RAPID SITUATION ANALYSIS ON EXPERIENCES OF WOMEN IN MATERNAL HEALTHCARE IN KOROGOCHO AND KAWANGWARE INFORMAL SETTLEMENT AREAS.

(2022)

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1.0 BACKGROUND

Healthcare became the center of discussion when the world woke up to the terrifying acceptance of covid-19. Health status was worsened due to the containment measures put in place. Health dynamics were different between countries so, were the reactions. The projection was that the virus era would not take long. But, when the worse happened, social shocks were inevitable.

Interesting the number of hours increased for women in providing unpaid care work (UNWOMEN, 2019). This was attributed to the closure of schools, working from home, and, containment measures directives by the government. It was also noted that the pandemic received a fair share of attention and financial investment as compared to other health concerns. The priority at that time was to contain the situation as opposed to placing measures on the secondary effects of the virus.

A notable effect was the abrupt but, forceful embracement of Information Communication Technology by everyone. As the infection numbers rose, people were forced to work from home. Despite the unknown future of work due to virtual connectivity, things had to happen. Workstations transitioned to online that, which made appreciation that physical interactions cannot be the only way of working.

On the other hand, political processes were still ongoing. It was at this time when, Kenya was at the peak of the constitutional amendment, political realignments in readiness for the general elections, and, development planning processes. It was noted that covid-19 did not halt any of the aforesaid processes from happening. Budget meetings happened that, informed the resource allocations without citizenry participation. This was justified by the gathering restrictions and, poor virtual engagement by the citizens in governance processes. Therefore, this situation facilitated unaccountable decisions made by those engaged on behalf of the huge population represented.

The population that was hard hit was women. With overstretched healthcare services, maternal healthcare bared the brunt. There were increased birth rates attributed to increased hours couples had to spend together; Stretched health services, especially in informal settlement areas as the virus came along with other anticipated illnesses and a low level of participation in informing maternal healthcare services.

1.1 INTRODUCTION

In the quest to strengthen maternal healthcare that will result in reduced mortality rates and healthy deliveries, Kenya abolished delivery fees in all public health facilities. This was through a

presidential directive effective on June 1, 2013, which, made this service to be accessed at zero cost by all expectant mothers. In 2014, the Office of the First lady Mama Margret Kenyatta initiated the beyond zero campaign[1] that aimed at reducing the proximity of mothers in accessing maternal care. In 2020, this was further cascaded to the primary healthcare facilities where Nairobi City County saw the construction of 24 level 2 and 3 facilities. These were spread out to the informal settlement areas that were envisioned to improve healthcare including maternal care.

In 2020, the government disbursed a cumulative sum of Ksh.11,651,431,063 (Ps Health, Susan M, 2020) as a means of enabling quality maternal and neonatal health services for mothers. County governments have also customized such policies as Linda Mama that ensure expectant mothers in this journey of motherhood. Ottichilo[2] and Oparanya care[3] program are case studies of such initiatives at the county levels, and they have been attributed to the reduction in mortality rates and stillbirths' occurrences. Nonetheless, there is still a need to address other factors[4] that contribute to pregnancy besides neonatal and actual delivery.

However, with all these initiatives the place of accountability in attaining Sexual Reproductive Health rights remains to be the main concern. These concerns are embedded in three key rights that, women face challenges while accessing:

1. The Right to Health, including Sexual and Reproductive Health
2. The Right to Decide the Number and Spacing of Children
3. The Right to Access Sexual and Reproductive Health Education and Family Planning Information

Health data is changing and, the urgency in incorporating ICT to inform improved service delivery is now a demand. ICT facilitates real-time raw data with a minimal margin of error. It can also be accessed and verified. Thus, making it reliable to inform decisions.

1.1.1 Problem statement

By many estimates, Kenya has a relatively high mobile phone and internet penetration rate. The number of active mobile subscriptions in the country is 49.5 million, and there are an estimated 43.45 million internet/data subscriptions. However, with many Kenyans holding multiple sim cards, the true internet penetration rate is difficult to measure, with some estimates placing it

[1] https://www.beyondzero.or.ke/

[2] https://www.development.vihiga.go.ke/event/launching-ottichilo-care-maternal-healthcare/

[3] https://oparanyacare.com/

[4] Lang'at, E., Mwanri, L. & Temmerman, M. Effects of implementing free maternity service policy in Kenya: an interrupted time series analysis. *BMC Health Serv Res* **19,** 645 (2019). https://doi.org/10.1186/s12913-019-4462-x

as low as 23% (World Bank, 2019). Therefore, this implies that accountability can still be conducted through phones as a way of civic engagement in advancing their entitlements.

Infrastructural inequalities and a lower purchasing power of citizens in informal settlements limit these citizens' access to smartphones and the internet. This means they lack access to crucial mobile and internet-based tools and resources for civic engagement, political empowerment, and self-advancement, such as the Kenya Public Procurement Information portal and the various government and public agency websites and tools. With the increased birth rates, there is a need for citizens to find alternative ways to hold the duty bearers to account for improved service delivery.

1.1.2 Research objectives

1. Greater civic participation and public oversight of critical public services serving vulnerable populations in the pandemic era, e.g., healthcare.
2. Improvements in access, performance, and transparency of public services serving vulnerable populations
3. Creation of accessible and reliable public datasets on critical public services for use by community advocates, Government, development agents, and the media.

1.3 Justification

The government has made huge and significant milestones toward the provision of affordable maternity services. The introduction of a free maternity program dubbed Linda mama in all public health facilities has greatly increased the number of expectant mothers seeking maternity and neonatal care. However, there is a need to fast-track what the experiences of women have been like. To understand the time, it takes to receive maternity services in informal settlement areas of Nairobi, a survey was conducted in Kawangware and Korogocho.

1.3.1. Significance of the rapid situation analysis

The findings will enable marginalized communities to provide critical oversight and feedback on maternal services to duty bearers. In so doing we seek to foster greater civic engagement, public accountability, and data-driven governance, and reduce digital inequality in public participation.

1.3.2 Methodology

Twenty research assistants were trained on research ethics and the administration of the USSD.

1.3.3 Scope and target

A total of 683 respondents were reached where 384 and 299 respondents for Kawangware and Korogocho respectively. 56% of the respondents at the time of the interview were either pregnant or mothers. Therefore, the majority of the targeted audience qualified for the study.

2.0 FINDINGS

2.1. Location

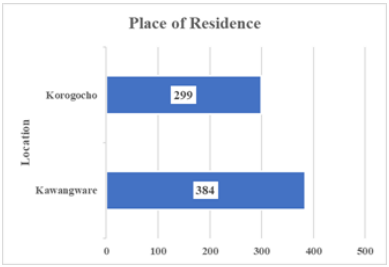


Figure 1: Representation of the location

Out of the 683, 384 were from Kawangware while, 299 from Korogocho. Women from Kawangware were more willing to take part in the survey compared to Korogocho. This alluded to the 'incentives' after participation. Upon the knowledge of being a voluntary exercise, they opted not to participate in the processes.

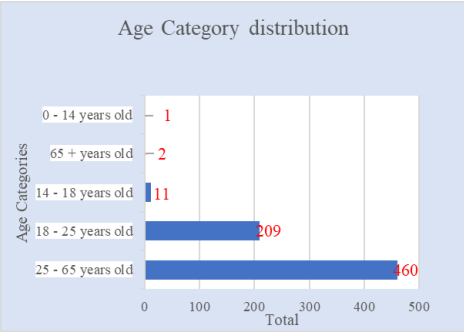
2.2 Age group category

The respondents were categorized into 5 age groups as shown in figure 7. 460 respondents in the 25 to 65 age categories participated in the study representing 67% of the respondents. Those between 18 to 25 years were 209 representing 33%.

		The attitude of the staff in your closest maternity ward facility was positive and supportive		
		No	Yes	Total
Age Category	0 - 14 years old	1	0	1
	14 - 18 years old	6	5	11
	18 - 25 years old	77	132	209
	25 - 65 years old	204	256	460
	65 + years old	1	1	2
Total		289	394	684

Figure 2: Data on age categories

The target age bracket was between 14 – 65 years. Out of the 683 respondents, 460 (25 – 65 years), 209 (18 -25 years), 11 (14 – 18 years), 2 above 65 years, and 1 (14 years). The interview



was conducted in the presence of a guardian for respondents between 14 – 17 years. Therefore, maternal healthcare is common above18 years.

Figure 3: Graphic representation of the age categories

2.3 Are you pregnant or a mother?

In terms of maternal status, 383 were pregnant at the time of the data collection while 300 indicated not to be pregnant at that time. This can be reflected as a true indicator as per the Nairobi City County Fiscal Strategy Paper (CFSP) FY/2022/2023, indicating an increase in birth rates in the last financial year.

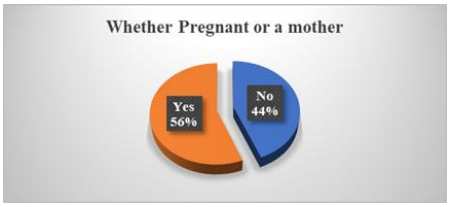


Figure 4:Data representation on maternal status

2.4 Are you a member of the Linda Mama programme?

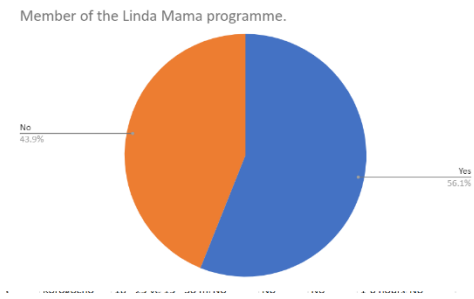


Figure 5: Linda Mama membership

383 of the 683 respondents indicated to have been or are current members of the Linda Mama program while 300 indicated not to have been members of the program. This implies that women are more familiar with the program and, others mentioned to have supported the enrollment of their friends while pregnant. The encouragement to join is the zero cost of the maternal period in any public health facility. However, the majority mentioned having delivered at Kenyatta National Hospital, Mbagathi level 5 hospital, and Mama Lucy hospital despite having level three hospitals (Korogocho and Riruta health centers) within their localities.

2.5 Have you ever experienced maternity complications due to not receiving maternity care on time?

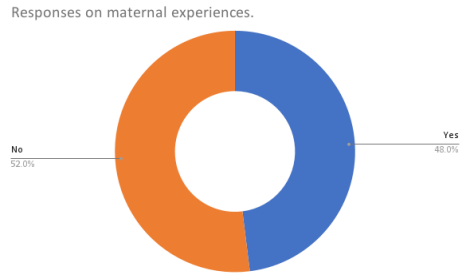


Figure 6: Experience complications due to not receiving maternity care on time

48% of the respondents mentioned having experienced complications while seeking maternal care due to a long time taken before they were attended to. Some of the complications mentioned include and are not limited to:

Delayed measuring of the baby's pathway resulting in abrupt deliveries; Absence of diet advice hence, affecting the wellbeing of the mother and the child; and delayed referrals systems that leaves the mother at risk of giving birth while on the road.

This delay is attributed to women who preferred level 4, 5 and Tertiary as opposed to close level 3s. Due to increased number of patients seeking the services, these facilities face a scale-up of ratio between service providers and patients.

The 52% indicated not to have experienced any complications due to settling in higher levels hospitals. Some respondents from Korogocho mentioned delivery to a midwife had reduced their chances of any maternal complications.

2.6 Does your closest maternity ward or dispensary facility have all the medicines you have been prescribed?

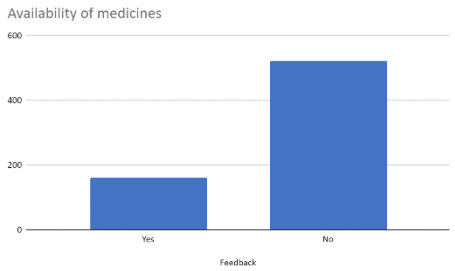
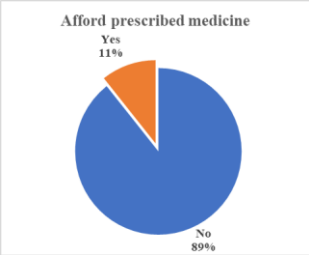


Figure 7: Representation on accessibility of prescribed medicines

Korogocho hosts Ngomongo level 2 and Korogocho level 3 hospitals. These serve an estimated over 100,000 households. Kawangware on the other hand hosts Gatina level 2 and Riruta health center respectively. Being densely populated areas, the four facilities are currently overstretched in providing healthcare services as well as keeping up with the growing pharmaceutical demand. Thus, they fail to have surplus as well as, meet all prescriptions.

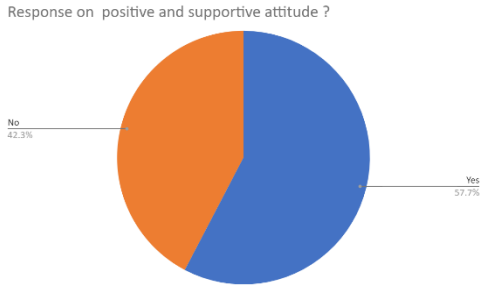
2.7 Are you able to afford all the medicines you have been prescribed?



89% of 683 indicated not to be in a position to purchase prescribed medicines while 11% indicated to be in a position to afford them. Some of the prescriptions are costly for the grassroots women to afford.

Figure 8: Affordability of prescribed medicines

2.8 Is the attitude of the staff in your closest maternity ward facility positive and supportive?



57.7% of the respondents indicated to have been handled by supportive medical personnel while seeking maternal services while 42.3% faced negative and unsupportive medical personnel. Women between 18 – 25 years indicated to have faced negativity and unsupportive staffs as young mothers.

Figure 9:Comparrison on positive and negative attitude

3.0 CROSS TABULATION ANALYSIS

3.1 Years and Time (G and H)

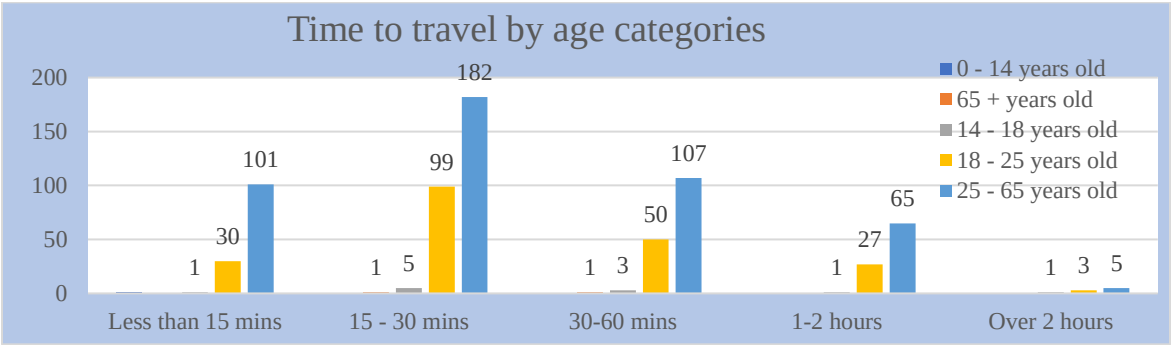
Cross-tabulation of time it takes to travel from the place of residence to the nearest public maternity facility for different age groups. From the table and figures below, it is clearly shown that majority of those who sought maternity services traveled within 1 hour from their place of residence to the nearest health facility. 287 claimed to have taken between 15 to 30 minutes to the nearest health facility. Cumulatively, 581 took less than 1 hour to reach the health facility. 390 of the respondents between 25 and 65 years said it took them less than 1 hour to get to the facility. Out of this majority (182) indicated they spend between 15 to 30 minutes to get to the health facility.

Table 1. Cross Tabulation of Age categories and Time it takes to travel to the nearest public maternal ward from your residence.

	The time it takes you to travel from your home to the nearest public maternity ward	Total

		1-2 hours	15 - 30 mins	30-60 mins	Less than 15 mins	Over 2 hours	
Age Category in years	0 - 14 years old	0	0	0	1	0	1
	14 - 18 years old	1	5	3	1	1	11
	18 - 25 years old	27	99	50	30	3	209
	25 - 65 years old	65	182	107	101	5	460
	65 + years old	0	1	1	0	0	2
Total		93	287	161	133	9	684

Figure 1. Graphical representation of age category against time to travel to the nearest public maternity ward



Conclusion: Women in both zones spend time while seeking maternal healthcare which, has contributed to the previous complications experienced.

3.3 Years and complications (G and I)

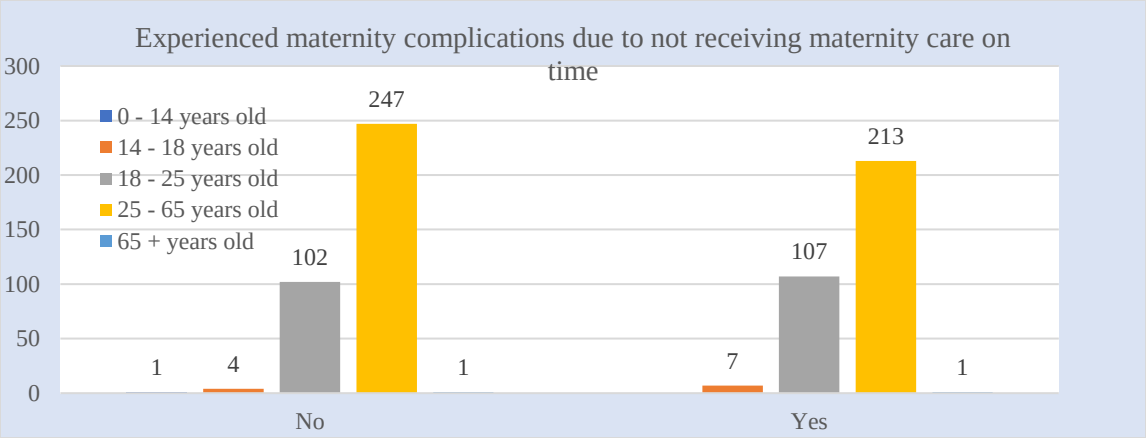
The study sought to understand whether maternity complications are caused by receiving the care late. A 52% (355/684) claimed they have never experienced complications due to delay in receiving the maternal service. The majority of these were found in the age category of 25 to 65 years. The rest (48%), agreed that they suffered complications due to delay in receiving maternal care as reflected in the age group of 25 to 65 years.

Table 2 Cross-tabulation of age category and Experienced maternity complications

	Experienced maternity complications due to not receiving maternity care on time		Total
	No	Yes	

Age Category	0 - 14 years old	1	0	1
	14 - 18 years old	4	7	11
	18 - 25 years old	102	107	209
	25 - 65 years old	247	213	460
	65 + years old	1	1	2
Total		355	328	684

Figure 2: Experience complications due to not receiving maternity care on time



3.4 Age and Medicine affordability (G and K)

A huge (89%) percentage of the women maintained that the medicine prescribed to them was not affordable. This is a big implication.

Table 3 Cross-tabulation of Age category and ability to afford all the medicines prescribed

		Ability to afford all the medicines prescribed		Total
		No	Yes	
Age Category	0 - 14 years old	1	0	1
	14 - 18 years old	10	1	11
	18 - 25 years old	182	27	209
	25 - 65 years old	416	44	460
	65 + years old	1	1	2
Total		610	73	684

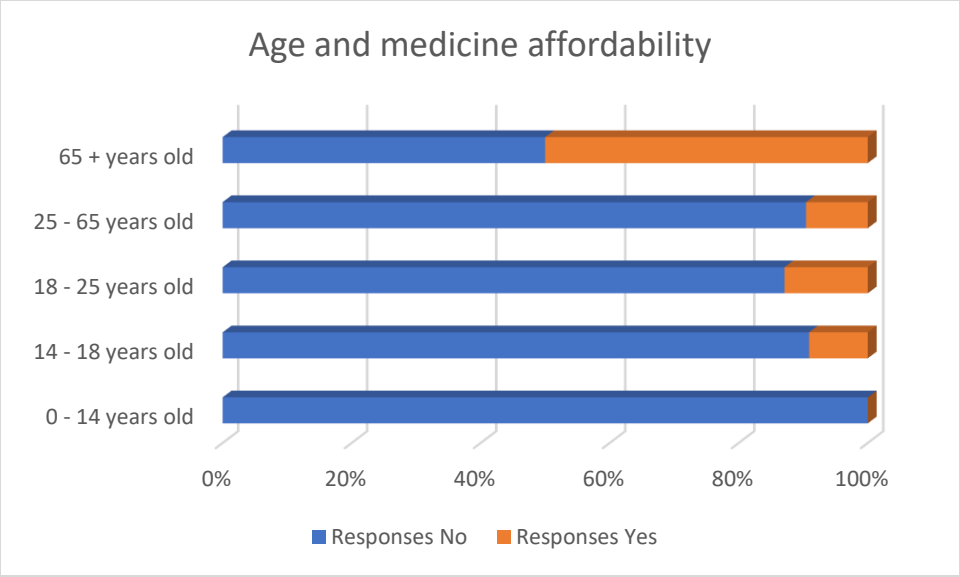


Figure 3: Comparison on the age categories and affordability of medicine

Conclusion: Women of all ages categories are not in position to afford prescriptions

3.5 Age and proximity (G and L)

An average waiting time for the respondent who sought maternal care at a health facility near them is the time between 1 - 6 hours. A sizeable percentage was reported by those between 25 to 65 years of age. The delay has not been experienced by a big percentage also (186 out of 684). A good number (159) also received a delay of less than one hour. This is shown in table 4 and figure 5 below.

Table 4 Cross-tabulation of Age Category by Experienced delays in accessing maternity care from your closest maternity ward facility

		Experienced delays in accessing maternity care from your closest maternity ward facility						
		1-6 hours	12 - 24 hours	6-12 hours	Less than an hour	No	Over a day	Total
Age Category	0 - 14 years old	0	0	0	1	0	0	1
	14 - 18 years old	3	1	0	4	3	0	11
	18 - 25 years old	86	3	8	45	67	0	209

	25 - 65 years old	206	8	21	109	115	1	460
	65 + years old	1	0	0	0	1	0	2
Total		296	12	29	159	186	1	684

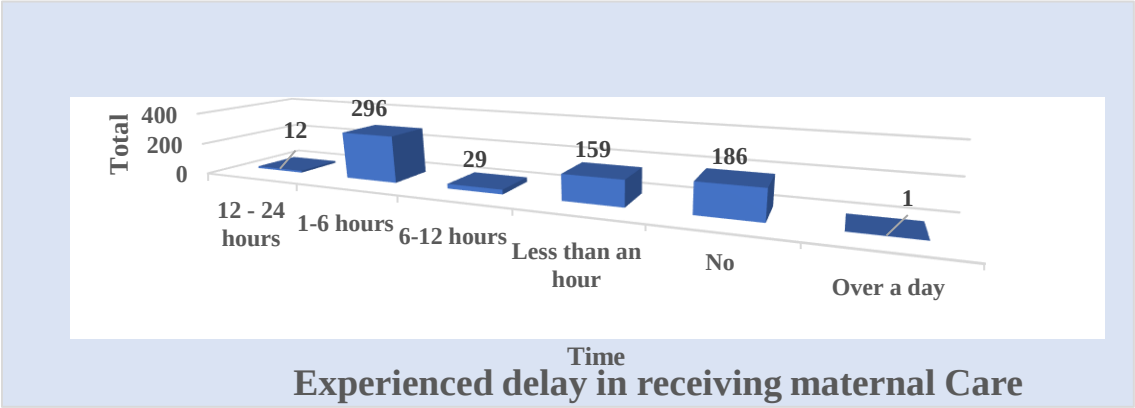


Figure 4: Comparison on time delay experiences on age categories

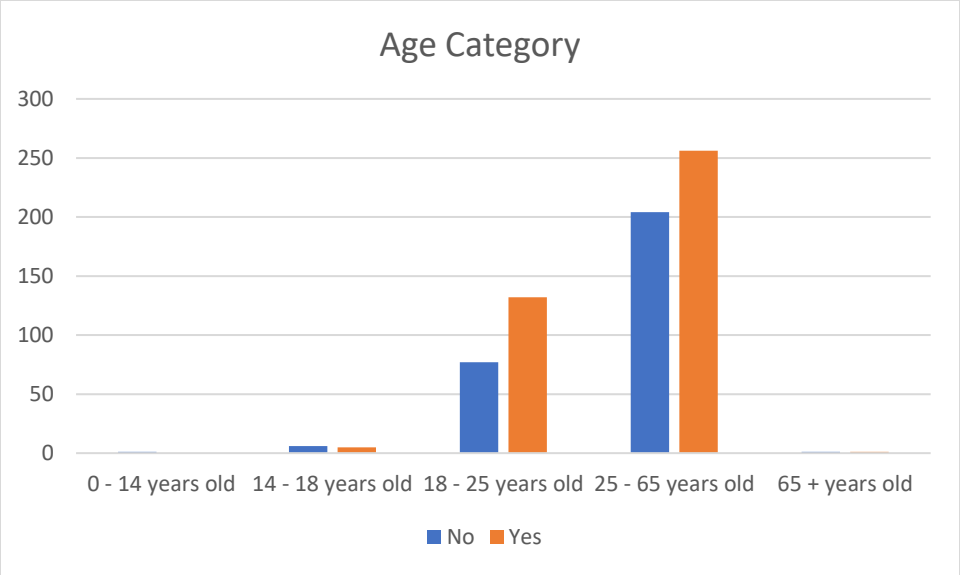
Conclusion: Women between 25-65 spend more hours dur to maternal hospital preferences compared to the other categories.

3.7 Age and attitude (G and M)

The study shows that 58% of the respondents across all the age groups were serviced by positive and support staff at the maternity ward. However, 42% disagreed and claimed that the staff they met were unsupportive and negative across the age groups. The 65% of the total respondents who claimed they were served by positive and supportive staff belonged to the 25 to 65 years age group.

		The attitude of the staff in your closest maternity ward facility was positive and supportive		
		No	Yes	Total
Age Category	0 - 14 years old	1	0	1
	14 - 18 years old	6	5	11
	18 - 25 years old	77	132	209
	25 - 65 years old	204	256	460
	65 + years old	1	1	2
Total		289	394	684

Table 6 Cross-Tabulation of Age category by the attitude of staff at the closest maternity ward facility



4.0 Identified maternal gaps

- Women in Korogocho prefer delivering by the help of a known mid-wife
- There is preference of other level 4 and 5 yet, there is existing level 3 hospitals
- Medicines prescribed are expensive to be purchased by the patients
- Absence of clear maternal referrals that has facilitated women to experience complications such as over bleeding
- Absence of comprehensive maternal services such as nutrition and physical wellbeing services
- Confusion between maternal services offered by Linda mama and National Hospital Insurance Fund covers
- Young mothers of below 18 years' experience negative treatment by the medical staff
- Lack of drugs plus poor personnel ethics in the facilities, this discouraged some pregnant mothers from attending clinics while some, started late .

5.0 RECOMMENDATIONS

- Awareness creation of Linda Mama cover by the health facilities that will facilitate admission in the first clinic visit
- Strengthening of the level 3 health facilities to provide holistic maternal care services as well as, reduce women's time in seeking services from level 4 and 5 which are a distance form them

- Nairobi City County to increase the number of trained mid-wives in Korogocho as, most women preferred delivery with the help of them as opposed to health facilities
- Uptake of family planning should be upscaled as, fertility age reflects increased number of conceptions
- Training of health personnel of positive attitude while handling maternal cases and a special attention to young mothers
- Equip the level threes with reliable and affordable medicines that, patients can afford
- Incorporation of other sectors that affect maternal health such as increased accessibility and reliability of water and good roads to ease transport

6.0 CONCLUSION

The maternal survey findings provided the overview and real-time data on specific experiences mothers and expectant go through as they seek health services. This data also depicted areas that need both tangible and intangible reforms to qualify maternal healthcare as attainable. There should also be close monitoring of maternal activities provided by the midwives to complement health standards.