

**DETERMINANTS OF IMPLEMENTATION OF MATERNAL-CHILD HEALTH
PROJECTS IN MOMBASA COUNTY, KENYA**

BY

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DECLARATION

This research project report is my original academic work and has not been presented in any university or any other institution of higher learning.

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This research project report has been submitted for examination with my approval as the University supervisor.

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DEDICATION

I dedicate this research project report to all mothers through whom lives are passed on from one generation to another. To every child who may not live to see its fifth birthday due to childhood diseases.

ACKNOWLEDGEMENT

I want to thank the almighty God who carried me through all my studies.

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God bless you all.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
APHIA	AIDS Population & Health Integrated Assistance
ANC	Ante-natal Care
CDC	Center for Disease Control
CIDA	Canadian International Development Agency
EOC	Essential Obstetric Care
EU	European Union
GoK	Government of Kenya
HIPC	Highly Indebted Poor Countries
IMCI	Integrated Mother & Child Illnesses
ICT	Information Communication Technology
IPV	Intimate Partner Violence
KEMRI	Kenya Medical Research Institute
KNCHR	Kenya National Commission of Human Rights
KDHS	Kenya Demographic Health Survey
KNBS	Kenya National Bureau of Statistics
MCH	Maternal Child Health
MDG	Millennium Development Goals
MoH	Ministry of Health
OR	Odd Ratio
PMTCT	Prevention of Mother To Child Transmission
STD	Sexually Transmitted Diseases
TBA	Traditional Birth Attendants
TB	Tuberculosis
UNICEF	United Nation Children Education Fund
USA	United States of America
UNFPA	United Nation Fund for Population
WHO	World Health Organization

ABSTRACT

The aim of this project research was to study determinants of maternal child health projects implementation in Mombasa County. This research sought to achieve four objectives. The objectives focused on four independent variables of financial resources, hospital infrastructure, technology and socio-cultural factors. The study dependent variable was successful maternal child health projects implementation. Cross sectional descriptive survey design was utilized with a questionnaire as the data collection instrument. The study targeted women of child bearing age in Likoni and Changamwe sub counties of Mombasa. Quantitative and qualitative data was collected, cleaned and entered in Statistical Package for Social Scientist software. Data analysis using descriptive statistics, frequency tables and percentages was run through the software. Test of significance using Chi-square was run to determine statistical significance between the observed and expected distribution frequencies based on the alternative hypothesis. The result indicates that financial resources, solid infrastructure, appropriate technology have a positive influence on successful implementation of these projects. Negative socio-cultural habits hinder successful maternal child health projects implementation in Mombasa County. Under financial resources, 64.5 % of the respondents indicated that the county government was not allocating additional funds to support maternal child health projects. 67.7% of the respondents had not seen any change in number of maternal wards in their areas. 64.5% of the sample reached agreed that technology is essential in improvement of maternal child health services delivery. However 45.2 had not interacted with any appropriate health technology in their interface with services delivery. 96.7% of the respondents believed socio-cultural factors have hindered maternal child health projects implementation success. 78 % cited religion and traditions as the main aspect of social- cultural challenges. Financial resources are key contributors of maternal child health project success World Health Organization has reported that increased funding of essential health services in Sub-Saharan, Asia and Latin America has led to improved maternal-child health. In Kenya, the ongoing health services devolution has isolated the commensurate funding and thus the challenges in service delivery. The study shows that the County Government of Mombasa has not developed modern, well equipped maternities and child welfare clinics. Infrastructure development has been cited as a key stimulant of health services uptake. Though most respondents cited technology as key to service delivery efficiency, majority had not interacted with such appropriate technology. Modern medicine requires technological interface to improve diagnosis, treatment and care. Technology has been shown to improve efficiency of service delivery and greatly reduce cost and thus affordability. Traditional values, religious doctrines and gender roles were highlighted as the main socio-cultural influences. Negative culture hinders service delivery and should be negated through mass education on alternative rites. The County Government of Mombasa and maternal child health services providers need to; progressively increase funding to maternal and child health services. In line with the funding, equip public health facilities with appropriate technology on diagnosis, treatment and care. More facilities need to be availed to improve accessibility by the public. Community education campaigns on alternative rites should be designed and executed by the county management and health services providers through folk and mass media. Positive cultural aspects should be reinforced. The researcher recommends a detailed multi-disciplinary study in all the six sub counties of Mombasa in order to provide an insight to drive county and National government maternal child health policies.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

According to the World Health Organization (WHO) report, there is a global estimate of 289,000 maternal deaths. Every day, approximately 800 women die while 10-15 million women suffer from morbidity caused by preventable conditions related to pregnancy and childbirth (WHO, 2013). Developing countries accounted for (99%) of the global maternal deaths with Sub-Saharan Africa region alone accounting for (62%). The world health organization identifies the global distribution of maternal deaths by cause as hemorrhage (27%), hypertension (14%), sepsis (11%), unsafe abortion (8%), embolism (3%), direct causes (10%) and other indirect causes (28%) including AIDS and malaria experienced during birth or before birth (UNICEF, 2013).

In his literature work, Yashide (2010) argues that the (WHO) estimates that more than 585,000 women of reproductive age die each year from pregnancy related causes worldwide, 99% of these deaths occur in the less developed countries. This is supported by the World bank in that, The ratio of maternal mortality in sub-Sahara is the highest in the world estimated at 686 per 100,000 live births (World Bank, 1994;2010), if timely and appropriate obstetric care and health care programmes were accessed in the event of complication an estimated 75% of the above deaths could be prevented (World Bank, 2010). While in many areas MCH services simply do not exist and where they do they are often underutilized, women play an important role in the society which includes reproduction, production and community services.

Studies have demonstrated that high levels of maternal mortality and morbidity, children deaths and malnutrition in developing countries are preventable through use of skilled birth attendants, equipping health facilities and provision of essential resources required to effectively implement standard maternal-child healthcare services in the LDCs and other developing countries around the world (UNICEF, 2012). According to Nakamura (2010) maternal-child health refers to, health of women during pregnancy, childbirth and the postpartum period. In addition, late presentation by pregnant woman in the event of a complication, combined with poor quality care,

contributes to high levels of maternal and perinatal mortality and severe morbidity (Tornui et al. 2010). All women are at risk of obstetric complications; access to adequate essential obstetric care (EOC)/MCH programmes needs to be universal (WHO, 2010). Indeed world health organization (WHO) estimates that over 500,000 women worldwide succumb to complications of pregnancy and child birth each year, millions more women survive but suffer from illness and disabilities related to child birth. It has been estimated by safe motherhood initiative (SMI) that 30 to 50 morbidities occur from maternal death (SMI, 2011). This brings us to the general agreement that; the goal of prenatal care is to detect any complications of pregnancy early, prevent them if possible and to direct women to the appropriate special medical services. Postnatal care issues include recovery from child birth, concerns about newborn care, nutrition breastfeeding and family planning. Maternal death is widely regarded as one of life's most tragic outcomes. There is a cruel irony in the death of a woman who is engaged in the act of creating life, and her death is an incomparable loss for any children who are left behind, such deaths are almost entirely preventable given proper medical surveillance and intervention, and as such maternal mortality is often viewed as a sentinel indicator of the quality of a health care delivery system (EDS, 2011). Therefore, all the countries need to heavily invest in MCH projects.

According to center for disease and control (CDC), the total amount spent on health care projects in the United States of America (USA) is greater than any other country in the world. Despite this, women in the USA have a greater lifetime risk of dying of pregnancy-related complications than women in 40 other countries in Europe but this immense investment in health care projects has placed them in a remarkable world position. In their study, Swanton and Frost (2013) argue that 32 presidents of the USA out of the 44 who have governed the country for the last 200s years discovered the importance of population increase in labour productivity, security providence and market provision for their goods and services; a factor that gave birth to a number of maternal-child health programmes revolution. In his quest for mother to child health providence, the Obama government had to be fueled by a number of factors for the implementation of these programmes that were not limited to: availability of financial resources from both the government and NGOs/charities, development of enabling infrastructure like alternative energy for ICU/cesarean operations, training of manpower for specialized services,

improved technology, information dissemination to the community, qualified and experienced management among other(Soya ,2013).

However, some countries in the EU have been found to have had better and more improved MCH programmes that have up to 87% reduced maternal and infant deaths. For example, the likelihood of a woman dying during childbirth in the USA is five times greater than in Greece, four times greater than in Germany, and three times greater than in Spain. The differentiating factor between Spain and Greece with the USA is that, opposed to the USA's belief in huge financial investments in MCH projects, the other two governments have up to 67% invested in refined technology, highly trained medical experts, proper management and the social ties between the expectant mothers and their medical doctors (Rowe, 2013).

In the developing countries child birth is associated with suffering ill health and even death .Indeed globally, the increasing attention given to maternal health has seen reduction of maternal deaths .There is a growing movement, globally and particularly in the Africa region, to reduce financial barriers to health care generally, but with special emphasis on high priority services and vulnerable groups (WHO, 2010). In Ghana for example, strides have been made in strengthening the MCH projects and institutions that offer maternal health care. It is in this note that an exemptions policy for delivery fees was introduced in 2004. It was intended to cover all facility costs for intrapartum care in both public and private facilities. Initially payment was effected through the local government administration but later through the health system. Funding was provided from a debt relief fund, under the Highly Indebted Poor Countries (HIPC) initiative. Furthermore, quality of care is an essential component of any programme that upholds the basic principle of a reproductive health approach. It is in this spirit that the Ghana government under Nana Atta Mills came up with strategies of educating all the girls in middle level colleges on better and essential maternal pre-natal and post-natal care (Ani, 2013).Therefore, factors like: financial resources mobilization and providence for both the expectant mothers and children below age 5years, professional training and changing the societal perception of MCH projects, acquiring relevant and modern technology, providing relevant infrastructure like electricity, medical laboratories and many more have greatly influenced the implementation of MCH programmes in the country(CAHR, 2014).

In Burundi, for example, free services for pregnant women and the under-fives were introduced in 2006, and utilization appears to have increased as a result, though no formal evaluation has been undertaken (CIDA, 2011). The introduction of the services forced the Burundi government to borrow extra funds from the World Bank to the tune of \$23.6 million in 2008/2009 to expand the MCH programme started in 2006, train extra 310 nurses and 34 doctors in Kenyan Universities between 2005 to 2010, acquire cheap but highly suited technology for China and Japan, increase its road network, electricity and clean water infrastructure to the MCH centres/clinics by 37% between 2005 and 2011 and have radios and TV programmes that sensitized mothers not to deliver in their homes. These were among the factors that have greatly influenced the implementation of MCH programmes to the tune of 41% between 2005 to 2013 and the country has so far seen a reduction in maternal deaths and infant mortality rates reduced by 46.12% between the said years (UNICEF, 2013).

According to the WHO (2012), maternal mortality and deaths of newly born children below the age of 5 years is a significant health problem in Kenya with an estimated 488 maternal deaths per 100,000 live births, against the millennium development target of 147 per 100,000 live births by 2015. For every woman who dies during child birth, another 20-30 women suffer serious injury (KDHS, 2009). Majority of the maternal mortalities in Kenya occur during child birth, a significant number are caused by postpartum hemorrhage (KEMRI/CDC, 2013). This could easily be managed by providing quality health facility delivery that would ensure women deliver safely and avert most of the complications that arise during child birth (UNFPA, 2011). All expectant women are at risk of developing unexpected complications during child birth but almost all of these complications can be managed by skilled birth attendants at well equipped health facilities. Yet in Kenya, only about (43%) of all deliveries take place at health facilities (KDHS, 2009). Investment in maternal-child health care projects is important in driving the country's economic growth as well as reducing poverty rates (KNHCR, 2012).

In a publication by KNHCR in 2012/2013, the Hon. Kibaki government first announced a major shift in the maternal-child health programmes through the then minister of health Hon. Charity Ngilu that saw the scrapping off of the maternal fee in all public hospitals (KNHCR, 2013). In its publication of 2006/2007, the ministry of health and sanitation wrote that, in Kenya for example,

various changes have been made to the user fee regime – most recently, in 2007, deliveries were announced to be free (MOH, 2007), though there is no evidence yet of implementation or impact. The services also were aimed at being provided at low cost, minimal supervision, well sterile environs, with high level of technology machines handling the operations and pregnancy scanning, experienced maternal care handlers from both the nurses and the doctors and electrification of almost 90% of the public hospitals and clinics through the rural electrification programme (GOK, 2010). The WHO (2012) argues that there has been progress in sub-Saharan Africa, but Kenya, unlike in the developed world where a woman's/infant's life time risk of dying during or following pregnancy is 1 in 3800, the risk of maternal death and infant impermanence is very high at 1 in 39. Increasing numbers of women seeking maternal health services during childbirth and after child birth in health facilities is therefore important to ensure that quality of care provided is optimal.

According to Kenya demographic health survey (2012), it is estimated that about 43% of births in Kenya are delivered under the supervision of skilled birth attendant; TBA continues to assist 28% of the births, 22% are home deliveries assisted by friends and relatives while 7% of expectant mothers deliver without assistance. Kenyan women have long suffered from high maternal mortality and morbidity for many years and utilization of antenatal and maternal services is an essential health indicator and step to the right direction (Yoshito, 2011). Increasing the proportion of mothers who are cared for in health facilities during pregnancy, delivery and post-delivery reduces health risk to both the mother and the child. In most communities motherhood is often celebrated as a positive gain in the community and fulfilling experience for the concerned couple/ family where it is seen as the continuation of family lineage while at the same time for many women it is associated with suffering, pain ill-health and even death associated with hemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labour (WHO, 2013).

As much as the government has put major strides in trying to achieve the MDG-4 and 5 which touches on maternal deaths and infant mortalities, a great number of determinants have been in central play. In its quest for example of inauguration of free MCH programmes in 2007, the Hon. Kibaki government was faced with great hostility politically from the opposition led by

Hon.Raila Odinga;who together with the ODM group saw the move as a scheme that was aimed at enticing voters to have Hon.Kibaki get into office for the second term. This resistance was hence great to the point that including the then Minister for Health Hon.Charity Ngilu was singing with the opposition while riding the public cars (GOK, 2012).Politics has only been a small factor in determining and giving the direction for MCH projects implementation in the country. The giant factor for influence has been availability of financial resources. The Kenyan budget has been constrained between development projects, education and repayment of debts. In his Speech of 2009/2010, Hon. Uhuru Muigai Kenyatta-the then minister for finance-read a budget that allocated less for medical facilities compared to infrastructural development and other sectors of the economy. This has left almost 41% of the MCH units across the country constrained with budgets, meaning that the programmes lack proper medicine and they cannot hire experienced experts.

In its comparative study between Central Asia and East Africa, CAHR (2014) argues that, unlike Japan and India whereby the rates of survival of the infants and their mothers is high, East Africa reports the highest rates of these deaths despite the fact that they have enjoyed independence over 50years now. The report shows that the hindering factors in proper implementation of MCH projects in Kenya for example includes: poor governance of MCH projects whereby the management is below par for the work but maintained on operation due to nepotism, preferentialism and clannish, insufficient financial resources from both the central government and donors, lack of sufficient skilled personnel to handle the expectant mothers' situations and their children, poorly informed locals especially those in ASALs areas on MCH series and their impedance, socio-cultural vies and positions like perceptions, religion, traditional values and taboos, the level of technology employed in these MCH units that is poor, poorly developed infrastructure like laboratories and many more.

The above mentioned factors have been worse in Mombasa's situation. For example, a report by UNICEF(2012) indicates that under-5 mortality remains at 151/1000 based on the 2008-2009 KDHS findings in Mombasa County, Kilifi, Kwale and Turkana; one of the highest although a reduction was recorded in some other counties like Nyanza from 149/1000 in 2008 to 91/1000 in 2011(MICS). Half of all child deaths are now due to neonatal causes; pneumonia, diarrhea,

malaria and HIV are also major contributors (CHERG 2010). The maternal mortality ratio ranges from 3,000 and 4,000/100,000 in deprived northern counties and coastal counties (National Council for Population and Development estimates, 2013). These high deaths in Mombasa have been attributed to socio-economic factors like lack of basic information about the MCH services, religious beliefs, superstition, political negligence/social injustices, lack of proper education, lack of medical expertise, poor MCH units managements, poorly developed infrastructure like roads network, power distribution to the Health Centres, politicking the MCH projects, lack of sufficient financial resources that have seen major strikes in MCH units in Mombasa for almost 3 years now and many more (World Bank, 2013; UNICEF, 2014). Having had the health docket being recently transferred to the county governments, the implementation of the MCH programs that aimed at touching on the rampart issues of women lacking proper places of giving birth, have been totally disturbed. For example, the government stopped the release of national budget allocated to 5 counties in coast, limiting the rate of success of various projects that were aimed at making the MCH program a success. This led to a number of strikes by both nurses and doctors who were never paid for long; extending the time taken to achieve the MCHS accessibility dream as underlined in the MDGs(MDGs Report, 2015). It is due to the insurgence of these factors that enable/hinder the implementation of the MCH projects in Mombasa County that the research gets its grounds of maneuver.

1.2 Statement of the Problem

More than 1,000 women die each day – 358,000 a year – during pregnancy and child birth mainly due to poor access to effective interventions: skilled care during childbirth is available only to 60 per cent of women; and even fewer – less than 40 per cent – receive a postnatal visit (WHO, 2010). Meanwhile, the number of unintended pregnancies is 76 million a year, and unsafe abortions reach 22 million accounting for 13 per cent of all maternal deaths. In most developing countries, access to family planning remains very limited despite its potential to avert deaths: satisfying the unmet need for contraceptives would reduce unintended pregnancies by two-thirds, which, in turn, would save more than 1.5 million maternal and newborn lives and prevent 505,000 children from losing their mothers (UNFPA, 2010). Over the last decade, progress has clearly been made towards achieving both MDGs 4 and 5. However, the achievements are very uneven across regions and countries. Both the under-five and maternal mortality is increasingly concentrated. About half of the world's child deaths in 2009 occurred in

only five countries (Danszen et al, 2010); and most (65 per cent) of all maternal deaths – in 11 countries (WHO, 2010).

Recent estimates indicate a significant drop worldwide in the number of women dying from pregnancy related causes, from an estimated 422 in 1980 to 251 per 100,000 live births in 2008. In Kenya however, this is not the case. For instance, the KDHS 2008 indicates that more women are dying of pregnancy and childbirth related causes than was the case in 2003. In 2008, reported maternal deaths were 488 per 100,000 live births compared to 412 per 100,000 live births reported in 2003. The KDHS 2008 also shows that majority of women who make minimal use of the maternal healthcare services are from the rural areas, marginalized areas and the socially isolated areas like Turkana, Mandera and the Kenya coast. For instance, 56% of births which occurred at home, majority of the deliveries (63.3%) were recorded from the rural areas and the coast while only 24.5% wherefrom urban areas. On the other hand, out of the deliveries which took place in health facilities, only 34.5% were from rural areas and marginalized coast areas while 74.7% came from urban areas (KDHS, 2008).

Based on the above discussions, it is clear that there is low utilization of maternal healthcare services in rural and marginalized areas like the coast region in Kenya which could be having adverse effect on the maternal mortality rate among these household. Despite the fact that both the national government, county governments, NGOs and the international corporations are struggling to improve the state of MCH services and programmes in the county, major factors have been at play .The factors that have for a long time influenced the extent to which these programmes are implemented include: infrastructural development that cuts across road linkage, power supply, clean/safe water, waste disposal and sanitation, political lineage and governance, corruption and embezzlement of funds, financial resources availability, community perceptions and inclinations among others.

According to the World Bank report of 2013, Kenya is still faced with a number of issues starting from poor governance to lack of prioritizing services for the citizens. Quoted in the report are the health services whereby the national government is said to be allocating a very limited budget to the sector, poor infrastructure development in the sector, corruption, nepotism

and many more that have made the providence and implementation of programmes like the MCH a dream of vision 2030. This study therefore intended to explore the determinants of implementation of maternal-child healthcare projects in Mombasa county-Kenya.

1.3 Purpose of the Study

The purpose of this study was to examine the determinants of implementation of maternal-child health projects in Mombasa County, Kenya.

1.4 Objectives of the Study

This study was guided by the following objectives:

- i. To examine the influence of financial resources on implementation of maternal-child healthcare projects in Mombasa County, Kenya.
- ii. To examine the influence of hospital infrastructure on implementation of maternal-child healthcare projects in Mombasa County, Kenya.
- iii. To investigate the extent to which technology influences the implementation of maternal-child healthcare projects in Mombasa County, Kenya.
- iv. To examine the extent to which socio-cultural factors influence the implementation of maternal-child healthcare projects in Mombasa County, Kenya.

1.5 Research Questions

The study sought to answer the following research questions:

- i. What is the influence of financial resources on the implementation of maternal-child healthcare projects in Mombasa County, Kenya?
- ii. What is the influence of hospital infrastructure on the implementation of maternal-child healthcare projects in Mombasa County, Kenya?
- iii. To what extent does technology influence the implementation of maternal-child healthcare projects in Mombasa County, Kenya?
- iv. To what extent do socio-cultural factors influence the implementation of maternal-child healthcare projects in Mombasa County, Kenya?

1.6 Research Hypothesis

The study was guided by the following alternative hypothesis:

- i. H₁.Financial resources have an influence on the implementation of maternal-child healthcare projects in Mombasa County, Kenya.
- ii. H₁.Hospital infrastructure has a significant influence on the implementation of maternal-child healthcare projects in Mombasa County, Kenya.
- iii. H₁.Technology has a great influence on the implementation of maternal-child healthcare projects in Mombasa County, Kenya.
- iv. H₁.Socio-cultural factors have a significant influence on the implementation of maternal-child healthcare projects in Mombasa County, Kenya.

1.7 Significance of the Study

This research came in easy reach to provide an insight into various factors that are likely to influence the implementation of maternal-child healthcare projects in Kenya. The primary stakeholders, Government and pregnant women may be the main beneficiary of this research since the study is to be carried out in a typical setting where factors highlighted would be most likely to be experienced. This would help understand factors influencing and possible alternatives to the health assistance which would assist the positive outcome in these MCH projects. The government is for example expected to benefit by getting the views from the demand side of MCH services. The county government is expected to benefit by a great deal, especially the Ministry of Health and sanitation. They may get the firsthand information on the factors they need to consider when improving the MCH programmes in the county.

Also, foreign and local investors may inject more help to the sector through the ministry of health after understanding some of the factors like financial resources inaccessibility and the effects this has to the MCH projects implementation. The study may also bring into light the various factors that the investors and the government need to focus on when targeting provision of maternal healthcare services like the role of technology, religion and taboos.

The results of this study would also be invaluable to researchers and scholars, as it would form a basis for further research. The students may use this study to form basis of discussion of maternal-child healthcare projects in developing countries.

1.8 Basic Assumptions of the Research

During the study there was an assumption that all respondents would cooperate in filling the questionnaire and provide accurate and honest answers to provided questions.

Another assumption was that the management would not treat the study suspiciously owing to the fact that Mombasa county health sector had been hit by perennial strikes for a long time due to poor pay to its workers and delayed salaries.

1.9 Limitations of the Study

The challenge of this research was limited access to information sought and inability to get accurate information from the respondents. The respondents were reluctant to provide information due to fear that that information provided may be used against them; owing to the fact that Mombasa health offices have been in trouble for over 2years now with regular strikes and misunderstandings. However, this was overcome by treating the information given as confidential as possible and by not allowing participants to use their names.

The study was limited on time and financial cost required to carry out comprehensive study on implementation of maternal-child healthcare services in Mombasa County. This is due to the fact that such studies requires multidisplinary team approach and take more time and resources. However this was overcome by planning on the efficient utilization of the available resources utilization.

The political heat in the public hospitals in Mombasa and the terrorism activities were a probable risk though the researcher did not fell victim of the actions.

1.10 Delimitations of the Study

Maternal-child healthcare involves a range of services/programmes categorized as contraceptive; abortion, obstetrics care, prenatal care and postnatal care up to age 5years of the child .This study limited itself to MCH projects services implemented in Changamwe and Likoni sub counties in

Mombasa County. The two sub counties are high density low cost residential areas where the populations are highly underserved on healthcare. The research also constrained itself to adult women of reproductive age bracket of 18 to 45 years.

1.11 Definitions of Significant Terms

Health care or Healthcare- Refers to the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions (WHO, 2011).

Hospital Infrastructure - include physical and organizational structures required for effective and efficient operation within the hospital set up. Physical structure include wards, theatre, incubators, beds, equipment and other facilities like toilet , bathroom while organizational structures include body of rules and regulations governing various system e.g. procedure of patient admission and discharge(Wikipedia, 2012) .

Financial Resources-The money available to a business for spending in the form of cash, liquid securities and credit lines. Before going into business/starting a project, an entrepreneur/investor needs to secure sufficient financial resources in order to be able to operate efficiently and sufficiently well to promote success (World Bank, 2010).

Maternal health-is the health of women during pregnancy, childbirth, and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to reduce maternal morbidity and mortality (WHO, 2012). Preconception care can include education, health promotion, screening and other interventions among women of reproductive age to reduce risk factors that might affect future pregnancies. The goal of prenatal care is to detect any potential complications of pregnancy early, to prevent them if possible, and to direct the woman to appropriate specialist medical services as appropriate. Postnatal care issues include recovery from childbirth, concerns about newborn care, nutrition, breastfeeding, and family planning.

1.12 Organization of the Study

This research proposal is organized in three chapters. Chapter one is the introduction which includes the background of the study, statement of the problem, purpose of the study, objectives of the study, research questions, statement of the problem, purpose of the study, objectives of the study, research questions, research hypothesis, significance of the study, delimitations of the study, basic assumptions and the definition of significant terms. Chapter two of the study

consists of the literature review with information from other articles which are relevant to the researcher. Chapter three entails the methodology to be used in the research. Chapter four focuses on how data was analyzed tabulated while chapter five gives a summary of research findings, conclusions and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The reflection and collection of the literature review to this chapter attempts to present a review of various previous studies that have been undertaken in relation to implementation of maternal-child healthcare projects in public hospitals. Various studies on this subject are reviewed herein to provide a broad perspective on how to implement MCH projects in public hospitals in Kenya. A conceptual framework has been generated to show the variables to be considered in the research.

2.2 Financial Resources on Implementation of MCH Projects

Reducing maternal mortality has seen international governments; Japan, china, USA, India, Bangladesh, Brazil etc. Kenyan government and the international agencies promote maternal healthcare projects that aim at giving quality maternal health services to the expectant mothers or the young born babies. Although reducing maternal mortality requires different strategies to promote health of pregnant women, in this study, maternal healthcare will be analyzed by looking at women who have gone to deliver and those seeking post delivery services in the available structured public hospitals. Literature review will focus on implementation of maternal-child healthcare services in public hospitals in various regions.

Studies carried across the world by WHO have shown that the emerging superpowers of the world realized the importance of manpower and high population growth in the production and consumption of their products; a factor that led to these countries' moves of investing heavily in projects that were aimed at taking care of the expectant mothers and the youngborns (WHO, 2012). One of the major cited countries that have been very successful in the past 40 plus years includes Japan, China, India, France, Korea etc. A report published by the World Bank (2010) indicated that Japan for example, after the Hiroshima and Nagasaki bombings, Japan underwent a lot of suffering for the new borns who were always having deformations. Due to the fact that the county wanted to grow economically, it greatly started door to door, locals to locals, regional and international mobilization of finances that were to build modern MCH hospitals and provide expertise MCH services so that their children could survive to the next generation.

In his writing, YlvaKalin (2009) argues that, 'were it Japan was Lesotho of today, it could have not only been deleted from the world map but it could be lacking even the few old people to entomb their fellows'. His argument is based on the role played by financial resources in health provision in either cases of an eventuality or just structured diseases. His research shows that Japan was able to mobilize its own resources, borrow from IMF, World Bank and also access packages of dollars from international bodies like the WHO that made it easier for the country to implement MCH projects that provided quality prenatal and postnatal cares for her population. Among the activities that were significantly carried out 5 years after the twin bombings were: training, hiring and employing expertise in the MCH services providing hospitals, Acquiring high levels of technology to protect and event prevent the mothers and their children from the effects of the nuclear bomb scissions, building of modern laboratories, acquiring of high treatment medicine and many more (World Bank, 2013).

A report by the UNICEF on the efforts made by Fidel Castro in empowering the Cuban people touched on his role in the providence of Medicare to almost 97% of his people by the time he went into a comma leaving leadership to the brother. According to the report, Cuban government invested up to \$100 million in the implementation of the various Medicare projects cited between 2006/2007. Included were 123 projects that aimed at sustaining and taking care of the infants and the pregnant mothers. World Vision writes in this reference and argues that it is only in Cuba whereby almost 90% of all the children survive up to age 10 due to the fact that its MHC programmes have the best funding (UNICEF, 2010). This therefore has implied that Cuba has made great progress in her health systems due to the fact that it realized the role played by financial resources in ensuring the success of the MCH programmes that were rolled out in the early ages.

Developing countries have not been left behind in the 21st century too (WHO, 2014). According to WHO (2014) report, infant mortality rates and the deaths to mothers as a factor has been on the reducing end in the developing countries like Libya, SA, Ghana, India, Brazil, Mexico and many more. The research shows that, in India and Ghana for example, the governments came up with 214 and 97 MCH projects in the years 2009-2014 that were aimed at helping the pregnant mother and the young born. The major constrain to these projects were financial resources that could be used in constructing new MCH clinics/hospitals especially in the slums and rural homes,

finances to get non-counterfeited medicine, finances to train the requires personnel and money to employ the best technology. However, World Health Organization (2015) has reported that most countries in sub-Sahara Africa, Asia and Latin America have been mobilizing their national resources to increase funding for the Medicare sector; a factor for example that reduced the child mortality rates in India and Ghana by 55% between 2005-2014.

Studies across the country have shown that since 2005-2012, the health services especially to the pregnant mothers and the unborn children were on the rise (MOH, 2012), while the figures of the number of women giving birth either in hospitals or health clinics increases tremendously between 2009-2011 (GOK, 2012) and the funding to the health sector increased by three folds in 2008-2010 (GOK, 2012). According to the report on health published by the then Minister of health Hon. Charity Kaloki Ngilu about the state of the Kenyan woman, she argued that the Kenyan woman has been left to just give birth helplessly just like a goat does in the grazing field. This led to the expansion of the services offered to women during and after pregnancy by doubling the national budgetary allocations targeting the health sector (MOH, 2009). Some of the other radical moves that were made by the Hon. Kibaki government in the MCH sector included: scrapping off the maternal bills for mothers, buying and distributing free mosquito nets to the expectant mothers and children under the age of 5yaers, launching several awareness campaigns in the media and many more (Trish 2010).

However, these services couldn't have any impact of the nation and more specifically to the poor woman in the slums or villages without the large sums of money allocated and resourced for by the Hon.Kibaki government. According to (Bosire 2013) service provision /delivery/MCH projects implementation in any country is an immediate output of the input into the health system, such as health workforce, supplies and finances. He continues to argue that in his survey researches done, financial resources is the central input into a project that will give birth to other factors that will uniformly see its success. Increased input especially the finances leads to an increase in other inputs like expertise, technology and therefore it should lead to improved services in the health services deliveries. Ensuring availability and access to health services is one of the main functions of health systems; meaning that implementation of various healthcare programmes in the country is the main function of the health sector. According to Nakamara (2010), Safe Motherhood Initiative is a worldwide effort that aims to reduce the number of

deaths and illnesses associated with pregnancy and childbirth. Nakamara noted that the following projects need more than surplus financing since they are paramount to achieving safe motherhood and they include; deployment/employment of Skilled birth attendance at all births, building of operational laboratories/access to quality emergency obstetrical care and access to quality reproductive health care (through well structured awareness channels like focused groups, mass media, barazas etc.), including family planning and safe post abortion care.

In addition to the above reasoning for financing of MCH projects in the country, Kenya has signed on to several regional mandates regarding reproductive health especially that touching on women and children. Kenya participated in and committed to the 2001 Abuja Declaration, pledging to commit at least 15% of the national budget to health care. Also Kenya signed (but did not ratify) the Maputo Protocol on the Rights of Women of 2003, which recognizes reproductive rights and commits state parties to establishing and strengthening existing pre-natal, delivery, and post-natal health and nutritional services for women(UNICEF, 2012). Successful programme implemented require prudent human capacity management, human resource must be empowered to steer the initiative to succeed. The human resources like the expert doctors, nurses, midwives and other medical systems manager in our country have not only been humiliated for a long time now but have been reduced to mendicants. The doctors, nurses and other health workers who could otherwise be in the fore front of implementing the MCH projects across the country in our public hospitals and clinics have run to the bush or other countries because the Kenyan system has for a long time been allocating little finances to the sector; leaving the human resource poorly paid.

The Kenya Health Sector Strategic and Investment Plan (2012-2018) also estimates that current staff levels meet only 17% of minimum requirements needed for effective operation of the health system while the hired staff to take care of the expectant women measures to only 9.83%, Kenya has only 7 nurses per 4,000 residents, half the number (14 per 4,000) recommended by the World Bank (Bourbonnais, 2013). According to Burns (2000) he asserts that employing qualified person to monitor labour in the health facility has a great impact on reducing maternal motility. In Kenya health workers are unevenly distributed across the country with particular gaps in the North Eastern, Coast region and Northern Rift provinces. Although it's known that attending to a

pregnant mother by a trained person in midwifery skill significantly decreases maternal morbidity and mortality.

Mombasa County has never been spared by the limitations brought about in the MCH programmes due to a shortage of workers or striking workers (WHO, 2014). Pregnant women seeking to deliver in hospitals have long suffered in the hospitals when they are unable to pay mandatory fees and many have been detained for a long period by the hospital administrators due to failure by their relatives to pay their bills or worse still majority of these women live in the urban informal settlement of Kisauni, Likoni, Changamwe and Mombasa's slums. The women have suffered for a long time to go to an extent of bribing the medical attendants so that they can get their times that they have diverted to their private clinics to get an extra coin since the payments in these public hospitals are poor. According to Bosire (2013), devolving healthcare has not only worsened the situation of funding of various medical projects but it has left the doctors and nurses, poor than they could be in any the 21st century. Regular strikes that have been experienced in almost 30 out of the 47 counties in the country recently- with the nurses strikes in Kisumu and Machakos ongoing-have derailed the rates of implementing the MCH projects in the counties. Mombasa has been hit by over 4 giant strikes that have been attached to the fact that the nurses and doctors are not remunerated well; a factor that left about 10 children and 6 women death in Makadara hospital alone last year (UNICEF, 2014).

After the introduction of free maternal healthcare services hospitals have reported increased overcrowding in maternity wards where some mothers are forced to leave the hospital early to make room for others or even deliver on the floor due to lack of beds. Nurses have also reported being overburdened due to the new policy, with nearly all working overtime and as few as three (3) nurses aiding about 20 mothers at a time. (On'gech, 2013). This has for a long time called for investment in constructing new rooms to be used as wards and laboratories and theatres. However, in their research Chuma and J. Maina (2013) argue that the counties have not only failed to implement projects that support the MCH services but have gone from broke to bankrupt of ideas. According to the two, MCH projects need extra wards, theatres and they need more room for emergency cases. All these needs financial investment; the finances that are missing in most county government owing to the fact that almost 85% of the county governments are servicing debts left by the defunct county councils.

According to Kitui County Health Board (2013), the Hon. Malombe's Kitui county, Joho's Mombasa county, Hon. Awiti's Homabay county, Isaac Rutto's Bomet county and many more failed to build the proposed average of 5 zones/wards and 5 clinics/health centres plus implementing the zero rate clinics due to the fact that the central government delayed in releasing the county revenue, failed to raise the county allocation to expected 40% of the national budget and in cases of Mombasa county, the county failed to raise its planned revenue to estimated 9.2 billion due to the security menace and other obstacles. This has left for example troubles in Makadara hospital, Likoni health centre, Kongowea health clinic, Kisauni, Frere and many more seeing the expectant mothers giving birth on the ground and some sharing beds; a factor that has accelerated the spread of communicable diseases like whooping cough. It is estimated that for proper implementation of MCHs in Mombasa County, we need like Ksh. 980 million; a fact that is too far down the dream since the county allocates only 10.1% of its budget into health while that set aside for MCH projects out of the 10.1% is only 3.2% (WHO, UNICEF, UNFPA & World Bank, 2013).

2.3 Hospital Infrastructure on Implementation of Maternal-Child Healthcare Projects

In their research on The challenges of meeting rural Bangladeshi women's needs in delivery Afsana et al (2010) argued that Bangladesh has for a long time wanted to be wealthy just like its neighbors and the only way to wealthy is by improving its infrastructural system. Therefore, Afsan argues that for any project to work, survive and give products, both the soft and hard infrastructure has to be put in place. Actually the major function of money in a project is to acquire either hard or soft infrastructure. According to Ajakaiye et al (2009) infrastructural facilities like maternal wards, delivery wards/theater rooms, electricity, clean piped water and many more makes the health process aimed at sustaining the lives of the unborns and their mothers in Kenya. However, despite the fact that there is variety of literature, our research will limit itself to three infrastructural facilities that determine the implementation of MCH projects in the county and these are: The structures that are the maternal wards, the power that operated the machines, and, the clean sanitized water.

2.3.1 Maternal Wards

Kenyan public health facilities have long suffered from insufficient infrastructure and equipment. Recent survey data found that only 36% of public health facilities offering delivery services had

all the basic delivery room infrastructure and equipment needed with rural areas and lower level facilities particularly ill-equipped to handle deliveries and emergencies associated with giving birth (KNBS and ICF Macro, 2010). A report published by the Kenya National Bureau of Statistics (2009) indicates that the population increase in the country has put pressure on all round available facilities. Among the affected in the report are the schools whereby the beds in public universities like UON, KU, and JKUAT etc. were filled beyond the limits forcing universities to develop new hostels like the Nyayo 5 and 6 in KU, modern hostel in UON campus-underway etc. This trickled down to other areas though the most hit is the health sector. According to Magadi M, Agwanda A, Obare F (2011) the health system in Kenya needs more rooms-more and more hospital wards need to be erected-to accommodate the increasing population. However, a challenge still exists in the construction of wards in new hospitals or the old ones. The Kenya government only allocates <15% of its national budget to the health sector and this worsens when it comes to the programmes targeting the under-fives and the expectant mothers whereby they just receive less than 3% of the national revenue (Magadi M., Madise N .2010)

According to Ochako R. A. (2010), there is a risk of many mothers having their children die of uncontrolled cold that could lead to pneumonia when the mothers lack space in the full hospital wards and opt to give birth in the corridors and the floor. According to Stephenson R. (2011) Kenya's' women giving birth in public hospitals like Makadara, Msambweni, Pumwani and many more have risks of their newborns being fed on by stray dogs when they are unconscious after births. This is because they share unsecure delivery environment where even stray dogs roam. Citing an incidence that was all over the local and international media in 2013-14 whereby a unassisted mother was seen out in the cold in the district hospital while giving birth in Kakamega and the woman whose child was eaten by a stray dogs in Pumwani in Nairobi during the 2013-2014 Pumwani crisis as cases of how the Kenyan government has failed to implement the MCH programmes, he maintains the complete maternal wards are a central factor in ensuring the success of the MCH services.

WHO (2010) carried out a research on the determinants of better health in Africa in the 21st century and argued that countries like Kenya, Tanzania, criteria and Madagascar has only 20% better equipped wards that could handle the sick. However when it comes to the MCH

programmes in Kenya, the report showed that the public hospitals unlike the private counterparts has only 32% of their hospitals being in the position of handling a pregnant woman until her kid grows to age 5 while the privates like Mater Hospital, Nairobi Hospital, Agha Khan etc. had up to 78% better rooms for women deliveries. The absence of delivery wards have led to about 12 deaths per 100 births of infants in Western Kenya(The World Health Report, 2010), 20 deaths in north eastern Kenya, 16 deaths in Kenya's coast, 17 deaths in HIV preference areas while the Nairobi case is reduced to only 9 deaths(EC/UNFPA ,2012).This has been attributed to the fact that up to 67% of the women in Nairobi go to private hospitals for deliveries ;that are equipped with enough maternal wards (Elizabeth, S. 2011).

In order to implement free maternity service/Programme in Mombasa county public hospitals, the government through the ministry of health need to build and /or equip already existing health dispensaries in the county to handle delivery cases(Fourth Annual Progress Report, 2011; 2013), while at the same time put in place proper referral network where patients experiencing complication are transferred to higher level hospitals as a means to handle congestions at a higher level hospital like Kenyatta National hospital and Pumwani Maternity hospital. This should be taken in account owing to the fact the figures have shown the MCH programmes rolled by various sectors for example in Makadara hospital have always succumbed to the tune of 45% due to lack of proper wards (Izugbara, C.; Ngilangwa, D. 2010), some have failed in the local health centres and clinics due to lack of wards that scare away pregnant women (John, F. 2010) or up to 32% of the mothers have opted to give birth at home or private hospitals due to the shying away from the poor conditions in the wards. The GOK (2012) for example collaborated with the UNICEF in 2011 and carried out a research on Why Women Never Delivered in Hospitals, and, found out that up to 56% of the respondents shied away from the public hospitals like Makadara and local health centres like Bombolulu because they could give birth on the cold floor, they could live in harsh wards that are congested and in poor conditions, could get harsh treatment form the nurses, could share beds with people and come back to their homes with skin diseases besides carrying bedbugs home. This for a long time has limited the rate at which MCH projects are implemented in Mombasa County.

2.3.2 Electrical Power Infrastructure

According to Paul, D. (2010), Japan has attained a reduced infant mortality rates for the last half a century effectively because it integrated and improved its power supply systems to almost 97% of its healthcare units. This providence included wind power, solar power, and coal and jatropha biofuels. According to Owino, B. (2011) power supply is a very sensitive determinant of MCH programmes in every country. In his study on the socio-economic factors influencing the implementation of MCH services in Nyakach, Rongo, Kuria and Kisumu, he found out that the power supply added value to the MCH services offered and the innovation attached. In Kuria for example, in 2007-2009, infant mortality rates and the deaths of the mothers were high in Mathare areas, Kubweye, Kegonga and the far Kuria South compared to the areas that were supplied with electricity like Kehancha Town, Isibania and Maberera. The major reasoning behind this is that the power is used to operate machines like scanners, computers and give a longer presence of midwives to take care of the expectant mothers/young borns as compared to areas without power.

According to Ochako, R. (2011), hospitals have been lacking basic mother delivery services like electrical machine including x-rays, scanners, microscopes and many more because they are not well supplied with power sources. In his research, he cited an example of Kiogoro dispensary, Riana, Nyamagundo and Menyinkwa that have for a long time sent their pregnant mother to the far distant Kisii general hospital for checkups including during the emergency situation since they lacked electricity. In Kajiado for example, up to the tune of 14 kids and 6 mothers died in 2009 while giving birth because the generators that were being used broke down (NCAPD and MoH, 2010). according to World Vision and World Bank (2013), up to 156 deaths of young children among the 1000 children born in rural areas in Kenya and the ASALS could be prevented were it that the rural electrification had been done to major health centres and other small clinics in the villages of the marginalized communities. In his studies, Sarah, McTavish (July 2010) argues that the women of the 21st century in the marginalized communities of north eastern, Pokot, Kenyan's far interior coast are dying due to the poor services they meet during emergency cases whereby sometimes power interruptions have no backups; leaving the women in the wards with no help during such situations.

A study by MOH showed that the ministry needed much urgent power backup like generators to take care of emergency cases. In the case of Mombasa county hospital for example, electrical

power supply has only been effective to the tune of 67%, the back-up generator has never been efficient due to the fact it has been breaking from time to time, and the other sources of power like wind or biofuels have not been developed. These power interruptions led to 3 deaths of mothers who were in the ICU during the 2013 doctors' strike and 6 children who were put under incubation. As Creswell, J.W. (2012) argues that power supply especially electricity is a major determinant in provision of health services, the researcher believes that power is the sole driver of machines, innovation and modern technology that is aimed at making it easy in implementing the MCH projects just like any other medical Programme and thus the county government needs to do more than it is doing to accelerate the use of machines like computers, scanners, x-rays and incubators so as to sustain the lives of the unborn/born Kenyans in the county.

2.3.3 Water Infrastructure

Dry pipes for a long time have put off women, children and any sick person from any environment for a long time. Water is life. In India for example, when the country was undergoing the major overhaul in its health sector, piped water was laid to almost 78% of the medical centres while 12% water was from dug wells and boreholes. The reasoning behind this is that, hospitals need to keep the highest hygiene standards as possible and as such, the hospitals had to be connected with sure channels of providing water all round the clock (Letamo G, Rakgoasi S. 2013). According to Amooti-Kaguna B, Nuwaha F. (2011), the implementation of Medicare services in the Jinja area of Uganda has been very possible compared to Northern Karamojong areas due to the fact that in Jinja town, water from river Nile has made the exercise easier than the northern Uganda parts.

A comparative study done between women who give birth at home and those at the hospitals in Rwanda and Kenya's central region had the respondents arguing that in the hospitals the hygiene standards were compromised especially in those hospitals whereby water was missing in the wards and women/kids were forced to share bathrooms, basins, shops, hanging lines and even towels. In Nairobi for example, the Kasarani health Centre has had dry pipes since 2009-2013 and this drove most women to their local mid-wives who were considered to be a bit cleaner than the conditions in the health centre (Kenya Demographic and Health Survey, 2009). In Vihiga for example, the installation of the multi water project that was aimed at supplying various water tanks to the various health centres in the region for rain water harvesting. This for a long time has

limited the implementation of projects that were meant to bring health services to people up to the tune of 46%; majority of them being those projects that targeted women and children under the age of five. This has scared women from going to get services, especially deliveries in these centres because the fear sharing dirty places of sanitation.

According to the Central Bureau of Statistics (CBS) [Kenya] (2013), Kenya is 80% dry land and the available water needs to be used carefully. Citing examples in hospitals in Mombasa, Kwale, Kilifi and Tana delta areas, the report shows that the rates of contamination of the water headed to these hospitals is up to 49.2% and the rates of water borne diseases spread among them expands to 34%.The report showed that in Tana and Kilifi for example, mothers at times were forced to take medicine using contaminated water, that later on gave them water borne diseases like dysentery and diarrheas. This has for example scared up 23% of the women from taking their medication in hospitals (MOH, 2012), 49% of the young kids being forced to take water from the bottles (WASHREB, 2010) and 56% of the attendants to sick women in Mombasa hospitals buying purified/bottled water for their daycare and use (Michael K Mwaniki, 2011); passing another extra cost to the above strained structures. However, much research has never been done on the role of water infrastructure in MCH projects in the Kenyan coast, a factor that the research aims at.

2.4 Role of Technology in Maternal-Child Healthcare Projects Implementation

According to Navaneetham K, Dharmalingam A (2012), technology enhances competitiveness in projects identification, implementation, and completion and also promotes industrial development. Competitive forces drive firms to innovate in order to develop more efficient production processes and adjust their products in response to changing consumer demand. According to The World Health Report (2010), Japan is cited as one of the G10 countries in the world that have made a remarkable positive impact in utilizing the ANC services. The major facilitator cited behind this massive success is the Japan's government idea of introducing modern technology in the hospitals. A study done in various ANC centres in Kham District of Huaphan Province in Japan in 2007 found out that the operation costs had reduced by a half between the years 2005-2007 in the ANC programmes (World Health Organization ,2010; 2013),the number of live births had increased by 55% between 2000-2007 due to the introduction of modern scanning machines that could detect the position of the child in the

mother's womb as early as 2 months (Filippi, Veronique; et al. 28 October 2012) and the number of ANC wards significantly increased from 1540 to 2011 between 2002 and 2007 (Gerald, J. P. 2010).

A comparative study done by Gwamaka, S (2012) on the state of MCH projects implemented between 2007 and 2010 in major hospitals in Japan's provinces, Nigeria's provinces and Kenya's provinces found out that in Ad District of Huaphan Province Japan alone, 800 new MCH wards were erected between 2008-2012, in northern Nigeria only 34 new wards had been built in Borno state while in Kenya only 231 wards had been built in the 7 provinces between 2008-2010. The major reason as to why Japan has implemented 800 modern maternal wards in this short period is due to the fact that the country introduced zero rated modern technology in all of its public sector (hospitals included) thus reducing the operation costs, fastening the rate of projects implantation and giving them a new better look.

In Nigeria for example the level of technology used in building one maternal ward in the Borno has made the process to be too expensive. According to Heston, P. (2012), building one hospital ward in Africa especially in Nigeria, Kenya, Angola and Eritrea is three times expensive that it could be done in China. This for a long time denied Kenya a chance of implementing a number of propose wards across the country to take care of the increasing number of expectant mothers and children. In Bomet County for example, building of maternal wards has been left in the dark for over 20 years now due to the fact that the timber technology used to build structures in the areas makes it very expensive (Rose, N. O. 2009). In their writing, The Millennium Development Goals Report (2013) reports that Kenya has not achieved universal healthcare because the type of technology imported/used makes the whole process become very expensive than it could be if it was in china, Venezuela and Israel.

A report by Marjorie, A. K. (2013) shows that Kakamega Provincial General Hospital, the main referral hospital for Western Province, is implementing one of the most comprehensive and high volume MCH models. For more than a year, the MCH department has been integrating all services under one roof ANC, postnatal care, child welfare services, immunizations, FP, HIV counseling and testing, antiretrovirals (ARVs), early infant diagnosis, TB screening, malaria, cervical cancer and STD screening and treatment (cervical cancer cases are referred for treatment in the hospital). APHIA support enabled the hospital to improve staff training and development

especially related to PMTCT, family planning, cervical cancer, and integrated management of childhood illness (IMCI). However the major challenge reported by the MOH (2014) that is facing the whole process is the fact that the projects are becoming expensive owing to the fact that almost 79% of the materials used for basic projects survival are either imported or are local but very costly.

In her work entitled 'Implementing Free Maternal Health Care in Kenya: Challenges, Strategies, and Recommendations,' Nicole, B. (2013) argued that Mombasa's hospitals are lacking the basic wards and even the basic materials that are required for the mothers to survive and their children. She cited an example where 4 health centres (Khadija, Frere, Kisauni and Likoni) had the building of their proposed wards took more time up to the tune of 3 years more than proposed and that in Kisauni was declared to be substandard. The major challenge that has been accompanying these four projects is the poor technology that resulted from the local companies contracted. In the case of Kisauni for example, extra expenses were incurred in restarting/redoing the work that was seen unfit by the county engineers.

Closely tied to MCH projects in Kenya is the ICT knowledge in medicine. The role of modern operation machines like the 21st century scanners, modern fracture systems that could replace the old methods like light microscopes, modern run computer systems with full diseases-symptoms-prescription and many more have been the drivers of projects in developed countries (Central Bureau of Statistics (CBS) [Kenya], 2013). However, a study done by Fotso JC, Ezeh A, Madise N, Ziraba A, Ogollah R (2010) has shown that up to 87% of midwives in Kenya may not be having any information about the use of modern ICT for health like computers, modern scanning systems and 21st century medicine that needs the involvement of computer programmes in prescription. This has made it difficult for new MCH programmes to be true. The prices of modern technology gadgets have also been found to be too expensive; owing to the fact that Kenya imports up to 95% of its technology (Kenya National Commission on Human Rights, 2012).

In the implementation of modern MCH Programme in Kakamega hospital that was later meant to roll down to all other district hospitals in the county, it was found out that up to 76% of the

workers had very little or no knowledge of how to use modern delivery technologies like the modern machines that could measure the temperatures of the kids, their weight, monitor the progress of the non-full born kids who have been put in the incubators, some had no knowledge of modern medical communications like the use of short phone messages, emails and even some couldn't reply to an emergency message sent via Whatsapp, vibe or hospital Facebook pages Pebley (AR, Goldman N, Rodriguez G. 2012). This has therefore hindered the implementation of such projects in the country up to the tune of 67%.

A study done by WHO, UNICEF, World Bank and UNFPA (2011) shows that Kenya is too far from achieving the MDGs 4 and 5 respectively that speak of maternal health and children mortalities by the set year which is this 2015. The report conducted in the health situation in the then 7 provinces mentioned coast and north eastern as the two major provinces greatly affected by lack of both doctors and medical practitioners that fully understood the role of technology in healthcare provision. In coast alone, 90% of the midwives, nurses and doctors out of the 167 interviewed, admitted that they had little knowledge of modern technology use in their work. In Mombasa hospitals, the figure was a bit fair but the rate of poor knowledge of modern technology that involved modern computer programmes for health, cesarean operators and modern medical administering had 55% of the staff. This means that up to 55% of the MCH projects in the county are at a risk of failing once the element of modern technology is attached to them. In coast general hospital for example, the type of machines used to scan the position of the unborn child, the incubators, the manual medical prescription, the old computers and many more have greatly and comfortably seen up to 13 mothers and 111 children avoid the services at the hospital and opt for private clinics per two weeks (Millennium Development Goal, 2013).

2.5 Socio-Cultural Factors' Role in MCH Projects Implementation

World Health Organization (2010) suggests that women's access to maternal health services is actually limited by constrictions on their independence. Female autonomy can be described as the ability of a woman to make decisions within the household relative to her husband. They claim that men play an important role in determining the health needs of a woman especially in developing countries. The decision to seek care depends on who controls the household resources, a decision which often lies with man and he then decides when and where the woman should seek care. However, the authors to some extent agree that the only place women have

independence on utilization of health services is concerns maternal health services. In their study, they found a positive relationship between female autonomy and service utilization (Creswell, J.W. 2012). However the society has not only limited a woman from accessing MCH programmes in the required manner in Kenya in one way only but it has been a problem that has seen most hospitals meant for women being left dry. In connection to the woman's lack of autonomy in decisions making, is the problem of Domestic violence against women.

Domestic violence against women is a serious and widespread problem in Kenya. Actually it is even worse in Kenya's coast region whereby drug and substance abuse is the song of the day (Hou X, Ma N. 2011). This is mainly due to traditional culture permitting a man to discipline his wife. The majority of the cases remain unreported or at least unpunished. Therefore precise data on the extent of domestic violence in Kenya is difficult to secure, and statistics are available from cases that are reported to authorities. Even then, some of the cases are withdrawn as parties prefer to settle matters out of court using other mechanisms. The several effect of these abuses is that, most women who are beaten in public or abused while pregnant develop a special hatred and shame that makes even some of them miss going to clinic/health centres to take care of their unborn children (Nicole Bourbonnais, 2013).

However, Jaoko conducted a study to explore the correlation between wife abuse in Nairobi (urban area), Maseno (rural area) and Coast (Kilifi and Mombasa). His data indicates that the use of alcohol and drugs by either the participant or her husband and a history of family violence in the husband's family were found to be significantly associated with wife abuse. Additionally, educational levels and the employment status of the participant and her husband were found to be significantly associated with wife abuse. Partner violence in urban settlements is likely to be associated with alcohol and drug use, which are common (Jaoko, 2010). The most affected areas were the slums of Nairobi like Kibera, the slums of Mombasa like Kisumu Ndogo and the rural homes of Kilifi. In Mombasa for example, up to 25 out of 50 women had been abused by their drunken husbands or husbands who were in one way or the other under drugs that are readily available in the Kenya's coastal beaches. The situation was even worse in Kilifi county at areas like Mzongolani where up to 57% of the locals were illiterate and regular beatings/abuses to a woman is the only way of correcting a problem; a factor that left most women never want to go to clinics especially when with wounds of beatings and insults in their hearts.

Work done by NGOs in Kenya especially in relation to urban areas indicate that a larger number of reported cases of intimate partner violence occur in urban informal settlements, characterised by high levels of unemployment, poverty and physical insecurity like Kisauni, Likoni etc. and this trickles down the young children and mothers who from time to time are left in the poor cold with means of attending the Health centres (Oxfam GB, 2009, EDS. 2011). Emily Rico (2010) used DHS data to conduct an analysis of the relationship between intimate partner violence and maternal health, child nutrition and mortality in Kenya, Egypt, Honduras, Rwanda and Malawi and established that intimate partner violence (IPV) plays a role in child malnutrition and mortality, especially for children below two years of age. They found that the strongest relationship between, any 'IPV and the mortality of children under 2 yrs of age was observed in Kenya (adjusted odds ratio (OR) 1.42, 95% CI 1.18 to 1.71). In attempting to explain such findings they suggest that, a plausible explanation could be that the physical or psychological consequences of IPV may impair maternal ability to cater for her unborn child's or infant's nutrition, health and other needs thus influencing their survival negatively.

Another social factor that is closely related to the above is religion. From time to time, religious believes like the Roman Catholic has preached against the use of modern contraceptives and birth control methods (Kenya Demographic and Health Survey, 2009). A study done by Ouma (2010) shows that Kenya's catholic church just like the rest of catholic churches operating in various area of the world has from time to time discouraged mothers from use of maternal health services like free mosquito nets given to pregnant mothers and under five children, the iron enhancing pills and the idea of giving birth through cesarean operation. In Kakamega, Kilifi, Rachuonyo, Kwale and Nandi Hills, the situation was rated to be from bad to worse. In Kwale county for example, women from the Roman catholic church in areas like Kaya Tiwi, Shimba Hills, Kichaka Simba, Lungalunga and Godo had given birth at an interval of 2 kids in 3 years, putting the first child under the risk of malnutrition and survival because the kid is not even given enough time to suckle and enjoy the mother's care and protection to age 5. A major contributor to this was the fact that mothers are discouraged from using modern family planning methods; things considered to be the western way of making Africans look like animals; a contradiction to God's message of giving birth and filling the earth.

Religion has been found to be one of the determinants of maternal utilization. Shariff and Singh (2012) in their study observed that Muslims have low utilization of maternal healthcare services. Religion was also a strong determinant of health facility delivery in their studies in Kenya's Somali community living in Mombasa, North eastern provinces and Western Kenya provinces. Women who believed in traditions and those who reported to be Protestants were less likely to use health facilities for delivery as compared to those from other religious affiliations. Women in polygamous households had reduced odds of health facility delivery as compared to those from non-polygamous households.

Patton (2009) conducted a study to investigate the effect of mother's age on demand for health facility delivery in Botswana. The information was obtained from women aged between 15-49 years, who had been pregnant in the five years prior to the survey. They analyzed data from the 1996 Botswana Family Health survey using simple cross-tabulations and logistic regression. The results showed that, age was a significant factor in determining health facility delivery. They further explained that the teenagers were less likely to deliver at a health facility compared to older women. A similar study was done by UNICEF (2012) in 15 developing countries Kenya included. They analyzed data from the Demographic and Health Survey using a logistic regression. The study examined adolescents' use of delivery care compared with use by older women. The results showed that women aged 18 years or younger were less likely to use delivery care than women aged 19-23 years of the same background characteristics. This factor has for a long time affected the Kenyan coast people of whom see about 78% of their young mothers give birth at home using the traditional caregivers.

Soya Barnett (2013) estimated the demand for maternal health care utilization in several states in India. Using Data from the National Family Health Survey (NFHS 1992-93), they analyzed using a logistic regression model. Results showed there were differences in utilization of maternal health care services among states. Positive significant effects were seen among women in states that had implemented maternal health care programs and those that provided information on importance, availability and accessibility of maternal health care services. The study also revealed that having access to information through modern media could increase women's knowledge about delivery risks and also help them to know the available maternal health care services hence making them demand more of these services.

Ochako et al.; (2011) investigated utilization of maternal health services among young women in Kenya. He analyzed data from KDHS, 2003 using bivariate and multivariate logistic regression models. The significant factors that influenced use of health facility delivery identified in the study were place of residence, household wealth, education, and marital status. Urban young women were more likely to use skilled professional assistance compared to rural young women. He further explained that this may be due to advantages urban women have over their rural counterparts in terms of higher levels of maternal knowledge, better access to health services and health promotion programs, thus leaving out their rural counterparts. Educated young women were also better users of skilled professionals. However, a study done by JAOKO, J. (2010) shows that coast province in Kenya, north eastern and parts of north rift have had little information for the mothers; a factor that has made it had to implement ANC programmes in the region.

Various literatures have brought in rich socio-cultural factors like, Cultural practices of the women. Globally, women are disadvantaged compared to men in not only health issues but many other developmental aspects. Cultural practices are as varied as there are ethnic groups in Africa. Though some cultural practices promote both prenatal and maternal health, many of the practices are exceedingly detrimental and discriminatory against the health of the women (Patton, 2009). Formal education which is one of the proven interventions that contributes to better outcome of maternal health is very low for many African women. Related to this is economic empowerment and ownership of properties which marginalize many women that is also linked with cultural practices (Bosire Boniface, 2013).

Women in north Eastern Province and coast province equally encounter considerable problems that stem from cultural practices which make them more vulnerable than men (Trish, P. May 2010). They have less access to general health care including reproductive health, education - both formal and informal as well proper health information ((NCAPD and MoH, 2010). Essentially, this means few skills, little decision making, translating to less power and no control over income (Owino, B. 2011). Some studies claim the Somali women, Digo women and Swahili women are subordinate to men in virtually all aspect of their life to the extent that the health of the pregnant mother and unborn baby largely depend on the husband (Bousery et al, 2009). All these affect their ability to make prompt decision to access health care including during

emergency. It has been shown in a previous study that the more the women are educated the higher chances of using antenatal care (Sheikh, 2010).

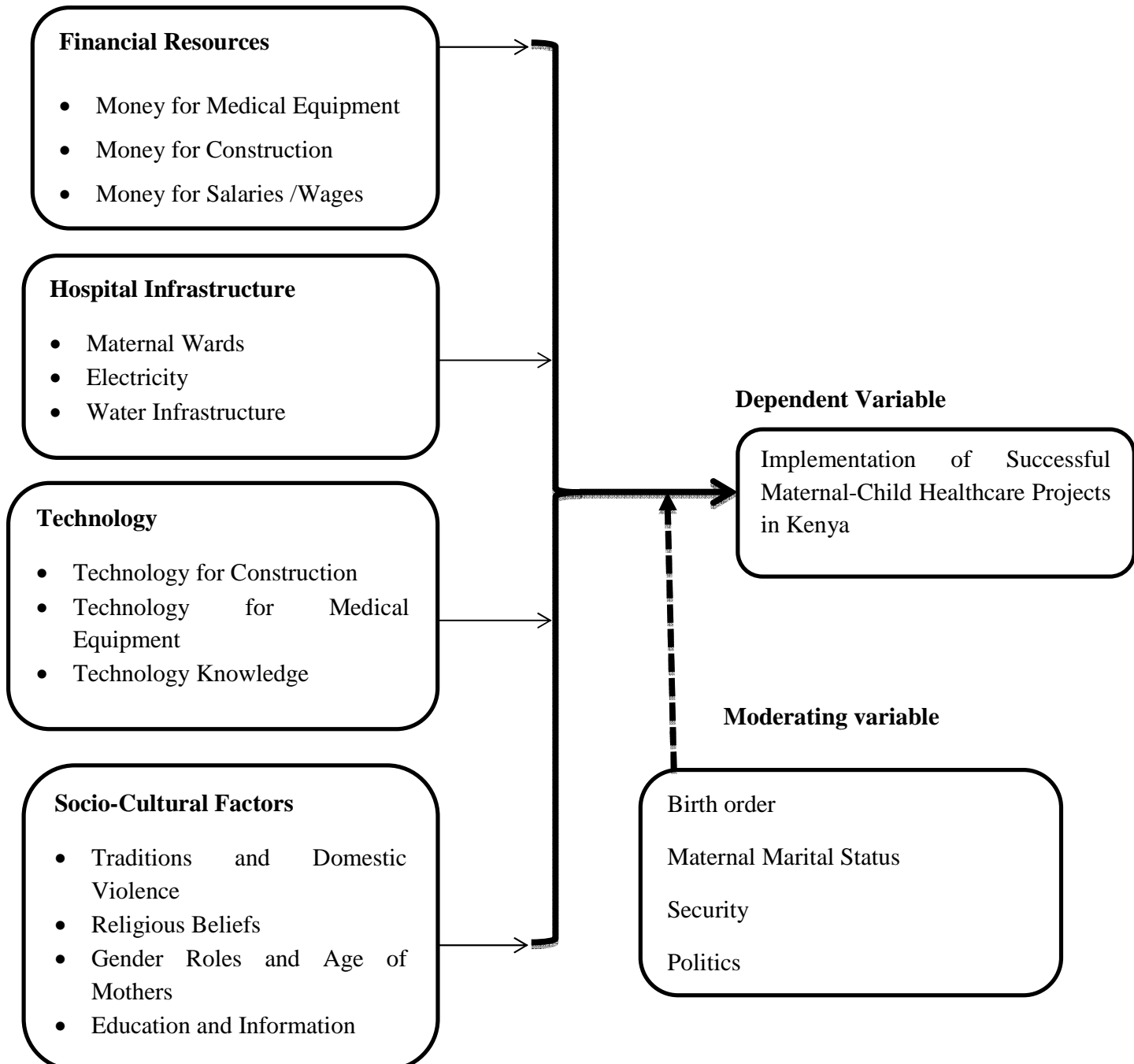
Factors like Influence of Traditional birth attendants have also been cited to a great extent. Many African countries previously encouraged the Traditional Birth Attendant (TBA) to conduct deliveries after undergoing training (WHO, 2013). However, though some success has been reported on reduction of neonatal tetanus through cord care, they have no major impact on reduction of maternal death and therefore cannot replace the midwives (UNICEF, 2012). TBA is embedded in many African culture and cannot be easily wished away especially in the rural set-ups where the practices are popular (Mubyazi et al, 2010).

According to some studies in Mombasa County, most mothers trust the traditional birth attendant over health facilities during deliveries (Boursery et al, 2009). However, there are strong indications that most mothers understood and embraced the importance of antenatal and immunization services (Sheikh, 2010). Some argue that the design of existing lower facilities were not catering for the need of the mothers as maternal services were unavailable because of many factors including the basic in design of health facilities and lack of the necessary equipment (Ganga-Limando et al 2006). Currently, this seems changing as the ministry of health encourages all government health facilities to provide maternity services. Closely tied to this is the problem of the male illiterate husbands who traditionally couldn't stand seeing their women are being assisted by male care nurses/doctors after giving birth. This has been a problem not only among the illiterate majority Mijikenda community in the Kenyan coast but it has extended to some semi-literate individuals who have interacted with the locals for a long time (GOK,2012).

2.6 Conceptual Framework

The conceptual framework outlines the dependent, independent and intervening variables as discussed in the literature review. Elaborations have been done in the Figure 1 below.

Independent variables



In relation to the literature review, the conceptual framework has underlined has underline four major factors influencing the implementation of MCH programmes in the world, country and the

county. The factors have been the centre determinants of whether these MCH projects are going to succeed or fail. They are collectively called independent variables and assisted by a dependent variable that is the Implementation of MCH Projects in the country.

Independent variables include: financial resources, level of technology, hospital infrastructure, and socio-cultural issues that have interacted to influence the projects implementation. Politics, geographical distance, state of security, birth orders and rule among others have been cited as intervening and extraneous variables; whose influence is significant in the projects but they have not been included in the literature.

2.7 Summary of Literature Review

Previous studies indicate that the factors that determine ANC projects implementation include sociocultural factors such as: mother's age at birth, mother's level of education and her partner's level of education and socio-economic factors like finances, technology and infrastructure. Women who believed in traditional practices and those in the protestant religious sect were less likely to utilize health facility delivery (Elo et al.; 1992; Yoshito et al.; 2011 & Fotso et al.; 2008). Economic accessibility was a significant determinant for health facility delivery. The family's level of income was positively related to health facility delivery. Physical accessibility factors that include place of residence would also determine a mother's decision to deliver at a health facility, urban women were observed to demand institution delivery care more than their rural counterparts other factors such as long distance to the health facility and high cost of transport were also negatively related to health facility delivery (Ochako et al.; 2011, Kitui et al.; 2013, & Fotso et al.; 2013).

Structures like wards and theatre rooms have influenced the rate of the projects while finances are central. Also the role of technology has been in the central play ground with up to 55% of projects being pegged to the technology employed (WHO, 2012). This is what the chapter has highlighted in our literature that we seek to find out on the ground. The chapter also highlights the conceptual framework, relationship between variables and research gaps.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the methodology that was used to conduct the study, focusing on research design, target population, sampling procedures and sample size, research instruments, questionnaires, pilot study, reliability, validity, data collection procedure, methods of data analysis, ethical consideration and operationalization of the variables.

3.2 Research Design

The research used a descriptive survey design. The design involved collecting information from the subjects without manipulating the environment. The Office of Human Research Protections (OHRP) in USA defines a descriptive study as “Any study that is not truly experimental.” In human research, a descriptive study can provide information about the naturally occurring health status, behavior, attitudes or other characteristics of a particular group. The descriptive survey design used in this research was cross-sectional study as involved one time interaction with the sample population. The researcher applied a quantitative research that was used to check on the financial investments that were put into the establishment of the MCH projects and to see if there was any profits/success associated with these financial inputs. Descriptive data was collected and categorized in the field survey using questionnaires. The major purpose of descriptive research design is the description of current state of affairs as it exists at present (Kothari, 1999). Conclusions were drawn as the study progressed. The study also reviewed both primary data obtained through questionnaires, individual and key informant interviews and; secondary data referenced from journals, baseline / assessment research and strategy reports by different agencies, text and e-books and other related materials.

3.3 Target Population

The targeted populations in this study were women of reproductive age (15-49 years) in Likoni and Changamwe sub counties plus a number of medical attendants who were involvement with the projects. These were women who had most likely interacted with maternal child health services in the recent past. According to Mombasa county Integrated development plan (CIDP 2013), 28.8% of the total populations are women aged 15 to 49 years. The Kenya Bureau of statistics 2009 census established that the total population for Likoni and Changamwe was 176,426 and 282,279 respectively. This gave the total population in the two sub counties at 458,705. Therefore the two sub counties have 132,106 women of reproductive age with an inclusive of their medical attendants. The study targeted 10% of this women group. The total target population was therefore 13,210 women and medical attendants.

3.4 Sample Size and Sampling Procedure

Estimation of sample size in research using Krejcie and Morgan (1970) is a commonly employed method. The Krejcie and Morgan (1970) sample size formula and table provide guidance on the sample size of study for a quantitative study. A sample population of reproductive women plus the medical attendants who have been handling them was drawn to participate in the research. This from the sampling table as shown by Kerlinger (1986) equated to 375 respondents. The sample population was spread proportionately across Likoni and Changamwe sub counties with 144 and 231 women respectively. For this study purposive and snowball sampling methods were employed. According to Kerlinger (1986) purposive sampling is non-probability sampling method, which is characterized by the use of judgment and a deliberate effort to obtain representative samples by including typical areas or groups in the sample. On the other hand Mugenda and Mugenda (2003) note that purposive sampling allows a researcher to use cases that have the required information with respect to the objectives of the study. Purposive sampling was utilized since respondents must be female and within the target age of 15-49 years.

In snowball sampling desired respondents were identified through purposive sampling and they will be used to name others persons that they may know have the required characteristics. Through snowballing a respondent was optionally requested to nominate another mother living in the vicinity that has interacted with MCH services. This was done due to limited time as it is difficult to identify all the participants as the employees change shifts while others could not

show up for work for a couple of days as they were engaged in other activities outside their work stations or others might have worked long ago and left to other centres. Women also might have moved to various points since the period they visited the ANC units.

3.5 Validity and Reliability

Validity is the degree to which evidence supports inferences based on the data collected using a particular instrument to check whether the information obtained was relevant to the study or not. The prepared questionnaires were piloted on 30 women before full administration to the selected sample. Triangulation on the feedback was also used to validate the instrument structure and content. Desk review to undertake content analysis on the subject was conducted which enhanced validity of the instruments.

Reliability is a measure of the consistence of results or scores obtained. A pilot test was done with the key informants before full administration of the questionnaires. A test-retest method was carried out to determine the reliability of the data collected. Split half method was used to assess the instrument. Ten percent of the research tool was split into two and a test administered to the halves. Spearman's Ranks co-relation method was used to generate a co-efficient. The tool was determined to be reliable since the coefficient of 0.802 was achieved. The coefficient indicated a strong positive co-relation between variables.

3.6 Data Collection Procedure

Data was collected through administration of questionnaires and face to face interviews in some cases for clarity. The questionnaires was administered to the women who have benefited from the MCH services using two trained research assistants and the researcher so as to get a clear picture of the MCH projects in the county. Secondary data was collected from documented records of government, those in the county government ministry, NGOs council and through internet searches. This study was conducted in a period of two weeks.

3.7 Data Analysis and Presentation

The technique that was used for data analysis was quantitative technique. The identified independent variables were analyzed through review of existing documentation, field visits to undertake observation and feedback from population attending the interviews from key informants. This gave a vivid descriptive account of the current MCH projects implementation

situation in Kenya and particularly in the services uptake of MCH projects in Mombasa. Quantitative data was coded and the data was entered in SPSS (version 20.0) for analysis. The results were presented in forms of tables for easy understanding. Qualitative data was analyzed through thematic content analysis technique. Inferences were drawn from the analyzed data. Conclusions were drawn continuously throughout the course of a study. Hypothesis was tested by use of Chi-Square.

3.8 Ethical Considerations

Respective health county authorities were informed prior to the study to avoid suspicions and resistance from the community members and county development project managers. Consent was sought from the respondents whose participation in this study was voluntary. The information they provided was treated with utmost confidentiality. Privacy and dignity of the respondents were considered during the research. Names of the respondents were not being taken but codes were used instead. The respondents were assured that a feedback session was to be organized in order to disseminate the research findings to interested stakeholders.

3.9 Operational Definition of Variables

Research objectives	Type of variable	Indicator	Level of scale	Data collection method	Level of analysis
To examine the influence of financial resources on implementation of maternal-child healthcare projects in Mombasa County, Kenya.	Independent variable: Financial Resources	Money for Medical Equipment Money for Construction Money for Salaries /Wages	Ordinal	Questionnaire	Descriptive: Central tendency
To examine the influence of hospital infrastructure on implementation of maternal-child healthcare projects in Mombasa County, Kenya.	Independent variable: Hospital Infrastructure	Maternal Wards Electricity Water Infrastructure	Ordinal	Questionnaire	Descriptive: Central tendency.

<p>To investigate the extent to which technology influences the implementation of maternal-child healthcare projects in Mombasa County, Kenya.</p>	<p>Independent variable: Technology</p>	<p>Technology for Construction Technology for Medical Equipment Technology Knowledge</p>	<p>Ordinal</p>	<p>Questionnaire.</p>	<p>Descriptive: Central tendency.</p>
<p>To examine the extent to which socio-cultural factors influence the implementation of maternal-child healthcare projects in Mombasa County, Kenya.</p>	<p>Independent variable: Socio-Cultural Factors</p>	<p>Traditions and Domestic Violence Religious Beliefs Gender Roles and Age of Mothers Education and Information</p>	<p>Ordinal</p>	<p>Questionnaire.</p>	<p>Descriptive: Central tendency.</p>

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

This chapter presents analysis and findings of the study as set out in the research methodology. The study findings are presented on to investigate the determinants of implementation of maternal-child health projects in Mombasa County, Kenya. The data was gathered exclusively from the questionnaire as the research instrument. The questionnaire was designed in line with the objectives of the study. Chi-square has been employed in testing the hypothesis.

4.2 Response Rate

Questionnaires were the main instrument of data collection used. They were administered to 375 respondents as guided by the sampling table. Out of the total administered questionnaires, only 155 were returned, well filled and thus were the relevant ones in this study. This made 41.33 % positive return rate while the non-positive return rate was taken by 58.67%.

4.3 Background Information of the Respondents

The study wanted to find out the general information of the respondents and results below reached at as per their gender, age, occupation etc.

4.3.1 Gender of the Respondents in the Study

The study found out the sex composition of the respondents who participated in the research as shown in the table 4.1 below.

Table 4.1 Sex of Respondents as per the Questionnaire

Sex	Frequency	Percentage
Female	120	77.42 %
Male	35	22.58%
Total	155	100%

Female respondents made majority of the respondents at 77.42% while the male respondents who participated in the study made 22.58%.

4.3.2 Age Distribution of Respondents as per the Questionnaire.

From the study, ages of the respondents were as table 4.2 below.

Table 4.2 Age Distribution

Age	Frequency	Percentage
Below 18	20	12.90%
Between 18-35	90	58.06%
Between 36-49	30	19.35%
Over 50	5	9.69%
Total	155	100%

From the responses, the highest number of those who filled the questionnaires was between 18-35 age brackets who made 90 respondents, 20 of the respondents were below 18 years, 30 of them were between 36-49 years while the remaining were over 50 years. This can be attributed to the fact a higher number of women who are their peak reproductive ages are between 18-35 years.

The study sought to establish the level of education of the respondents as tabulated below.

Table 4.3 Academic Qualification of Respondents

Education level	Frequency	Percentage
Primary	30	19.35%
Secondary	60	38.71%
Tertiary	60	38.71%
Never enrolled	05	3.23%
Total	155	100%

Respondents with secondary and tertiary education tied at 38.71%. They were followed by those with primary education at 19.35% and this was finally followed by 3.23% who never enrolled in any of the educational levels who were assisted by research assistants.

The working experience of the respondents was as shown in the table below:

Table 4.4 Working Experience of Respondents

Work experience	Frequency	Percentage
Jobless	75	48.38%
1 to 5 years	30	19.35%
5 to 10 Years	35	22.58%
10 to 15 years	10	6.45%
Over 15 years	5	3.24%
Total	155	100%

48.38% of the respondents were jobless, 1 to 5 years of work experience had 19.35% of the respondents, 5 to 10 years had 22.58% of the respondents, and 10 to 15 years had 6.45% and above 15 years went to respondents who made 3.24%.

4.4 Financial Resources

The research sought to find out the position financial resources hold in the implementation of MCH projects and results as per tables below:

When respondents were asked if they have ever utilized MCH services within their area, the responses below were gotten;

Table 4.5 Showing Access to MCH Services

Type of Response	Frequency	Percentage
YES	111	71.61%
NO	44	28.39%
Total	155	100%

111 respondents said that they have had MCH services being utilized in their area in one way or the other, while the remaining 44 who represented 28.39% said that they have never utilized the services. While defining the type they have attended to, 40 went for Antenatal care, 30 went for prenatal care 35 for Delivery and 6 went for Immunization program.

Respondents gave a yes or no answer to whether they were charged for MCH services as follows;

Table 4.6 Responses on Payments.

Response	Frequency	Percentage
YES	150	96.77%
NO	05	3.23%
Total	155	100%

In the responses gotten, 150 respondents who made 96.77% indicated that they paid for their services while the remaining 5 who made 3.23% went for a no answer.

With giving a reason(s), respondents were asked, ‘Do you think the government at county has provided enough financial resources required to support the MCH programs in Mombasa County?’ Answers were:

Table 4.7 Responses on County Government Allocations

Response	Frequency	Percentage
YES	35	22.58%
NO	100	64.52%
Not sure	20	12.9%
Total	155	100%

64.52% respondents had the idea that the county government is not allocating the required amounts for MCH programs in the county, 22.58% agreed with the idea while the remaining 12.9% were not sure with the idea. When asked to give reasons for yes, out of the 35 respondents, 20 said that compared to previous governments, the county government has allocated funds for MCH and campaigns are on to increase the amount. The remaining 15 said that the county government increased its budget from that of the previous years.

In a scale of 1-5, where: strongly opposing (1) opposing (2) weakly support (3) support (4) Strongly supports (5) and results below arrived at.

Table 4.8 Rating of Financial Resources

Statement	1	2	3	4	5
The government and other stakeholders have provided enough funds for medical equipment acquisition	90	20	20	15	10
There is enough amount of money provided for construction of structures required by the MCHs in Mombasa county	95	25	25	6	4
The workers and contractors are paid sufficient salaries and wages in time.	99	31	23	2	0

From the Responses, 90 respondents were strongly opposing the statement that the government and other stakeholders have provided enough funds for medical equipment acquisition, 20 were opposing, 20 were weakly supporting, 15 supporting while the remaining 10 strongly supported the statement. A statement that read, ‘There is enough amount of money provided for construction of structures required by the MCHs in Mombasa county, attracted 95 respondents who strongly opposed the idea, 25 respondents opposed, 25 weakly supported, 6 supported while the remaining 4 strongly supported. Finally on the statement, the workers and contractors are paid sufficient salaries and wages in time, attracted 99 respondents who strongly opposed the statement, 31 respondents opposed, 32 weakly supported, 2 supported while the remaining 0 strongly supported.

4.5 Item on Hospital Infrastructure

A number of questions were asked in relation to hospital infrastructure and responses below arrived at;

On the question that asked, ‘Where did you delivery your last baby?’, had 79 respondents who said that it was within Mombasa county , 29 went for outside Mombasa while the rest gave no specific place. In relation to the question on how respondents rate the state of all the facilities in the hospital they were admitted or knew that were closest to them, 10 went for very good 19

went for good 19 went for fair ,60 went for poor , while the remaining 47 went for very poor. When asked to give reasons, those with the fair to good caliber has almost all their responses similar by arguing that the hospital beds and the newly renovated hospital wards made their lives better than before. The remaining over 100 respondents argued that the hospitals have poor beds, poor equipment, the latrines are very dirty and many more. Others argued that mothers gave birth on the floor in the health facilities.

When asked to indicate the degree to which they agree or disagree with the following statements where: SA-Strongly agree, A- Agree, U- Uncertain, D-Disagree, SD- strongly disagree , responses were discussed below.

Table 4.9 Likert Scale Rating of Infrastructural Facilities

Statement	SD	D	U	A	SA
The number of maternal wards in the past 5 years have been Increasing and built with the modern MCHSs requirements.	58	59	35	3	0
Modern maternal wards in the past 3 years have been built.	90	40	25	0	0
Modern maternal wards are being well utilized	65	35	30	20	5
The MCH services providing health facilities in Mombasa county are well supplied with power sources	45	55	20	15	20
The MCH services providers in the county are well supplied with flowing clean water	75	55	25	0	0

From the discussion, 58 respondents strongly disagreed with the statement that the number of maternal wards in the past 5 years has been increasing and built with the modern MCHSs requirements, 59 disagreed, 35 were uncertain, 3 agreed while none strongly agreed with the statement. On the statement that read, modern maternal wards in the past 3 years have been built, 90 respondents strongly disagreed, 40 disagreed, and 25 were uncertain, 0 agreed while none strongly agreed with the statement. Modern maternal wards are being well utilized statement attracted 45 respondents who strongly disagreed, 55 who disagreed, 20 who were uncertain,15 agreed wile 20 strongly agreed. The statement that read, the MCH services providing health

facilities in Mombasa County are well supplied with power sources attracted, 45 respondents who strongly disagreed, 55 who disagreed, 20 who were uncertain,15 who agreed, while the remaining 20 strongly agreed. Finally, the last statement read, the MCH services providers in the county are well supplied with flowing clean water, and attracted the following responses. 75 respondents strongly disagreed, 55 disagreed, 25 were uncertain while the rest had no respondents.

4.6 Technology

Here, the respondents were asked questions in relation to technology and respondents had the following.

Respondents were asked to indicate the degree to which they agreed or disagreed with the following statements where: SA-Strongly agree, A- Agree, U- Uncertain, D-Disagree, and SD-strongly disagree.

Table 4.10 Rating of Technology

Statement	SD	D	U	A	SA
MCH services that you have interacted with use technology in service	60	10	40	10	35
Modern technology has a significant influence in the implementation of MCH projects in the county.	12	13	20	10	100
Modern delivery technologies have reduced infant mortality rates	21	12	21	60	41

From the responses as per the first statement that read, MCH services that you have interacted with use technology in service, attracted, 60 who strongly disagreed,10 who disagreed, 40 who were uncertain,10 who agreed while the remaining 35 strongly agreed with the statement. Modern technology has a significant influence in the implementation of MCH projects in the county statement attracted 12 who strongly disagreed, 13 who disagreed, and 20 who were uncertain, 10 who agreed while the remaining 100 strongly agreed with the statement. On the final statement that read, modern delivery technologies have reduced infant mortality rates attracted, 21 respondents who strongly disagreed,12 who disagreed ,21 who were uncertain, 60 who agreed while the remaining 41 strongly agreed with the statement.

4. 7 Item on Socio-Cultural Factors

A number of questions in the questionnaire touched on the role played by item on socio-cultural factors and responses in the tables below were given

Respondents were asked, ‘Do you think that there are cultural factors that influence the implementation of MCH projects in the county? And responses were:

Table 4.11 Responses of Yes or No on Socio-Cultural Factors

Response	Frequency	Percentage
YES	150	96.77%
NO	5	3.23%
Total	155	100%

The table above shows that 96.77% of the respondents feel that social cultural factors have an influence in the implementation of MCH projects while the remaining 5 respondents feel that there is no link. When asked to give reasons, over 78% of the respondents for example argued that their religion doesn’t allow the women private parts to be examined by anyone who is not a close relative of the family. The other remaining said, those times for traditions is long gone.

The respondents were asked to rate on a Likert scale to indicate their position on the factors below appropriately: **1= Strongly Disagree 2= Disagree3= Weakly Agree 4= Agree 5= Strongly Agree.**

Table 4.12 Likert Scale Rating of Socio-Cultural Factors

Statement	1	2	3	4	5
Traditions and domestic violence have a significant influence in women's attending maternal clinics and implementation of MCH in general	4	4	3	99	45
Religious Beliefs have been a hindrance in MCH projects implementation	1	4	6	96	48
Gender Roles of Mothers have been a great impediment towards the implementation of MCH project in the county	5	5	5	70	70
Lack of Education and Information among the women in Mombasa county has made it difficult for them to buy the idea of MCH Programme.	6	0	9	60	80

From the responses traditions and domestic violence, attracted, 4 who strongly disagreed that it influences the rate of women accessing MCH projects, 4 who disagreed, and 3 who were uncertain, 96 who agreed while the remaining 45 strongly agreed with the statement. 1 strongly disagreed with the view that religious beliefs have been a hindrance in MCH projects implementation, 4 disagreed, 6 were uncertain, 96 agreed while the remaining 48 strongly agreed with the statement. As per the third statement on gender roles of mothers, 5 strongly disagreed, 5 disagreed, and 5 were uncertain, 70 agreed while the remaining 70 strongly agreed with the statement. Lack of Education and Information among the women attracted, 6 who strongly disagreed, none disagreed, and 9 were uncertain, 60 agreed while the remaining 80 strongly agreed.

4.8 First Hypothesis Testing Using Chi-Square

H₁: Financial resources have an influence on the implementation of maternal-child healthcare projects in Mombasa County, Kenya.

Table 4.13 Showing Chi-Square Testing for the First Hypothesis

O	E	(O-E)	(O-E) ²	(O-E) ² /E
95	31	64	4096	132.13
25	31	-6	36	1.16
25	31	-6	36	1.16
6	31	-25	625	20.16
4	31	-27	729	23.51
				$\sum (O-E)^2/E = 178.11$

$$\chi^2_C = 178.11 > \chi^2_{0.05} = 9.488 \text{ at 4 degrees of freedom and 5\% level of confidence.}$$

Since the calculated chi-square value of 178.11 is greater than the critical chi-square value at 5% level of confidence, we accept the alternative hypothesis. Thus, financial resources have an influence on the implementation of maternal-child healthcare projects in Mombasa County, Kenya.

4.9 Testing of the Second Hypothesis

H_1 : Hospital infrastructure has a significant influence on the implementation of maternal-child healthcare projects in Mombasa County, Kenya.

Table 4.14 Showing Chi-Square Testing for the Second Hypothesis

O	E	(O-E)	(O-E) ²	(O-E) ² /E
58	31	27	729	23.52
59	31	28	784	25.29
35	31	4	16	0.516
3	31	-28	784	25.29
0	31	-31	961	31.0
				$\sum (O-E)^2/E = 105.16$

$\chi^2_C = 105.16 > \chi^2_{0.05} = 9.488$ at 4 degrees of freedom and 5% level of confidence.

Since the calculated chi-square value of 105.16 is greater than the critical chi-square value at 5% level of confidence, we accept the alternative hypothesis. Thus, Hospital infrastructure has a significant influence on the implementation of maternal-child healthcare projects in Mombasa County, Kenya.

4.10 Testing of Third Hypothesis

H₁. Technology has a great influence on the implementation of maternal-child healthcare projects in Mombasa County, Kenya.

Table 4.15 Showing Chi-Square Testing for the Third Hypothesis

O	E	(O-E)	(O-E) ²	(O-E) ² /E
12	31	-19	361	11.65
13	31	-13	169	5.45
20	31	-11	121	3.9
10	31	-21	441	14.23
100	31	69	4761	153.5
				$\sum (O-E)^2/E = 188.72$

$\chi^2_C = 188.72 > \chi^2_{0.05} = 9.488$ at 4 degrees of freedom and 5% level of confidence.

Since the calculated chi-square value of 188.72 is greater than the critical chi-square value at 5% level of confidence, we accept the alternative hypothesis. Thus, technology has a great influence on the implementation of maternal-child healthcare projects in Mombasa County, Kenya.

4.11 Testing the fourth Hypothesis

H₁, Socio-cultural factors have a significant influence on the implementation of maternal-child healthcare projects in Mombasa County, Kenya.

Table 4.16 Showing Chi-Square Testing for the Fourth Hypothesis

O	E	(O-E)	(O-E) ²	(O-E) ² /E
6	31	-25	625	20.16
0	31	-31	961	31.00
9	31	-22	484	15.61
60	31	29	841	27.13
80	31	49	2401	77.45
				$\sum (O-E)^2/E = 171.53$

$\chi^2_C = 171.53 > \chi^2_{0.05} = 9.488$ at 4 degrees of freedom and 5% level of confidence.

Since the calculated chi-square value of 171.53 is greater than the critical chi-square value at 5% level of confidence, we accept the alternative hypothesis. Thus, Socio-cultural factors have a significant influence on the implementation of maternal-child healthcare projects in Mombasa County, Kenya.

CHAPTER FIVE

SUMMARY OF FINDINGS, DISCUSSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of the study findings, discussions and recommendation of the research. The chapter also contains suggestions of related studies that may be carried out in the future with the aim of enriching the literature and other related areas of interest.

5.2 Summary of Findings

From an analysis and review of the research data and additional data gathered through interviews and questionnaires filled, a number of issues became apparent in relation to this study that aimed at investigating the determinants of implementation of maternal-child health projects in Mombasa County, Kenya.

In relation to the first objective that sought to examine the influence of financial resources on implementation of maternal-child healthcare projects in Mombasa County, 64.52% respondents had the idea that the county government is not allocating the required amounts for MCH programs in the county, 22.58% agreed with the idea while the remaining 12.9% were not sure with the idea. When asked to give reasons for yes, out of the 35 respondents, 20 said that compared to previous governments, the county government has allocated funds for MCH and campaigns are on to increase the amount. Similarly, on a rating in a scale, 90 respondents were strongly opposing the statement that the government and other stakeholders have provided enough funds for medical equipment acquisition, 20 were opposing, 20 were weakly supporting, 15 supporting while the remaining 10 strongly supported the statement. A statement that read, 'There is enough amount of money provided for construction of structures required by the MCHs in Mombasa county, attracted 95 respondents who strongly opposed the idea, 25 respondents opposed, 25 weakly supported, 6 supported while the remaining 4 strongly supported.

In relation to the second objective which sought to examine the influence of hospital infrastructure on implementation of maternal-child healthcare projects in Mombasa County, a number of responses were given as per the questions. In a scale of rating for example, 58 respondents strongly disagreed with the statement that the number of maternal wards in the past

5 years has been increasing and built with the modern MCHSs requirements, 59 disagreed, 35 were uncertain, 3 agreed while none strongly agreed with the statement. On the statement that read, modern maternal wards in the past 3 years have been built, 90 respondents strongly disagreed, 40 disagreed, and 25 were uncertain, 0 agreed while none strongly agreed with the statement. Modern maternal wards are being well utilized statement attracted 45 respondents who strongly disagreed, 55 who disagreed, 20 who were uncertain, 15 agreed while 20 strongly agreed. The statement that read, the MCH services providing health facilities in Mombasa County are well supplied with power sources attracted, 45 respondents who strongly disagreed, 55 who disagreed, 20 who were uncertain, 15 who agreed, while the remaining 20 strongly agreed.

As per the third objective that sought to investigate the extent to which technology influences the implementation of maternal-child healthcare projects in Mombasa County, responses were as shown below. Modern technology has a significant influence in the implementation of MCH projects in the county statement attracted 12 who strongly disagreed, 13 who disagreed, and 20 who were uncertain, 10 who agreed while the remaining 100 strongly agreed with the statement. On the other hand, the responses as per the first statement that read, MCH services that you have interacted with use technology in service, attracted, 60 who strongly disagreed, 10 who disagreed, 40 who were uncertain, 10 who agreed while the remaining 35 strongly agreed with the statement.

On the final objective that sought the extent to which socio-cultural factors influence the implementation of maternal-child healthcare projects in Mombasa County, a number of responses were reached. For example, when the respondents were asked a simple question that read, 'Do you think that there are cultural factors that influence the implementation of MCH projects in the county?' the following was found. 96.77% of the respondents for example felt that social cultural factors have an influence in the implementation of MCH projects while the remaining 5 respondents felt that there is no link. When asked to give reasons, over 78% of the respondents for example argued that their religion doesn't allow the women private parts to be examined by anyone who is not a close relative of the family.

5.3 Discussion of Findings

From the study findings in chapter four, there is a great link and relationship between MCH projects implementation in Mombasa County and the four discussed independent variables as per the objectives.

In relation to the first objective that touched on financial resources for example, the findings indicated that 64.52% respondents for example had the idea that the county government is not allocating the required amounts for MCH programs in the county, 22.58% agreed with the idea while the remaining 12.9% were not sure with the idea. When asked to give reasons for yes, out of the 35 respondents, 20 said that compared to previous governments, the county government has allocated funds for MCH and campaigns are on to increase the amount. When linked to the literature discussed in chapter two, World Health Organization (2015) for example has reported that most countries in sub-Sahara Africa, Asia and Latin America have been mobilizing their national resources to increase funding for the Medicare sector; a factor for example that reduced the child mortality rates in India and Ghana by 55% between 2005-2014. Also, Bosire (2013) argues that devolving healthcare has not only worsened the situation of funding of various medical projects but it has left the doctors and nurses, poor than they could be in any the 21st century. This is a possible problem linked to funding especially from the counties as found in chapter four.

As per the second objective focused on the hospital infrastructure, the following responses were obtained. In a scale of rating for example, 58 respondents strongly disagreed with the statement that the number of maternal wards in the past 5 years has been increasing and built with the modern MCHSs requirements, 59 disagreed, 35 were uncertain, 3 agreed while none strongly agreed with the statement. On the statement that read, modern maternal wards in the past 3 years have been built, 90 respondents strongly disagreed, 40 disagreed, and 25 were uncertain, 0 agreed while none strongly agreed with the statement. From the discussion, Ochako (2010) supports the idea by saying that, there is a risk of many mothers having their children die of uncontrolled cold that could lead to pneumonia when the mothers lack space in the full hospital wards and opt to give birth in the corridors and the floor. Also, according to Stephenson R. (2011) Kenya's' women giving birth in public hospitals like Makadara, Msambweni, Pumwani and many more have risks of their newborns being fed on by stray dogs when they are

unconscious after births. This is because they share unsecure delivery environment where even stray dogs roam. Citing an incidence that was all over the local and international media in 2013-14 whereby a unassisted mother was seen out in the cold in the district hospital while giving birth in Kakamega and the woman whose child was eaten by a stray dogs in Pumwani in Nairobi during the 2013-2014 Pumwani crisis as cases of how the Kenyan government has failed to implement the MCH programmes, he maintains the complete maternal wards are a central factor in ensuring the success of the MCH services.

As per the third objective that focused on role of technology in MCH projects implementation, the following was reached at, modern technology has a significant influence in the implementation of MCH projects in the county statement attracted 12 who strongly disagreed, 13 who disagreed, and 20 who were uncertain, 10 who agreed while the remaining 100 strongly agreed with the statement. This is for example in agreement with literature review. for example, A comparative study done by Gwamaka, S (2012) on the state of MCH projects implemented between 2007 and 2010 in major hospitals in Japan's provinces, Nigeria's provinces and Kenya's provinces found out that in Ad District of Huaphan Province Japan alone, 800 new MCH wards were erected between 2008-2012, in northern Nigeria only 34 new wards had been built in Borno state while in Kenya only 231 wards had been built in the 7 provinces between 2008-2010. The major reason as to why Japan has implemented 800 modern maternal wards in this short period is due to the fact that the country introduced zero rated modern technology in all of its public sector (hospitals included) thus reducing the operation costs, fastening the rate of projects implantation and giving them a new better look. In Nigeria for example the level of technology used in building one maternal ward in the Borno has made the process to be too expensive. According to Heston, P. (2012), building one hospital ward in Africa especially in Nigeria, Kenya, Angola and Eritrea is three times expensive that it could be done in China due to technology issue.

On the final objective that sought the extent to which socio-cultural factors influence the implementation of maternal-child healthcare projects in Mombasa County, a number of responses were reached. For example, when the respondents were asked a simple question that read, 'Do you think that there are cultural factors that influence the implementation of MCH

projects in the county?' the following was found. 96.77% of the respondents for example felt that social cultural factors have an influence in the implementation of MCH projects while the remaining 5 respondents felt that there is no link. This is tied to the issues raised in chapter two. For example, World Health Organization (2010) suggests that women's access to maternal health services is actually limited by constrictions on their independence. Men play an important role in determining the health needs of a woman especially in developing countries. The decision to seek care depends on who controls the household resources, a decision which often lies with man and he then decides when and where the woman should seek care. However, the authors to some extent agree that the only place women have independence on utilization of health services is concerns maternal health services. In their study, they found a positive relationship between female autonomy and service utilization (Creswell, J.W. 2012). However the society has not only limited a woman from accessing MCH programmes in the required manner in Kenya in one way only but it has been a problem that has seen most hospitals meant for women being left dry. In connection to the woman's lack of autonomy in decisions making, is the problem of Domestic violence against women.

5.5 Recommendations

Based on the findings of the study, the researcher recommends, for successful implementation of MCH projects in Mombasa there must be sufficient funding for both infrastructural development and acquisition of MCH experts like medical doctors, specialist in deliveries and many more.

The study also recommends that for proper success of the MCH projects in the country and more specifically in Mombasa County, infrastructure like hospital buildings, beds, equipment, water, electricity and other sanitation infrastructure have to be considered as priority needs.

The management of the hospitals and other bodies handling the MCH need to come up with ways of adopting appropriate technology so as to improve the rate of major projects success and reduction in costs of operation.

Finally, the researcher recommends that the community through their leaders need to educate the women and men on the importance of seeking MCH services in health facilities. This can be coupled with campaigns from the ministry of health at national and county levels. This will finally enrich the people with sufficient knowledge to support the MCH programmes.

5.6 Suggestions for Further Research

MCH programmes and the various projects in it are wide; therefore a future research can be done to re-evaluate the same research done here. Also someone can criticize this study to come up with new ideas.

There is need to carry out a multi disciplinary detailed similar study in the other 4 sub counties of Mombasa County. This will provide a greater insight to guide maternal child health policy development at county and national government levels. This study was delimited to Changamwe and Likoni sub counties of Mombasa.

A study can also be carried out to seek determinants of sustainability of MCH projects in Mombasa County, and other parts of the country.

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APPENDICES

APPENDIX 1:

Letter of transmittal

Charles Nderitu

P.O Box 14628-00400

Nairobi.

Tel: 0720732075

Email: Charles.nderituw@gmail.com

Dear participant,

My name is Charles Nderitu and I am a student undertaking a Master of Arts Degree in Project Planning and Management at the University of Nairobi, Mombasa Campus. To fulfill the completion of this course, I am carrying out a study on the determinants of successful maternal child healthcare projects implementation in Mombasa County, Kenya. Since the matter affects the whole community, I am inviting you to participate in this research study by completing the attached questionnaire.

If you choose to participate in this research, please answer all questions as honestly as possible. Participation is strictly voluntary and you may decline to participate at any time. In order to ensure that all the information will remain confidential, you do not have to include your name. The data collected will be for academic purposes only.

Thank you.

Yours,

Charles Nderitu

APPENDIX 2:

Research Questionnaire

A. Bio-Data (Tick where appropriate (√))

1. Your gender

() Male () Female

2. Your age (in years)

Below 18 () Between 18-35 (), Between 36-49 (), Over 50 ()

3. Level of education

Primary () Secondary () tertiary () Never enrolled ()

4. Work experience.

Jobless () 1 to 5 years () 5 to 10 Years () 10 to 15 years () Over 15 years ()

SECTION B: Item on Financial Resources

5. a) Have you ever utilized MCH services within your area?

Yes () No () if No proceed to question 6.

b) If yes, which services?

Antenatal care () Prenatal care () Delivery () Immunization program ()

Others (specify) _____

c) Did you pay for the services?

Yes () No ()

6. a) Do you think the government at county has provided enough financial resources required to support the MCH programs in Mombasa County?

Yes () No () Not sure ()

b) If yes, briefly explain how? _____

7. In a scale of 1-5 , where: strongly opposing (1) opposing support (2) weakly support (3) (4) Strongly support (5), rate your support in relation to the following

statements in relation to the finances and MCH projects implementation in Mombasa county.

Factor	1	2	3	4	5
The government and other stakeholders have provided enough funds for medical equipment acquisition					
There is enough amount of money provided for construction of structures required by the MCHs in Mombasa county					
The workers and contractors are paid sufficient salaries and wages in time.					

SECTION C: Item on Hospital Infrastructure

8. a) Where did you delivery your last baby?

Within Mombasa county () Outside Mombasa ()

b) How do you rate the state of all the facilities in the hospital you were admitted or you know that is closest to you.

Very good () Good () Fair () Poor () Very poor ()

c) In relation to the answer you have given above, try to explain the state of this infrastructure

d) Indicate the degree to which you agree or disagree with the following statements.

SA-Strongly agree, A- Agree, U- Uncertain, D-Disagree, SD- strongly disagree

Factor	SA	A	U	D	SD
The number of maternal wards in the past 5 years have been increasing and built with the modern MCHSs requirements.					
Modern maternal wards in the past 3 years have been built.					
Modern maternal wards are being well utilized					
The MCH services providing health facilities in Mombasa county are well supplied with power sources					
The MCH services providers in the county are well supplied with flowing clean water					

SECTION D: Item on Technology

9. Indicate the degree to which you agree or disagree with the following statements where:

SA-Strongly agree, A- Agree, U- Uncertain, D-Disagree, and SD- strongly disagree.

Statement	SD	D	U	A	SA
MCH services that you have interacted with use technology in service					
Modern technology has a significant influence in the implementation of MCH projects in the county.					
Modern delivery technologies has reduces infant mortality rates					

SECTION E: Item on Socio-Cultural Factors

e) a) Do you think that there are cultural factors that influence the implementation of MCH projects in the county? Yes() No()

b) Support your answers

f) Indicate your position on the factors below appropriately: **1= Strongly Disagree 2= Disagree 3= Weakly Agree 4= Agree 5= Strongly Agree**

Factor	1	2	3	4	5
Traditions and domestic violence have a significant influence in women’s attending maternal clinics and implementation of MCH in general					
Religious Beliefs have been a hindrance in MCH projects implementation					
Gender Roles of Mothers have been a great impediment towards the implementation of MCH project in the county					
Lack of Education and Information among the women in Mombasa county has made it difficult for them to buy the idea of MCH Programme.					

g) Give brief explanations that could be considered to be the strongest points from the socio-cultural perspective that have hinders the implementation of the MCH projects in Mombasa county

APPENDIX 3:

Budget

Item	Description	Frequency	Cost	Total
Personnel	Research assistant	3	10,000	30000
Travel	Field travel hire	10	1000	10000
Computer services	Typesetting, printing and binding	1	25,000	15000
Equipments	Laptop	1	30000	30000
	Modem	1	1500	1500
	Calculator	1	1000	1000
Communication	Telephone	5	1000	5000
	Internet	10	500	5000
Grand Total				97500

APPENDIX 4:

Work plan

Research Action	2014		2015						
	Nov	Dec	Jan	Feb	March	April	May	June	July
Student Research seminar/allocation of supervisors	■								
Choosing/approval of topic and title	■								
Development of proposal		■	■	■					
Proposal defense					■				
Proposal corrections						■			
Pilot test						■			
Data collection							■		
Data entry and analysis							■		
Project report writing								■	
Presentation of final project (2 nd defense)									■
Corrections of final report									■
Filing of final report									■