilization by health workers, NGOs, and government agencies on maternal health for instance other diseases and illnesses decreases the risk of maternal deaths. One example is HIV/AIDS control and treatment; others include malaria, venereal diseases, and other infectious diseases. Insufficient food and lack of micronutrients can lead to nutritional deficiencies and poor health. Other society and community level factors include increasing awareness and support of maternal and new born health with the involvement of a extensive variety of groups and persons comprising of community and leaders from different

religions, groups of women, youth groups, other local associations and health experts. Another issue is the identification and coordination of resources to implement safe motherhood strategies such as referral, emergency transport, distribution and healthcare support for providers and cost-sharing. Also, the community must play a role in monitoring and evaluating the effect of these interventions. Legislative and policy actions are essential to create sustainable and comprehensive programs in the whole country. Danger sign awareness is a key foundation for all these levels of mobilization (WHO, 1999).

2.3 Cultural Factors and Community Participation

According to Lerberg, (2014) culture can be defined in numerous ways. In the words of anthropologist E.B. Tylor, it is “complex whole which comprises information, belief, art, ethics, law, tradition and any other abilities and behaviors acquired by man as a member of society.” Else, in a present variant, "Culture is a communal territory that stresses the performances, dialogues and material expressions, which, over time, express the continuities and discontinuities of social meaning of a life held in common.

Health of women and girls is sensitive specifically to cultural influences. Cham, Sundby and Vangen, (2005) say that in communities where women are allowed to make decisions, specifically about their education and choices of reproductive health, they have longer life expectancy, lower rates of fertility and above all, better health. When political dictatorship and religious fanatic try to flourish, women as the recipient of oppression usually suffer oppression extremely compared to men, and this can badly disturb their wellbeing and long life.

Walraven, (2000) adds that wellbeing of women and girls can greatly be harmed by the patriarchal values. These beliefs may have prevalent effect in numerous situations, mostly in traditional agricultural settings, and also in some urban markets. Lack of sunlight can impair coetaneous synthesis of vitamin D, causing a deficiency of this vitamin and putting women at risk of rickets, especially in strict Islamic societies where women and girls are separated and allowed to appear in public only when covered from head to toe.

Transmission of disease can severely be encouraged by cultural setting context. (Barasa, & Jelagat, 2013) suggests that a terrible example is spread of human immunodeficiency virus/acquired

immunodeficiency syndrome (HIV/AIDS), mainly in Africa, where choices that are dangerous to health are shaped by economic necessity.

According to Hoestermann,(1996) marks that like many other Sub-Saharan African countries, Gambia has long been overloaded with maternal health problems. The densely populated West African nation, with a population of approximately 1.8 million, has been ranked among countries with the highest levels of maternal mortality. The country's maternal mortality ratio (MMR) is estimated at 400 deaths per 100,000 live birth which has fallen by 46% over the last 20 years.

Although, women were generally worried about their health, the cultural background of gender roles blinded them from recognizing their right to maintaining good health, as reported by a Cameroonian women study. They considered right to good health as subject to satisfying their purpose of taking care of and satisfying needs of "others" for instance, their spouses at the cost of their own physical health and well-being, King, (2015)

(Hansford, Anjorin, and Pittore,2014), write in a study among Hausa of Northern Nigeria, that most significant causes contributing to maternal deaths include an Islamic culture that belittles women; an perceived societal needs for women's reproductive health abilities to be under firm male control and the practice of seclusion, which limit women's medical care; nearly complete female illiteracy; early marriages and pregnancy regularly happening earlier than maternal pelvic is complete and dangerous outdated medical practices among others. Agha and Carton, (2011), also says that a study in Benin Republic also stated that issues like husbands' endorsement and money for treatment had harmful effects on maternal health seeking behavior. These finding displays the absence of decision-making autonomy and economic independence of women. Practice of men abandoning older wives for younger ones is leading to a vicious cycle of abuse of women, where multiple partners are considered part of masculinity in Rwanda, which is a common marital practice of polygamy, in many African countries, and which is deeply engrained in Rwanda culture. King (2015), argues that some of the aspects of women's role in society are the main determinants of the clinical causes of maternal mortality: hemorrhage, eclampsia, obstructed labor, and pelvic infection, with occur disproportionately in girls under 18 and in women over 34. Female illiteracy and ignorance, and also in older men and women who have power over them, results in self-neglect and low self-esteem in women. Sex discrimination in all areas, but especially food and health care, directly affects maternal health by contributing to obstructed labor and its mismanagement.

Kilpatrick (2009) suggests that the hard labor of women that produces 60-90% of all food, child care and transport of water and firewood, is added to malnutrition. African customs related to sexuality constrain women to demonstrate fertility before marriage, undergo circumcision and its obstetric risks, and participate in polygamy, are all witness to women's vulnerability, White, (2013),

In most of Africa, particularly Muslim cultures, women marry young without individual choice, and do not use contraception. Consequent early childbearing increases the risk of obstructed labor, vesico-vaginal fistula, hemorrhage, toxemia, and death. African culture and son preference demand unlimited childbearing, so that women spend 16-20 years bearing children, ending at age 35-38, under pain of abuse, loss of status, or ostracism Namasivayam, (2012). White, (2013), says that traditional practices involving childbirth such as dietary restrictions or excesses, religious rituals at delivery that preclude medical assistance, frequent vaginal exams, use of harmful herbs or caustics, and punishments for long labors, add to maternal morbidity and mortality. In Kenya culture plays a role of significance in maternal health in a way, as household chores have not been taken by men as their responsibility, maybe as they cannot simply see the need for household chores because of the way they are acculturated, or simply, their competing social responsibilities don't warrant them to these household duties Kitui County is predominantly Kamba people of the Abantudialic. Culture and traditional medicine men and women play a big role in terms diagnosing, healing, and treatment.

2.4. Referral Mechanism and Community Participation

The process of getting a woman in contact with an individual professional or health institution about her situation, and how professionals and institutions communicate and work together to provide her with comprehensive support generally means referral. Cheng, D., et al., (2011). Referral network partners usually includes different departments of government, women's organizations, medical institutions, community organizations and others. A system of referral can be an organized structure that unites different bodies with clearly defined and delineated instructions, responsibilities and rules into a system of collaboration, with the overall goal of ensuring the safety and support of survivors, to help in their full recovery and empowerment, the prevention of Gender Based Violence (GBV), prenatal cases, Female Genital Mutilation (FGM), abortion cases and the prosecution of criminals. Referral mechanisms work on the basis of

well-organized lines of communication and clearly defined referral paths and procedures, with clear and simple sequential steps (UNFPA 2010).

Governmental, non-governmental and, as appropriate, relevant international organizations should be involved in a referral system and based on international human rights principles and standards, work at levels of both multi-sectoral structure and individual agencies. The operation of referral mechanisms should be grounded in legislation or standardized protocols that define the roles and responsibilities of all organization involved, to ensure that cooperation among stakeholders is grounded in sustainable structures, rather than relying on the contributions of committed individuals. At different levels, for instance, national, regional and municipal or community a referral mechanisms may operate. (Timmermans, *et al.*, February 2011).

According to Richardson, *et al.*, (2011) responds that maternal health care services accessibility relies on more than their mere existence. Access to care for the delivery is complicated by the impromptu nature of labour, by women's other responsibilities, and by fears for women's safety during night travel, although, access to routine prenatal care can be increased through use of mobile outreach clinics or peripheral health facilities. To make care accessible, current modes of service delivery must be changed. Piper, *et al.*, (2011), says that physical obstacles posed by shortage of communication and transport need to be overcome. Establishment of maternity waiting homes, emergency transport and referral mechanisms, enhanced communications systems are some of the possible strategies to overcome these obstacles. Equipping the lowest levels of health facility like dispensaries, and providing skilled personnel to perform emergency obstetric services such as Cesarean Sections, is another good strategy. Kenya as a government is dedicated to upgrading access and fairness to essential health care services and to ensure that health sector plays its role in the realization of the Kenya Vision 2030. Kenya has expressed its commitment to the achievement of Millennium Development goals, as a signatory to these goals. Further policy documents to the health sector in the provision of health services comprise of; Second Medium Term Plan (2013-2017) of Vision 2030, Kenya Health Policy 2013-2030, and the Kenya National Health Sector Strategic and Investment Plan (2013-2017). There is need to strengthen the referral system in order to provide equitable and cost-effective health services. In response to this need, Kenya Health Sector Referral Strategy has been developed. This process of developing the strategy was made possible by the stewardship of Referral System Technical Working Group. The procedure further

involved; desk review of relevant documents, situation assessment of the referral system, development of goals, objectives, priorities and implementation framework for the strategy. The overall policy and strategic framework for operation of the referral system, is provided by Kenya Health Sector Referral Strategy. Government policy direction is outlined in Kenya Vision 2030. The Millennium Development Goals (MDGs) and the Kenya Health Policy 2012–2030 are also guiding policies to health sector. The policy direction is translated into 5-year medium-term strategic objectives outlined in the Second Medium-Term Plan (MTP) 2013–2017 for the overall government and the Kenya Health Sector Strategic and Investment Plan (2013– 2017) for the health sector.

2.5 Cost of Health Care and Community Participation

According to merriam-webster online dictionary, defines cost as the amount or equivalent paid or charged for something. O'Sullivan, (2003) says value of money used up to produce something, and hence is not available for use any longer is referred as cost. Due to differences used to evaluate costs, comparisons of costs across studies are difficult. Cross-country contrasts of cost data are also challenging as the unit costs of interventions may differ significantly across countries owing to variances in resource availability and costs, (Odhiambo, 2013). India experiences same economic difficulties and is said to be one of the key reasons for reduced uptake of maternal healthcare services. For instance in Bihar, one of India's poorest states where above 80% of births are home births, nearly 50% of women reported financial concerns as the purpose for not choosing skilled delivery care, despite the fact that maternal healthcare services are in theory offered without charges in public health facilities in India,(Leone James, &Padmadas, 2012). Nonetheless, out-of-pocket expenditures account for more than 70% of total health spending. These extra costs discourage women from seeking healthcare services and likewise push families more into poverty. Lack of transport or its exorbitant is one of the barriers to accessing health care for women in rural areas of Nigeria, not well served by health facilities. The best cost effective model was described in Nigeria, Ogunjimi, (2012) using trained drivers from local transport union, with cost per transportation amounting to US\$4.67 per case. Example of Ghana (Senah, Richardson, Kwofie, 1997) specifies that the renewal of a neglected structures to serve as a health centre and offer MCH/FP clinics was very economical. Costs of patients have been projected in a number of papers, for instance: antenatal care charges, delivery care (Knowles 1998); antenatal care charges, delivery care: normal and c-section (Mirembe, Ssengooba & Lubanga 1998); charges and unofficial fees for

c-section in Bangladesh (Kawaine, Guinness, Amin 1998); direct and indirect costs including charges for antenatal care, vaginal delivery, c-section (Levin, McEuen, Dymatraczenko, 2000); direct and indirect costs including charges for antenatal care (Borghi, Bastus, Belizan , 2000). One study (Anand, Pandav, Kapoor 1995) projected cost of home-based in Sub-Saharan countries and postnatal care as the same as for antenatal care. Additional study (Mitchell, Littlefield & Gutter 1997) assessed that the cost at US\$5.43 per visit, is like that of antenatal care. In Nigeria, (Kalu-Umeh, 2013) states that almost half of the women delivered at home as opposed to a health facility. On average, women spent between Nigerian Naira (N) N1, 350-N14, 850 (USD\$9-99) for a entire package of maternal health services. Out of pocket expenditure by the husbands or household heads and the women themselves accounted for 73.3% of expenses, (Ogunjimi, 2012)

According to Borghi,*et al.*, (2003) write that a study in Uganda valued the payment of treatment for postoperative infection with procaine penicillin during an ectopic pregnancy was at US\$31.22 and US\$24.50 for ampicillin prophylaxis (including the cost of hospital admission) (Reggiori, Ravera, Cocozza et al. 1996). The same study projected the price of antibiotic treatment for postoperative contamination after caesarean section, at US\$44.79 for treatment with penicillin and US\$28.06 for ampicillin prophylaxis. The cost of dealing with after birth bleeding/postpartum haemorrhage varied from US\$35.44 in a Ugandan public hospital to US\$114.83 in a mission hospital in Uganda. However, for lesser estimate for Uganda, it was not clear whether the cost matched to the management of before/ante partum or after/postpartum haemorrhage. Extra cost in public health settings, are mainly attributed to the absence of medicines and diagnostics facilities. This is a big concern specifically in rural households where women rely on public clinics situated in small towns or cities and regularly borrow money to cover transport, food and accommodation costs,(Leone T, James KS, & Padmadas SS2012) Women should never die during pregnancy and childbirth. Regrettably, no significant progress have been made yet by Kenya in reducing the maternal mortality rate, which at last stood at 360 maternal deaths per 100,000 births. Over the last 20 years, this rate has only come down by ½ of one percent per year. With year 2015 having passed, no achievement on MDG 5, (Gill, 2007). WHO, UNICEF, UNFPA and the WB's, (2012) report that the government of Kenyan is devoted to eradicating avoidable maternal deaths, both as a health goal and because of its wider effects for the well-being of Kenya's families and communities being hindered by the expenses of provision of maternal services. There are even unknown costs when

services are provided with no charges or for a nominal charge. Efforts to overcome these economic barriers include health insurance schemes, through membership contribution in NHIF.

While comparing costs associated with seeking care during pregnancy, labour and postpartum, discloses that women who died experienced dramatically greater overall costs than women who experienced safe or uneventful pregnancy and delivery. The charges during pregnancy included fees, transport costs, and other medical and non-medical costs incurred outside of the health facility. The average total cost during pregnancy was KES 7,322 for cases and KES 934 for controls, and the average total costs during labour and postpartum for cases was KES 8,127 compared to controls at KES 1,970, WHO's (2016). One woman stated that "Whenever I want to go to the antenatal care, if asked my husband for transport, he complained that he doesn't have money, and if I insisted, it resulted in problems. He gets annoyed easily and will start to insult me". Asking for money may even bring about incidences of domestic violence as reported by several participants. Pregnant women do not enjoy privileges such as taking sick leave from ordinary work or receiving assistance in having antenatal check-ups as shown in the statement. Lack of economic independence may be part of the problem but further reasons may contribute to their unfavorable position within the household, (Namasivayam *et al*, 2012). Woman's death during their most productive years can have profound consequences for their household and the community at large given their critical roles in the family and society. Nevertheless, half of the households in cases of maternal death had to seek financing from sources outside of the household, including fund drive and welfare groups, versus only a fifth of the control households. In addition, over a quarter of the families reported selling assets, and close to 15% reported seeking help from a financier or lender to pay for burial costs, (Odhiambo, 2013).

2.6 Theoretical Framework

This section dealt with theories that support the literature under the study and other frameworks for easier verification and suggestions. The theories to be looked at are: the health model theory and stakeholder theory, which are deemed to be relevant to the study.

2.6.1 The Health Model Theory

This is a psychological model that attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals. It was developed in the 1950s as part of an effort by social psychologists in the United States Public Health Service to

explain the lack of public participation in health screening and prevention programs. (example, maternal health care). This theory looks at various aspect of health treatment with regard to the patient. The aspects are;

Perceived Threat contains two parts: perceived susceptibility and perceived severity of a health condition-Perceived Susceptibility is one's subjective perception of the risk of contracting a health condition-Perceived Severity are feelings concerning the seriousness of contracting an illness or of leaving it untreated (including evaluations of both medical and clinical on sequences and possible social consequences)-Perceived Benefits are the believed effectiveness of strategies designed to reduce the threat of illness-Perceived Barriers is the potential negative consequences that may result from taking particular health actions, including physical, psychological, and financial demands. Cues to Action is the events, either bodily (e.g., physical symptoms of a health condition) or environmental (e.g., media publicity) that motivate people to take action. Cues to actions are an aspect of the HBM that has not been systematically studied. Other Variables - Diverse demographic, socio-psychological, and structural variables that affect an individual's perceptions and thus indirectly influence health-related behavior. Self-Efficacy is the belief in being able to successfully execute the behavior required to produce the desired outcomes. One of the first things one can do is determine the respondent's preconceived notions about the role of health behavior change in illness prevention. The simplest technique a person can use is to assess the patient's perceived barriers and benefits to engaging in the behavior change. The health educator can engage in this process by discussing with the patient his/her perception of the pros and cons for engaging in the behavior. During a discussion of the barriers, the patient can begin addressing how to overcome some of the obstacles to the performance of the behavior, thereby increasing self-efficacy for its performance. Cues to action also influence whether a person will be motivated for lifestyle change. Cues can include illness in other family members, information from the media, and concurrent symptoms experienced by the individual. Health educators can elicit from the target group or person the potential cues he/she is exposed to on a daily basis and then use these cues as reminders of the potential consequences of failing to change unhealthy behavior practices.

This theory is most relevant to this current study on community participation on maternal health projects, since many of the mothers have a negative notion regarding visiting various health cares

across the county due to perceived aspects. The community's traditional healers and mid-wives have got an influence in the people's minds and their choices of what to do. HBM research has been used to explore a variety of health behaviors in diverse populations. For instance, researchers have applied the HBM to studies that attempt to explain and predict individual participation in programs for influenza inoculations, high blood pressure screening, smoking cessation, seatbelt usage, exercise, nutrition, and breast self-examination. With the advent of HIV/ AIDS, the model also has been used to gain a better understanding of sexual risk behaviors. Perceived barriers are the most influential variable for predicting and explaining health-related behaviors. Other significant HBM dimensions are perceived benefits and perceived susceptibility, with perceived severity identified as the least significant variable. More recently, though, researchers are suggesting that an individual's perceived ability to successfully carry out a "health" strategy, such as going for maternal health care, using a condom consistently, greatly influences his/her decision and ability to enact and sustain a changed behavior.

General limitations of the HBM include: a) most HBM-based research to date has incorporated only selected components of the HBM, thereby not testing the usefulness of the model as whole. b) as a psychological model it does not take into consideration other factors, such as environmental or economic factors, that may influence health behaviors; and c) the model does not incorporate the influence of social norms and peer influences on people's decisions regarding their health behaviors (a point to consider especially when working with adolescents on HIV/AIDS issues, adolescent birth).

2.6.2 Stakeholder Theory

Stakeholder theory came from four major academic fields: economics, politics, sociology, and ethics (Wagner Mainardes, Alves & Raposo, 2011). It was highly influenced by many concepts that were raised in the planning department of the Lockheed Company. These ideas were developed from the research done by Igor Ansoff and Robert Steward in this company (MacIntosh & Maclean, 2014).

Muchlinski (2011) viewed the stakeholder theory from different perspectives. There is the Normative Stakeholder theory, which contains theories of how managers or stakeholders ought to act and view the method of reasoning of organization on some moral guideline (Koschmann, 2008). The other point of view is the unmistakable partner hypothesis that is worried with how

administrators and partners act and how they see their duties and activities. The aim here is to know how supervisors manage partners and how they remain for their interests. The partnership is viewed as an accumulation of interests, at some point aggressive and different times helpful. Instrumental stakeholder theory majors on the hierarchical consequences of considering partners in administration by analyzing the relations between the act of partner administration and the achievement of different corporate administration targets. It concentrates on how administrators ought to do in the event that they need work for their own great. In some writing their own particular intrigue is acknowledged as the interests of the association, which is to get the most out of benefit or to boost shareholder esteem.

This demonstrates if supervisors treat partners in accordance with the partner idea the projects was more fruitful over the long haul (Freeman, Harrison, Wicks, Parmar, and DeColle, 2010). Freeman defines stakeholders as those groups who are fundamental to the survival of the organization (Bailur, 2006). There is concern for mapping the stakeholders, provision of comprehensive list of the specific groups associated with each category of stakeholders, and an equivalent list of interests. How does each stakeholder affect us? What are their interests? Who are our current and potential stakeholders? How do we affect every stakeholder? How do we measure these variables and their impact and how do we maintain score with our stakeholders?

Freeman, Harrison, Wicks, Parmar and De Colle, (2010) incorporates in this list of stakeholders employees, stockholders, suppliers, and the organizations local community. This list, though similar to list given by stakeholder theorists, is not uncontroversial. The stakeholder concept itself has its critics. Those critics imply that the stakeholder approach is not capable of guiding essential enhancements in corporate government in that numerous lines of accountability inferred by acknowledging a multiplicity of stakeholders, minimizes efficiency and that the idea of stakeholders as ethically important undermines the morally significant relations between community and stakeholders.

2.7 Conceptual Framework

The conceptual framework for this study was researcher based framework depicted in figure 1.1 below. In the framework the researcher intended to determine how effective level of awareness, cultural factors, referral mechanisms and cost of health influences community participation in community projects.

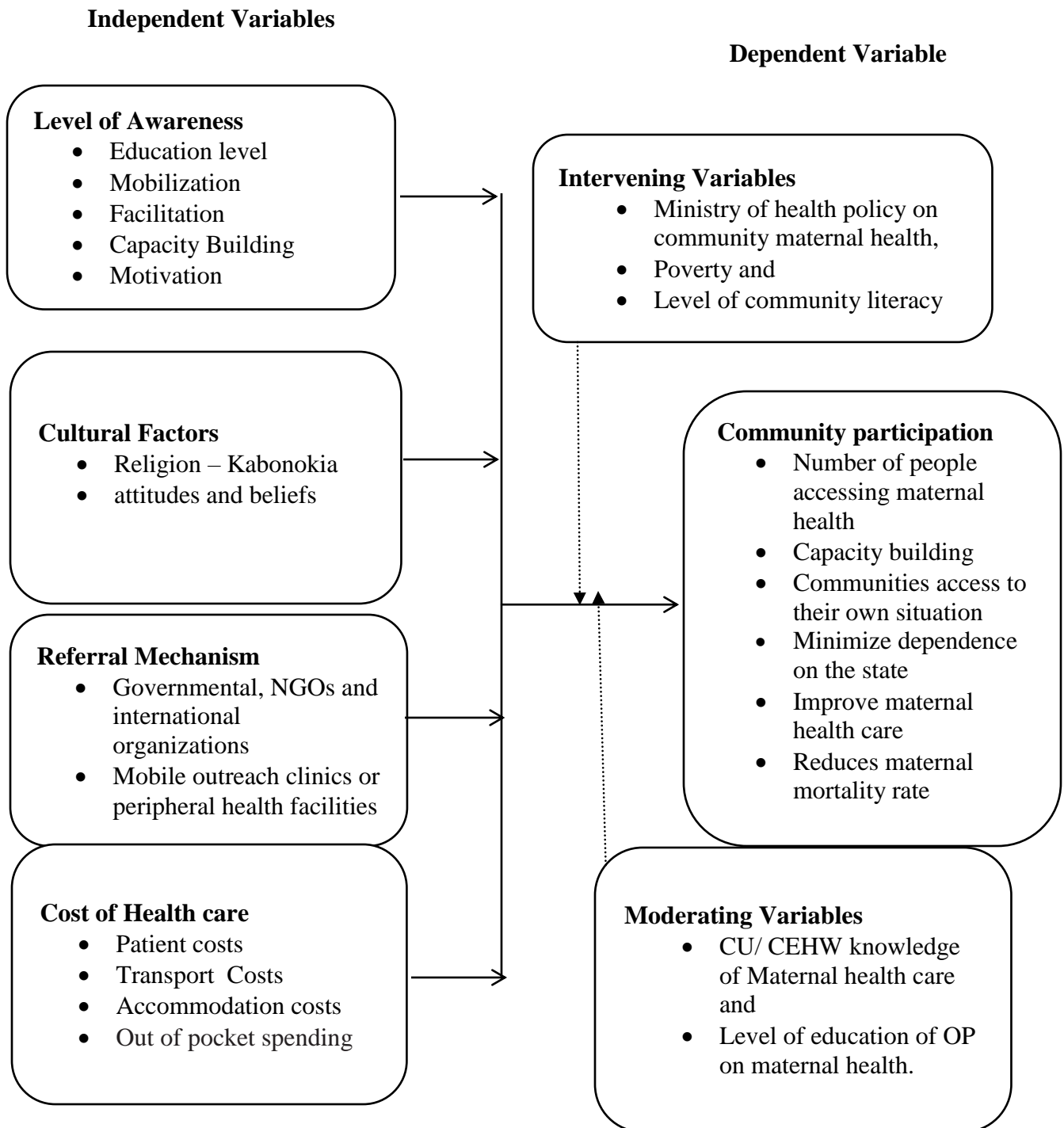


Figure2: Conceptual Framework

2.8 Summary of Literature Review

In this chapter the researcher introduced the research topic, defined it, discussed in details the objectives using dependent, independent, moderating variable and intervening variables. Researcher also put theoretical framework and conceptual framework which were explained. The literature review above indicated a lot of misgivings and many issues about community participation on maternal health project. It's acknowledged that many studies have been done on the issue of community participation pointing out why communities do not participate fully in a given project yet an immediate attention need to be put in place to understand this in view of the growth of maternal health problems day in and day out. Clearly there is a glaring importance in finding a lasting solution to this gap once and for all by researching on other areas like influence of community participation on health which is the back born of this study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

Methodology refers to the system of methods or procedure used in sampling and collecting data required for a particular research. It is also the application of the principles of data collection methods and procedures in any field of knowledge. In this chapter the researcher covered research design, target population and calculate the sample size and sampling procedure/technique. The research also looked at research instrument, piloting of the study tool, validity of the instrument, data collection procedures, data analysis technique and ethical consideration

3.2 Research Design

The research adopted descriptive survey research design. Descriptive research involves gathering data that describe events and then organizes, tabulates, depicts, and describe the data collection (Glass and Hopkins, 1984). Oftenly, it uses visual aids such as graphs and charts to help the reader in understanding the data distribution. This study used description as a tool to organize data into patterns that emerges during analysis and help in understanding, qualitative study and its implications.

Mostly, quantitative research falls into two areas, studies that describe events and studies aimed at discovering inferences of causal relationships. Descriptive studies are aimed at finding out “what is”, so observational and survey methods are frequently used to collect descriptive data (Borg & Gall, 1989). The main reason of descriptive survey research design is a description of the condition of affairs as they exist. (Kothari, 2003). According to Kerlinger (1973) descriptive survey design is part of social examining which studies large and small populations or universe by selecting and studying sample chosen from the population to discover the relative incidence, distribution and interrelations. The descriptive survey allowed collection of large amounts of data from the target populations. The study used descriptive because it described what is by use of quantitative and qualitative methods

The study was concerned with the role played by stakeholder implementation of community maternal health project in Kitui County. Such issues are best investigated through survey research design (Kerlinger, 1986) and this explains the choice.

3.3 Target Population

The definition of target population can be clearly defined as the total of all the selected individuals with peculiar characteristics and which interest the researcher. In a general, a research population comprises of all the features of a well-defined group. It describes the scope by which the research is applicable. A research population is classified into target and accessible populations. A target population describes all the members in the group to whom the investigation is related, while, accessible population signifies those elements within the target population that are within the reach and manipulation by the research. The study therefore, targeted population of stakeholders identified as Community units, maternal health workers, community health workers and opinion leaders in Kitui County with a target population of 3000 respondents. This was based on the archived records from the county director of health Kitui County, Ministry of Health.

Table 3.1: Target Population

Target Group	Target Population	Percentage (%) in relation to target population (%)	Sample Size
Community Units	500	17.0	50
Health Workers	910	30.3	91
Community Extension Health worker	910	30.3	91
Opinion Leaders	680	23	68
Total	3000	100	300

3.4 Sample Size and Sampling Techniques

A sample can be defined as a subset of the population, and can be considered as the smaller group of elements selected through a rigorous and definite procedure from a particular population; i.e. the elements that constitute the sample are those that are actually studied. Kerlinger (1986) has offered

a comprehensive definition of Contextualizing Scientific Research Methodologies DOI: 10.9790/7388-05615257 www.iosrjournals.org, random sampling as the method of drawing a portion (sample) of a population so that all possible samples of fixed size n , have the same probability of being selected. This is a generalized definition and thus satisfactory. Simple random sampling is perhaps the oldest, easiest and simplest sampling technique in terms of application and conceptualization. (Ololube & Egbezor, 2012). It does not necessarily require knowledge of the exact composition of the population, only that we can reach all the members of the population

The study used systematic simple random sampling technique whereby, after every 10 respondent one was picked from the whole population as respondents. According to (Mugenda and Mugenda, 1999), 10% -30% is the procedure of systematically acquiring and recording information about the members of a given population. Thus, the sample size of 300 community stakeholders was considered adequate from the targeted population of 3000 respondents. The simple random sampling selected 30% of the community participants, grouped as 51 community units, 91 health workers, 91 community extension health workers and 68 opinion leaders, as stated by (Mugenda & Mugenda, 2003), with recommendation that 30% of target population to be representative.

3.5 Research Instrument

The main instrument for data collection was questionnaire for community units, health workers, community Extension Health Workers and opinion leaders members. Document analysis involved reviewing the contents of the documents with the aim of adducing some relevant secondary data (Oslo and Onen 2005). The questionnaire is the convenient tool especially where there are large numbers of subjects to be handled. It facilitates easy and quick derivation of information within a short time and hence its use in this study.

The questionnaires were used as the main research instruments in this study. They were structured with both closed ended items and open ended questions. The researcher arranged with all the community members involved to fill the questionnaires. The questionnaires had three sections; section I introduction, section II the personal details of the respondents and the questions in groups of various study variables. The questionnaires with closed ended items were only used in order to ascertain collection of numerical data and consistency of data elicitation from the selected community members.

3.6 Validity of the Instrument

According to (Rubin & Babbie, 2008) validity is the accuracy and meaning fullness of inferences, which are based on the research results. In other words validity is the degree to which results obtained from the analysis of the data actually represent the phenomenon under study. Validity exists if the data measure what it is supposed to measure. Saunders *et al* (2009) argued that there a reason why all people don't have the same test score is that they differ in terms of the attribute the test measures. For this study, questionnaires were pre-tested to ensure they were not faulty and that the participants understood the questions.

3.7 Reliability of the Instrument

Reliability is the consistency or the degree to which an instrument measures the same way each time it is used under the same condition with the same subjects and the repeatability of the measurement. A measure is considered reliable if a person's score on the same test given twice is similar. Reliability is not measured, but estimated and does not imply validity because while a scale may be measuring something consistently, it may not necessarily be what it is supposed to be measuring (Best & Kahn, 2008). Koul (1993) states that the type of reliability of a test refers to ability of that test to consistently yield the same results when repeated measurement are taken of the same individual under the same condition. Basically, reliability concerned with consistency in the production of the same results and refers to the requirement that, at least in principle another research on another occasion, should be able to replicate the original piece of researcher and achieve comparable evidence or results, with similar or same study population. To establish the reliability of the questionnaire, pre-testing through piloting was done in Mui basin, Mwingi sub County of Kitui County. The reliability of the items was based on estimates of the variability among items. The community units that were used in piloting study were not used in the main study. The entire instrument was tested before data collection is to be carried out in the field. The reliability coefficient was determined using the retest method. A reliability coefficient of 0.65 was considered high enough for the instrument to be used for the study (Kerlinger, 1986). It is expected that feedback that would be obtained from the study would assist the researcher in revising the instrument of data collection to ensure that it covers the objectives of the study. The main reason for piloting the questionnaire was to ensure that the items would detect the kind of responses the researcher intends to get, that the item they are acceptable in terms of their content, and they

adequately covers any aspect of the unit which the researcher particularly wishes to explore. In a case where it was discovered that the items in the questionnaire are difficult for the respondents, they were rectified accordingly.

3.8 Data Collection Procedures

The researcher sought permit from the County Health Management Team (CHMT) to be allowed to collect data. The community units were pre visited by the researcher to make them aware of the study, before actual data collection date and to familiarize with the respondents. The researcher self-administered the questionnaires to the respondents to fill in the data and the researcher collected the filled in the questionnaires before having the selected community participants,

Questionnaires to the sampled respondents were administered by the researcher and two competent research assistants who were trained. They were used to ensure correct interpretation of questions asked in cases where the respondents were illiterate or had low educational levels. The researcher also booked an appointment with the necessary officers to facilitate obtaining of information through document analysis with an aim to compliment the data collected using the questionnaires.

3.9 Data Analysis Techniques

Data Analysis is the processing of data to make meaningful information (Saunders *et al*,2009). Maddalla (2009) defined data analysis as a mechanism for reducing and organizing data to produce findings that require interpretation by a researcher. According to Hyndman (2008) data processing involves translating the answers on a questionnaire into a form that can be manipulated to produce statistics. Data analysis involves coding, editing, data entry, and monitoring the whole data processing procedure. After data collection, data collected was organized according to the research objectives and then was analyzed using descriptive statistics and inferential statistics. A statistical Social Package was used preferably SPSS version 22.0. Analyzed data was presented using descriptive statistics which involved use of frequencies, percentages and cross tabulations. Tables were used where emphasize are required in presentation of the findings.

3.10 Ethical consideration

Permission to carry out the research was sought from the relevant authorities before the study is initiated. The respondents were made aware of the objectives and the general overview of the

study. The respondents were also made aware that participation in the study does not warrant them any gifts, monetary or otherwise.

In addition this study utilized human participants so certain issues were addressed. The consideration of these issues is necessary for ensuring the privacy as well as the security of the participants. These issues were identified in advance so as to prevent future problems that could have risen during the research process. Among the significant issues that were considered included consent, confidentiality and data protection.

3.11 Operational definition of variables

There are four variables that were considered in this study, namely; independent, intervening, moderating and dependent variables. The independent variable will be Level of Awareness, Cultural factor, Referral mechanism and Cost of Health while dependent variable Community participation on maternal health project, the intervening variables will be ministry of health policy on community maternal health, poverty and level of community literacy. The moderating variable will be on CU/ CEHW knowledge of Maternal health care and level of education of opinion leaders on maternal health.

The information is presented in Table 3.2

Table 3.2: Operationalization of the variable for the study

Objectives	Types of Variables	Indicators	Method of data collection	Data Analysis Technique
1. To establish how level of awareness influence community participation on maternal health project in Kitui County.	Independent variable: Level of Awareness Dependent variable: Capacity Building	Capacity Building	Questionnaire	Percentages
2. To assess how cultural factors influence community participation on maternal health project in Kitui County.	Independent variable: Cultural factors Dependent variable: Communities access to their own situation	Communities access to their own situation	Questionnaire	Percentages
3. To examine how referral mechanism influence community participation on maternal health project in Kitui County.	Independent variable: Referral Mechanism Dependent variable: Minimize dependence on the state Improve maternal health care	Minimize dependence on the state Improve maternal health care	Questionnaire	Percentages
4. To determine how cost of health influence community participation on maternal health project in Kitui County.	Independent variable: Cost of Health Dependent variable: Reduces maternal mortality rate	Funding source Sustainable Funding	Questionnaire Questionnaire	Percentages

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION, INTERPRETATION AND DISCUSSIONS

4.1 Introduction

This chapter dealt with data analysis, presentation, interpretation and discussion of the findings on the factors influencing community participation on maternal health project in Kitui County. The data were analyzed with the help of the SPSS computer programme. This enabled the researcher to present the data in frequencies, percentages, and summarized in tables. The chapter was divided into two main sections, namely results and discussion of the findings.

4.2 Questionnaire Response rate

The following table shows the response rate obtained for the study.

Table 3.3: Questionnaire Response Rate

Respondents	Sample size	Response rate	Percent
Community Units	50	39	78
Health Workers	91	71	78
Community Extension Health worker	91	66	73
Opinion Leaders	68	52	76
Total	300	228	76

Out of the 300 questionnaires issued, only 228 were returned which represented a response rate of 76%. According to Mugenda & Mugenda, (2003), a response rate of 50% is adequate for analysis and reporting, a response rate of 60% is good and a response rate of 70% and over is very good. This implies therefore that the achieved rate was representative of the target population and was adequate and good enough to enable the researcher generate a conclusive report.

4.3 Demographic Characteristics of Respondents

The demographic representation of the respondents was presented as follows including age, gender and level of education.

4.3.1 Age of the Respondents

The respondents were asked to give their age bracket. Table 3.4 shows their results.

Table 3.4: Age of the Respondents

Age of the Respondents	Frequency	Percent
Below 18 years	24	10.5
18-24 years	56	24.6
25-34 years	78	34.2
35 to 44 years	24	10.5
Over 44 years	46	20.2
Total	228	100.0

On their age category, 78 (34.2%) were aged between 25-34 years, 56 (24.6%) were aged over between 18-24 years, 46 (20.2%) were aged over 44 years while 24(10.5%) each were aged less than 18 years and 35-44 years respectively. The result suggests that the study collected information from a wide section of age category thereby validating the responses of the study. Moreover, the results suggests that most of the community population in the area of study, fall under the reproductive age of up to 49 years.

4.3.2 Gender of the Respondents

Table 3.5 shows the distribution of the respondents by gender.

Table 3.5: Gender of Respondents

Gender	Frequency	Percent
Male	126	55.3
Female	102	44.7
Total	228	100.0

Results on gender of respondents show that 55.3% were male while 44.7% were female (table 3.5). This distribution shows that there was sufficient representation in understanding the influence of community participation on health.

4.3.3 Level of Education of the Respondents

Table 3.6 showing the distribution of the respondents by educational levels as revealed in the study.

Table 3.6: Level of Education

Level of Education	Frequency	Percentage
None	4	1.8
Primary Education	13	5.7
Secondary Education	91	39.9
Tertiary	120	52.6
Total	228	100

Education level was also necessary in order to understand the literacy level of the respondents which could probably influence their understanding on influence of community participation on health. According to the findings, majority of the respondents (52.6%) had tertiary level of education, 39.9% had secondary level education, and 5.7% had primary level education while 1.8% had no education. This was an indication that the majority of the respondents had either attained secondary education or tertiary level of education.

4.4 Level of Awareness and Community Participation

The study sought to find out the influence of level of awareness on maternal health projects. Table 3.7 shows the data obtained from the respondents concerning whether they ever informed about mother's health during pregnancy while visiting homesteads.

Table3.7: Level of Awareness

Response	Frequency	Percentage
Sometimes	125	54.8
Always	69	30.3
Never	34	14.9
Total	228	100

From the findings, more than 54% indicated that they sometimes talked about mothers' health during pregnancy while visiting homesteads, 30% always talked about it while 15% never discussed the subject. This indicates that most of the health workers would discuss the issue of the health of pregnant women with the community. The results further explains the how levels of awareness influence community participation in that, due to levels of awareness, mobilization of community concerned on the matters of maternal wellness services, can bring about policy awareness hence policy examination and support initiative to influence those in power to bring about changes that make an actual change to people's health

In addition, the respondents were asked to indicate the health issues they discussed. Table 3.8 shows their responses.

Table 3.8: Health Issues Discussed

Response	Frequency	Percentage
Antenatal care	63	32.5
Family planning	25	12.9
Mortality	62	32.0
HIV/AIDs	37	19.1
None of the above	7	3.6
Total	194	100

Table 3.8 shows that most of the respondents (32.5%) talked about antenatal care, 32% talked about mortality, and 19.1% talked about HIV/AIDS while 12.9% talked about family planning. The rest 3.6% talked about none of the above but other health issues. This was a good indication

that matters pertaining to mother’s health were discussed as key, and were taken seriously by respondents, who were the community participants.

4.5 Cultural Factors and Community Participation

The study also sought to seek the influence of cultural factors on community participation of health projects. To address this objective, the respondents were first requested to indicate whether their culture plays a role in the maternal health care. Table 3.9 shows the results obtained.

Table 3.9: Influence of Cultural Factors on Community Participation

Response	Frequency	Percentage
Yes	198	86.8
No	30	13.2
Total	228	100

From the results in table 3.9, majority of the respondents as indicated by 198 (86.8%) said yes, that their culture plays a role in maternal health care. In addition, 13.2% said no.

Further, it was revealed that the cultural background of gender roles to an extent blinded women from accessing maternal health care. Table 3.10 shows these results where more than 51% indicated yes while the rest 48% indicated no. This shows that the role of culture cannot be ignored in influencing how women participate in maternal health projects. The results demonstrate culture and maternal health where culture influence, deprives mothers wellness in that some religious believes preclude medical assistance like Kabonokia which is predominant in Kitui county. Moreover, use of harmful herbs or caustics add to maternal morbidity and mortality

Table 3.10: Cultural Background and Access to Maternal Health

Response	Frequency	Percentage
Yes	118	51.8
No	110	48.2
Total	228	100

In recognizing the role of cultural background in influencing participation on maternal health, the respondents were required to show the role of the medicine men in their community. Table 3.11 shows their responses.

Table 3.11: Role of Medicine Men

Response	Frequency	Percentage
Source of Healing	54	23.7
More Educated on Women Issues	51	22.4
Don't Matter in Women Issues	61	26.8
Get Money for Nothing	62	27.2
Total	228	100

The study revealed that 27% indicated the medicine men get money for nothing, 26.8% said that medicine men don't matter to women issues, 23.7% indicated the medicine men are a source of healing while others (22.4%) said that the medicine men are more educated on women issues.

4.6 Referral Mechanism and Community Participation

To find out the respondents' response on referral mechanisms, they were asked about the supporting agents in their area. The findings were presented in Table 3.12.

Table 3.12: Supporting Agents

Response	Frequency	Percentage
NGO	48	21.0
Government only	56	24.6
Religious bodies	58	25.4
Private individuals	25	11.0
NGOs and Government	41	18.0
Total	228	100

From the results, 25.4% of the respondents indicated that the supporting agents available in their area are religious bodies, 24.6% indicated government bodies, 21% indicated NGOs, 18% indicated government and NGOs while 11% indicated private individuals. The results furthers

demonstrated how government, non-governmental and other relevant organizations should be involved and work to ensure cooperation among all stakeholders for sustainable structures in improving mothers wellness and health care services.

Additionally, the respondents were required to indicate some of referral mechanism used in their area and results indicated as follows.

Table 3.13: Referral Mechanisms

Response	Frequency	Percentage
Mobile Clinic	61	26.8
Peripheral facilities	33	14.5
District Hospitals	116	50.9
Others	18	7.9
Total	228	100

The study in table 3.13 shows that referral mechanisms were at 51% district hospitals, 27% mobile clinics, 15% peripheral facilities and 8% other mechanisms. The response rates showed that to make health care services accessible, there must be referral mechanism right from lowest level of service delivery that is from the communities to peripheral facilities, and government of Kenya should be dedicated to upgrading access and fairness to essential health care services right from the community level.

4.7 Cost of Health and Community Participation

The final research objective sought to find out the influence of cost on community participation on maternal health. First, the respondents were required to indicate whether they paid any money for hospital services. Their responses were indicated in table 3.14 as follows.

Table 3.14: Payment for Hospital Services

Response	Frequency	Percentage
Yes	188	82.5
No	40	17.5
Total	228	100

From the findings, 82.5% as represented by majority indicated they had paid money for hospital services while 17.5% indicated no. In addition, the respondents indicated the roles of central government, county government and private business in relation to the cost of health care. They indicated that central and county governments have got duties and responsibilities to undertake when it comes to healthcare as provision of affordable ambulance services, surveillance and response of disease, provision of health facilities and pharmacies as well as promoting the primary health care.

Further they indicated that the private sector has a role to identify ways to improve the public private interface to increase equity, access, and efficiency in the health system to create new opportunities for investment and lending for growth of the health sector. Cost of patients have been blamed for poor seeking of medical services from skilled providers, as direct and indirect cost, prevent women from seeking health care services because of the extra cost attached to it. This is a big concern specifically in rural households where women rely on public clinics situated in small towns or cities and regularly borrow money to cover transport, food and accommodation costs.

CHAPTER FIVE

SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents and discusses briefly the summary and the findings of the study. The chapter further makes conclusions and recommendations based on the findings of the study as well as suggestions for further studies.

5.2 Summary of Findings

This study was guided by four important research objectives. From the analyzed data related to objective one, respondents 54% and 30% first recognized the importance of creating awareness on health matters. As a result, they said that either always or sometimes talked about health issues during their work such as family planning, HIV/AIDS, antenatal care and mortality. However, other respondents never discussed at all. The findings further explains how levels of awareness influence community participation in that, due to levels of awareness, mobilization of community concerned on the matters of maternal wellness services, can bring about policy awareness hence policy examination and support initiative to influence those in power to bring about changes that make an actual change to people's health. From the findings, if more than 54% indicated that they sometimes talked about mothers' health during pregnancy while visiting homesteads, and 30% always talked about it, it is clear that health of the mothers cannot be ignored and discussions should start right from the community level, and community should be involved in discussing matters that pertain their health and more so, wellness of mothers.. This indicates that most of the health workers would discuss the issue of the health of pregnant women with the community.

The second objective sought to determine whether cultural factors had any influence in community participation of maternal health projects. The study revealed that more than 86% believed that their culture plays an influential role on maternal health care. They also indicated

that gender roles blinded women from accessing maternal health care while the role of medicine men was also appreciated by many. From the findings, majority of the respondents as indicated by 198 (86.8%) said yes, that their culture plays a role in maternal health care. In addition, 13.2% said culture does not play a role in maternal health care which is a small percentage compared to those who believe that culture plays a role in maternal health care. This finding is a clear indication that culture plays a role of significance in maternal health in a way in Kenya, and in Kitui County which is predominantly Kamba people of Abantudialic, hindering women from seeking maternal wellness services from health facilities, and even seeking the same services from traditional medicine men in terms of diagnosing, healing and treatment. Further, it was revealed that cultural background of gender roles to an extent blinded women from accessing maternal health care. The findings revealed that more than 51% indicated yes while the rest 48% indicated no. This indicates that the role of culture cannot be ignored in influencing how women participate in maternal health projects. The results demonstrate culture and maternal health where culture influence, deprives mothers wellness in that some religious believes preclude medical assistance like Kabonokia which is predominant in Kitui county. Moreover, use of harmful herbs or caustics add to maternal morbidity and mortality.

The third objective of the study was to determine whether referral mechanisms influence community participation on maternal health projects. Data was analyzed related to this objective and revealed that there were other supporting agents in the community such as NGOs, private individuals, religious bodies besides the government. The study also revealed that the referral mechanisms included mostly district hospitals, mobile clinics and peripheral facilities. The findings revealed that referral mechanisms were at 51% district hospitals, 27% mobile clinics, 15% peripheral facilities and 8% other mechanisms. The reaction rates further exhibited that to make health care services accessible, there must be referral mechanism right from lowest level of service delivery that is from the communities to peripheral facilities, and government of Kenya should be dedicated to upgrading access and fairness to essential health care services right from the community level. The findings demonstrates that there is need to strengthen the referral system in order to provide equitable and cost-effective health services. Further, Kenya Health

Sector Referral Strategy should be developed to meet the dire need of referral needs to encourage participation of communities in seeking health services.

The fourth and final research question of the study wanted to find out the influence of cost of health on community participation on maternal health projects. The findings with regard to this objective revealed that majority had paid for hospital services while others had not. Additionally, the respondents also indicated that in relation to the cost of health, the government, both central and county had roles to play as well as the private business. Further, from the findings, 82.5% as represented by majority indicated they had paid money for hospital services while 17.5% indicated they had not paid for health care services. Cost of patients have been blamed for poor seeking of medical services from skilled providers, as direct and indirect cost, prevent women from seeking health care services because of the extra cost attached to it. This is a big concern specifically in rural households where women rely on public clinics situated in small towns or cities and regularly borrow money to cover transport, food and accommodation costs. Government should be concerned in waving these costs related to wellness and specifically for mothers when seeking maternity services from skilled health professionals, to encourage the rural communities, especially from Kitui County which is among the vastest, to easily access facilities with no or minimal costs.

5.3 Discussion of Findings

The purpose of this study was to establish the factors influencing community participation on maternal health project in Kitui County. This section reviewed each objective in relation to the findings and other related literature.

Concerning the level of awareness, health talking of health issues was considered important in helping increase community participation on maternal projects. Most of the respondents always or sometimes talked about health issues during their work such as family planning, HIV/AIDS, antenatal care and mortality. This study relates to Ayeni et al (1985), who found out that utilization of health services among rural women depend on awareness of the services, beliefs in their efficacy, proximity and availability of the services.

On cultural factors, the study found that cultural background of people would influence their attitude towards maternal health services. Gender roles on the other hand blinded women from accessing maternal health care while the role of medicine men was still recognized by many. In similar study conducted by Gordis (1993) in Oyo and Bauchi States with respect to attitudes and practices of women to pregnancy, child birth and post partum care, the data revealed that cultural taboos, beliefs and socio-economic factors often place women at a disadvantage position from the start of pregnancy. Attendance of pre-natal care clinics were found not to be wide spread.

Maternal and child healthcare system is an important segment of medical system in every society. This is as a result of large number of human population involved in this health sector, coupled with the significance of this group to the overall sustenance of the human population. It is also noticed that this sector of medical system is affected by less difficult health problems, which are usually preventable. Similarly, the increasing wave of gender equality has significantly stimulated attention towards the study of women and children. It is in the light of these, that this sector has attracted overwhelming attention especially from health related researchers, health providers, and health implementers (Kerber K. J, et al, 2007). As observed in all cultures, each society has its peculiar way of dealing with bio-cultural problems affecting its human population. Responses to various interventions seem to differ considering the peculiar knowledge displayed by the population in each society. Environmental factors also play considerable role on the health seeking strategies, thereby making the health interventions and responses greatly different across the culture (Jegade, 1999). Jegede, (1999), in his study of socio-cultural factors influencing therapeutic choice have identified age, education, occupation, religion, kin group influence and ethnicity as the determinant factors to use of health services.

The study on referral mechanisms revealed that most referrals were district hospitals, mobile clinics and peripheral facilities. As well, supporters in this area included government, NGOs among other partners. These findings are in tandem with Cheng, D., et al., (2011), who says that partners in a referral network usually include different government departments, women's organizations, community organizations, medical institutions and others.

Further, the study revealed cost of health as a significant factor which influenced the participation of many people.

It was also found that transportation to these healthcare facilities and the cost of drugs and vitamins represented obstacles to clinic utilization for many of these rural women. Respondents from this study cited long waits, scarcity of drugs, equipment and the hostile attitude of hospital personnel as reasons to avoid hospital delivery.

5.4 Conclusions of the Study

Based on the findings of this study, the researcher concluded that creating awareness on health issues influences the community participation on maternal health projects. Due to the level of awareness on the matters of maternal health, individuals can be made to make changes that can improve their health and welfare. Many individuals have really low knowledge of awareness regarding maternal health which has created misconception in the way mothers handle ANC.

Secondly, cultural factors play a role in influencing community participation on health projects. Culture and belief systems are vital factors in determining the participation of people as well as their health utilization services which can form the major concern of those who formulate and implement government health policies. The role which belief system, understanding the concept of disease, illness and health, improvement in the socio-economic status of the people and well planned education can all help in ensuring maximum and most efficient utilization of the health services cannot be over emphasized.

Thirdly, it can be concluded that referral mechanisms as well as supporting agents are critical in ensuring that people participate in maternal health projects. There should be an effective processes of how a woman should get in touch with an individual professional or institution about her case and how professionals and institutions communicate and work together to provide her with comprehensive support. As a result, referral systems should involve governmental, non-governmental and, as appropriate, relevant international organizations and individuals.

Finally, it can be concluded that the central government, county government and private individuals have a role to play as far as the cost of health is concerned. It can be concluded that there were barriers to accessing health care for women in rural areas, not well served by health facilities, is transport: the lack of transport or its exorbitant costs among others.

5.5 Recommendations of the Study

Based on the study findings, the following recommendations are suggested to help boost the community participation on maternal projects.

Communities on their own part should encourage their members to appreciate health facilities, provided by the government and utilize them. In order to combat the problem of maternal and child mortality and morbidity, the standard of living of the community must be raised. The community should actively be involved in the implementation of maternal health service projects at all phases. This is because engaging the community in its own development ensures that there is ownership of health care services by the community members, who are also the beneficiaries of such services.

The study also recommends the need to improve financial and social support for women and families facing maternal health crises. NGOs, government and private individuals should invest highly towards this program. These factors are therefore important intervention points for the government as well as the Non-Governmental Organizations in the effort to minimize maternal mortality and morbidity among women.

Community sensitization programs should be increased and to be implemented through the county government, cultural groups, youth and women's organizations, schools and extension services. Trained health workers can be mobilized to transmit health messages to women and can serve as agents of change in their own communities. Religious leaders should also be involved in disseminating messages especially against harmful traditional practices.

It was revealed that cultural beliefs and misconceptions play a key role in continued use of maternal health services. Health education about the delivery process and more knowledge about family planning could greatly benefit the women and start the process of changing health and health-seeking behavior.

Lastly, religious leaders should encourage their followers on the needs for family planning choices and community leaders should discourage the habit of not having family planning choice in their cultural norms. Limiting family size and reducing fertility rates would greatly improve the maternal mortality and morbidity rate as well as quality of life for women. Increasing the

time between births is proven to reduce maternal mortality. To increase the use of family planning, women need more sensitization about the benefits and possible side effects that they can get to reduce misconceptions surrounding its use. Family planning methods also need to be made more available and affordable at health centers.

Communities should be trained to be able to recognize complications, and learn more reproductive health information to be able to better inform pregnant mothers about good practices during pregnancy, refer those with high-risks for complications, and conduct deliveries in cases where women cannot access health centers. It is vital that someone with training be available in the community.

5.6 Suggestions for Further Studies

Although this study provided insight on the influence of community participation on health projects, with focus on level of awareness, cultural factors, referral mechanisms and cost of health, several other areas still need to be addressed by future researchers. First, the researcher suggested further studies on how cultural traditions influence reproductive health which would complement the findings of this study. Secondly, other researchers may seek to focus on other factors likely to influence community participation in health projects. Thirdly, the researchers may seek to study on improving community participation as a key factor in improving mothers' wellness.

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APPENDICES

APPENDIX I: LETTER OF TRANSMITTAL

Dear Respondent,

I am a student at University of Nairobi pursuing a Masters degree in Project Planning and Management and carrying out a research on “factors influencing community participation in maternal health care projects in Kitui County Kenya”. I am kindly, requesting your assistance. Do assist by filling in the questionnaire provided. The information will be helping me accomplish the research objectives. All responses will be treated with total confidentiality.

Thank you.

Yours faithfully,

Ann Kiaro Muriithi

APPENDIX II: QUESTIONNAIRE

This questionnaire is to collect data for academic purposes only. The study seeks to investigate the Factors Influencing Community Participation in Maternal Health Care Projects, in Kitui County Kenya. All information will be treated with strict confidentiality. Do not put any name or identification on this questionnaire. Answer all questions as indicated by either filling in the blank or ticking the option that applies.

1. QUESTIONNAIRE (FOR SURVEY TOOL) QUESTIONNAIRE (FOR SURVEY TOOL)

A) DEMOGRAPHIC DATA

County population male..... Female

Name of sub-counties _____

Number of community units in S/C _____

Number of health facilities providing maternal health care_____

Total number of CEHW in the sub-county -----

Number of community health units present -----

SECTION A: PERSONAL INFORMATION.

1. What is your average age?

- < 18 years
- 18 to 24years
- 25 to 34 years
- 35 to 44years
- >44 years

2. What is your sex?

Male

Female

3. Level of education (highest affordable)

Primary education

Secondary education

Tertiary (specific)

None

4. Have you ever been trained on community Maternal Health Care?

Yes

No

5. If yes how long was it?

One day

Three days

6. If yes in (5) did it add value to you in maternal health management?

Yes

No

7. Who supports your community unit?

GOK

Partners

None

SECTION

B

QUESTIONNAIRE ON AWARENESS CREATION

1. Do you ever talk about mothers 'health during pregnancy while visiting homestead on your routine work?

- Sometimes
- Always
- Never

2. If positive response in above, what do you talk about? (Tick the correct appropriate)

- Antenatal care
- Family planning
- Mortality
- HIV/AIDs
- None of the above

3. Do you hold action days in your CU.?

- Yes
- No

4. If yes how frequent?

- Monthly
- Quarterly
- Biannually
- Annually

5. Have you ever talked about maternal health care in action day or Barazas

- Yes
- No

If No (explain why)

If yes (explain how)

6. In your opinion, are pregnant women with birth complications face stigma in your community?

- Yes
- No

If yes above, which type of stigma? (Tick where applicable)

- a). Isolation
- b). Use of separate plates
- c). Not visited by friends
- d) Sent back to the village to avoid shame in town
- e) Women with TB divorced/chased by husbands

- f) Gossip/teasing
- g) Mocking
- h)finger-pointing
- i) Church leaders condemn mothers for promiscuity, adultery, breaking moral laws
- j) Children separated/isolated from others
- k) Children teased i.e. “your parents died because of their bad behaviour”
- m) In market, people stop buying from a market seller who is suspected to have HIV

7. What re some of the effects of stigma on birth complications patients?

- i. Personal shame
- ii. Self-blame
- iii. Isolation
- iv. Loneliness
- v. Loss of status
- vi. Loss of self-esteem
- vii. Depression
- viii. Denial and anger
- ix. Violence and alcoholism
- x. Suicide and death
- xi. Family quarrels, mutual blame and conflict
- xii. Separation and divorce
- xiii. Property grabbing
- xiv. Defaulting treatment or getting tested

8. What can you do to reduce stigma?

- a) Involvement of patients, providers and commitment
- b) Use of “home care volunteers” to disseminate information.

C).QUESTIONNAIRE ON CULTURAL ACTORS AFFECTING MATERNAL HEALTH CARE

1. Do you think your culture plays a role in the maternal health care?

Yes

No

If No (explain why)

If yes (explain how)

2. What is the role of Religion in the maternal health care in your region?(Islamic, Christianity and others)

3. Do you believe that the cultural background of gender roles blinded women from accessing maternal health care?

Yes

No

4. What is the role of the medicine men in your community?

(i) They are a source of Healing and treatment

(ii) They are more educated in our issues

(iii) They don't matter in women issues

(iv) They get money for nothing

D.QUESTIONNAIRE ON REFERRAL MECHANISM

1. Who are some of the supporting agents in your area?

NGO

Government only

Religion bodies

Privet individuals

NGOs and Government

2. In your area are there any referral places

Yes

No

If No (explain why)

If yes (explain how)

3. What are some of referral mechanism used in your area?

(i) Mobile Clinic

(ii) Peripheral facilities

(iii) District Hospitals

Any other explain _____

E.QUESTIONNAIRE ON COST OF HEALTH CARE

1. Do you pay any money health care services?

Yes

No

If No (explain why)

If yes (explain how)

3. What is the role of the following institution in relation to cost of health care?

(a) Central Government

(c) County Government

(d) Private businesses

APPENDIX III: QUESTIONNAIRE TO HEALTH CARE PROVIDERS (CHEW).

1. How many community units do you manage?

- One
- Two
- > Three

2. How is the community units in your area funded?

- GOK
- Partner
- Community itself
- None

3. Please list down your roles as a CHEW in maternal health care control in the community.

4. How many public Barasa did you hold in the last 3 months?

- None
- <2
- > 3

5. Do you hold school Health program in your area of jurisdiction?

- Yes
- No

If yes, in above question; how many schools did you visit in the last 3 months?

- .1 – 5
- .6 - 9
- .None

6. Do you have records as regards community maternal health care?

Yes

No.

If yes in above question; please list down the records / reports you submit

. If yes above, list down the successes

7. In your opinion, do you think community strategy is succeeding?

Yes

No

8. Please list down; what you think can be done to improve community strategy on maternal health care?

APPENDIX IV: WORK PLAN

Activity	Nov Dec 2016	Jan Feb 2017	Mar 2017	Apr l 2017	May 2017	Jun July 2017	Aug. Sept 2017		
Research conceptualization									
Writing research proposal									
Proposal Defense									
Seminar Defense									
Progressive report writing									
Piloting and Data collection									
Pilot data analysis and interpretation									
Writing report and submission of pilot									
Data collection for the Thesis justification and									
Data entry and coding									
Data Analysis/interpretation									
Report Writing Thesis Defense									
Corrections and final thesis submission									

