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**INFLUENCE OF AWARENESS CREATION ON MATERNAL HEALTH IN VIHIGA COUNTY**

**Asembo, M. N., & Miroga, J.**

## INFLUENCE OF AWARENESS CREATION ON MATERNAL HEALTH IN VIHIGA COUNTY

Asembo, M. N.,<sup>1\*</sup> & Miroga, J.<sup>2</sup>

<sup>1\*</sup> Master Candidate, Jomo Kenyatta University of Agriculture & Technology [JKUAT], Kakamega, Kenya

<sup>2</sup> Ph.D, Lecturer, Jomo Kenyatta University of Agriculture & Technology [JKUAT], Kakamega, Kenya

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### ABSTRACT

*Reduction of maternal mortality has long been a global health priority and remains a target in the UN Sustainable Development Goals (SDG) frame work goal three (3) which is also a key concern of the Global Strategy for Women's and Children's Health. Given this scenario, an explanation of this requires studying the influence of health education advocacy strategies on maternal health in Vihiga County. The specific objective of the study was to determine the influence of awareness creation on maternal health in Vihiga County. The study adopted descriptive research design, which ensured ease in understanding the insight about the problem under study. Primary data was obtained from a sample of grassroots advocacy groups in Vihiga County making a total of 380 which was the target population. A sample size of 195 respondents was used in the study to represent the target population. A self-administered questionnaire was used for data collection since this could be sent to a large number of people. A pilot test of 10% of the target population on the questionnaire was carried out to ensure that it was manageable, relevant and effective. The collected data was analysed using inferential as well as descriptive statistics. Cronbach Alpha coefficient value of 0.7895 was attained, implying the research instruments were reliable. From the results, there was a significant relationship between awareness creation and maternal health. The study recommended CHVs to proactively conduct household assessments and make referrals to ensure that pregnant mothers visit health facilities for checkups. Grassroots need to plan and facilitate in chief barazas on issues of maternal health. Women need to actively participate in key family decision making process like the number of children and the use of family planning.*

**Key Words:** Awareness, Maternal Health

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## INTRODUCTION

Maternal health refers to the physical, emotional well-being of women of child bearing age in pregnancy, childbirth and after delivery. It encompasses use of contraceptives, ANC and postnatal service which aims at a decrease in women deaths (WHO, 2013). United Nation Fund for Population Activities (2013) estimated that 289,000 women died of pregnancy or childbirth related causes in 2013. These causes range from severe bleeding to obstructed labor, all of which have highly effective interventions. As women have gained access to family planning and skilled birth attendance with backup emergency obstetric care, maternal deaths have decreased by half in countries from 1990 to 2013. United Nation Population Fund, UNFPA (2012) showed a high mortality rate mostly in third world countries. Costello (2006) advocates for more community based interventions given that the majority of women still deliver at home in many low income countries, where the highest rates of maternal mortality occur. Maternal mortality is high in developing countries compared to the rates in developed countries (World Bank, 2001).

Assessment of global statistics suggests that despite major gains, among the 75 so called Countdown countries that have 98 percent of all maternal deaths and deaths among children younger than 5 years of age, only 17 countries are almost attaining child and maternal health. However, estimates from the Institute for Health Metrics and Evaluation suggest that 31 countries will be in the position to achieve MDG 4, 13 countries will achieve MDG 5, and only 9 countries will achieve both targets (Zulfiqar *et al.*, 2013). The health of mother and child remains a critical concern, not only in the developing world but also in Europe. However, maternal health is often a low priority on the healthcare agenda. 1 in 10 women in the European Union have no access to maternal health services in the first months of pregnancy. Nearly 1800 maternal deaths occurred in Europe in

2015 and 54% of pregnant women seen at Doctors of the World clinics in nine European countries lack access to maternal health care and also living in poverty (WHO, 2017).

Mothers in Nigeria die from birth related complication arising from severe bleeding, infection, abortion, pregnancy hypertension, and prolonged birth pains (Abass, 2008). All these dangers and complications happen without any early signs even though others are detected during the ANC visits thus exposing every pregnant woman. (Ijadunola, Esimai, & Abiona, 2010).

According to Kenya Demographic and Health Survey, KDHS (2014) an estimated lower MMR of 362 per 100,000 live births and lifetime risk of a maternal death of 1 in 67 and concluded that the decline in MMR between 2008 and 2009 and 2014 was not significant. Mandera County in Kenya had the highest MMR in 2008/09 according to KDHS which even surpassed that of Sierra Leone even being above the national average (Gacheri, 2016).

### Statement of the Problem

An estimated 287,000 maternal deaths occurred world wide in 2014, most of which were in third world countries Kenya included which were preventable. UN Sustainable Development Goals (SDG 3) targets ensuring healthy lives and promote wellbeing for all ages which is also a key concern of the Global Strategy for Women's and Children's Health (Say *et al.*, 2014). Governments in third world countries have put modalities in place to curb the increasing maternal mortality rates by allocating resources for the same. A democratic government calls for all the departments to account for resources allocated annually which creates avenues for donors to come in and fill the gap through financing and program implementation. Women most often than not go an extra mile to fend for their families thus resource allocation for maternal health is long overdue (WHO, 2018).

Despite its commitment to maternal health care, Vihiga County continues to make slow progress with an estimated 52% of women giving birth elsewhere apart from the health facilities (Ministry of Health Vihiga County, 2015), the county is off track in achieving the UN Sustainable development goals Goal on good maternal health and wellbeing. Existing research studies have mainly been on determinants of demand for health facility delivery (Nakhone,2013), determinants of implementation of maternal child health project (Nderitu, 2015) and determinants of maternal care services (Mungai, 2015). Other studies have explored reality in improving maternal health outcomes (Marianna, Vargas de Freitas & Cruz Leite, 2014). Despite these studies and their recommendations, maternal health remains a challenge, indicating that there still remains more that needs to be done. There was limited research linking awareness creation with maternal health in Vihiga County. This study sought to fill this knowledge gap.

### **Objective of the Study**

The objective of this study was to determine the influence of awareness creation on maternal health in Vihiga County.

The hypothesis of the Study was;

- Awareness creation has no significant influence on maternal health in Vihiga County.

## **LITERATURE REVIEW**

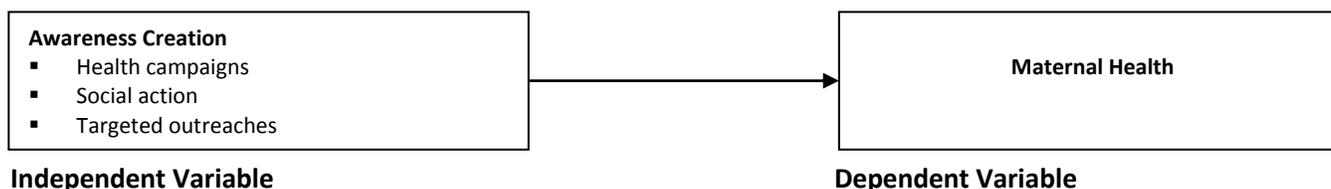
### **Empowerment and Advocacy Theory**

Empowerment and advocacy theory is a framework that seeks to alleviate individuals to take control over their lives on the decisions they make. The theory emphasizes on the need to remove obstacles so that people can live and achieve their full potential in

society (Grande, 2004). Empowerment ensures that individuals in the community are well equipped to tackle life's eventualities without fear as they will be in a position to know what they want. It gives individuals power to not be silence when justice is not being served (Payne, 2005). Empowerment ensures that gaps in people's lives are identifies though continuous engagement with skilled personnel. Advocacy on the other hand is being the voice to the voiceless while at the same time fighting for their rights to ensures that everyone in the society has space. Advocacy enables people to take charge of their own future (Howe, 2009).

The theory is concerned with ensuring equity in communities which would otherwise be denied access to what is rightfully theirs. Empowerment starts from the daily engagement and involvement of all the individuals concerned in identifying their problems and suggesting solutions which are practicable (Leadbetter, 2002). Scholars classify advocacy into the following; self-advocacy allows an individual to fight for their own rights thus giving them authority over what's done and which affect them directly. (Conlon & Lindow, 1994), another type of advocacy is peer advocacy where an individual fights for the rights of others who are going through similar challenge they have been through as they understand it better (Atkinson, 1999), citizen advocacy on the other hand involves professional advocates who offer their services and they are in turn paid (Brandon, 2001) and professional or paid advocacy involves an advocate who tackles the problem on a given duration and is often (Barnes, 2000).

This theory of empowerment and advocacy was important to this study as it directed the influence of awareness creation of the community members which was very impactful in maternal health of Vihiga County.



**Figure 1: Conceptual Framework**

According to Bruno (2002), the concept of 'grassroots' was once very specific: it meant the basic building blocks of society small rural communities or urban neighborhoods where the common man or woman lived. In some contexts, it was used to signify the poor, labor, or working class, as opposed to dominant social elites; in others, it was usually applied to rural, village-level communities rather than to urban ones. But today, globalization and the emergence of a global citizen have changed the way in which the term grassroots is used. Consequently, the meaning of grassroots advocacy is also undergoing a sea change.

Improving maternal and new born health quality of care and outcomes is seen as dependent not only on commitments and investments generally, but also increasingly on the strength of awareness creation for accountability for investments in relevant, evidence based strategies (WHO, 2014). Health practitioners have been held responsible over service delivery in health facilities over a period of time which did not have an in depth consideration on the lives of mothers and children in the third world countries (Bhutto *et al.*, 2016). Parties who do not operate as stipulated in the guide face resilience from the grassroots who create awareness apart from focusing on changing the operating system as a whole thus changing the direction of people who are answerable to the service delivery and use of mother and child services at the health facilities (Freedman, 2004).

Awareness creation ensures social accountability to the communities as the organized grassroots advocates through social movements hold the

individuals in charge of service delivery responsible even if it means storming their places of work (World Bank, 2016). Accountability is evident when the health workers are accountable to higher authority in place who carry out the supervisory role, provide direction and review their day to day reports at the facility. Accountability calls for sanctions of the office bearer if they cannot deliver as per the stipulated agreement and procedures where it becomes a bottom- top approach when the citizens are keen to follow service delivery of the government cadres and ask questions with clarity during public forums organized for the same which gives the masses an opportunity to follow on the laws in place, the budgetary processes and its utilization.

When government bodies supervise its employees, then it becomes horizontal accountability, and top down when public officials are answerable to citizens (transparency international, 2016). Nongovernmental organizations have used media to call upon public officers to account for the services delivered to the masses where the officers have concentrated on the public relations rather than service delivery. Awareness creation as an accountability tool to uplift MNH outcomes requires concerted efforts of all actors in development including; the health ministry, the civil society organizations, media, donors, private sector and government. Maternal and new born health face different barriers apart from those in the health system from the community ranging from the social, economic, political and retrogressive community practices thus grassroots

creating awareness should be clear on what they want changed (Kerber *et al.*, 2007).

Health care service delivery is assumed globally to undergo changes in the funding, public support and a strong political will when progress reports and country commitment is exposed to the public (Brinkerhoff, 2001). The sustainable development goals is keen on the services delivered by the UN and other donors to reach the target of good health and well-being of people around the world through their donations which will ensure decreased child and women death rates. Social accountability has actively been applied in MNH targeting the professional bodies, political activities, and grassroots advocates to ensure that the government ministries stay abreast on the law formulation, policy development and guidelines for efficient service delivery. (Ray, Madzimbamuto & Fonn, 2012).

Advocacy requires partnerships from the grassroots to the health professionals to ensure that all the actors in the MNH are held socially accountable for decreased maternal mortality which is evident in some countries in Africa. Researchers have related communities and government as key parties in increasing services in MNH and accountability (Ray, Madzimbamuto & Fonn, 2012). Community members have been put to be part of the health facilities committees in Kenya to be involved in the decisions which are made which affect them directly as the service seekers in all cadres (O'Meara, 2011), Pilot project of public participation of communities in decision making at the health facility in DRC was implemented (Mafuta, 2015) which had inadequacy in the established systems for MNH thus mothers were unable to report any misconduct in the facility.

Speaking for the voiceless in the society has been a tool used in both DRC and Kenya which required strengthening where availability of data was not evident in DRC, however in Kenya, community health strategy through the CHVs whose community units

are attached to the health facilities ensured that community data was availed. Support has been garnered on the grassroots demonstrations for social accountability both at the local and national level through clearly formulated (Garba, 2014). Advocacy has led to the government to abolish user fees in all government health facilities for mothers who go for child delivery (Center for Reproductive Rights, 2016).

## METHODOLOGY

This study adopted a descriptive research design. It represents perception of health education at the community level and provided a snapshot of strategies employed in maternal health sector in Vihiga County. According to records by the Social Services Department, Vihiga County, there were grassroots advocacy groups in each of the 25 wards of Vihiga County which were operational with membership totaling to 380 grassroots advocates.

Yamane (1967) statistical formula was employed to determine a sample size of 195. This was because the target population (380) was less than 10,000. The researcher used questionnaires to collect primary data. The data collecting instrument were pilot tested with 19 randomly selected grassroots advocates who constituted a 10% of the target population. Quantitative data was converted to quantifiable forms by coding using SPSS text editor (Mugenda & Mugenda, 2003). Data collected was sorted, cleaned and coded and then analysed using Statistical Package for Social Sciences version 22. The equation for the relationship between the predictor variables and outcomes was expressed as follows:

$$Y = \alpha + \beta_1 X_1 + \epsilon$$

Where:

Y = Health education advocacy strategies in Vihiga County,  $\alpha$  = Constant (Co-efficient of intercept),  $X_1$  = Awareness creation,  $\epsilon$  = Error Term,  $\beta_1$  = Regression coefficients for the independent variable.

## FINDINGS

The respondents indicated the extent of agreement with the statements on awareness creation.

The pertinent results were presented in Table 1.

**Table 1: Descriptive Statistics of Awareness Creation**

Statements	AS f(%)	A f(%)	NS f(%)	D f(%)	SD f(%)
Grassroots advocates at the community level have sensitized the pregnant mothers on importance of visiting the clinic in pregnancy early enough.	124(68.9)	38(21.1)	16(8.9)	2(1.1)	0(0)
Information about maternal health is well disseminated through the IEC materials.	146(81.1)	30(16.7)	4(2.2)	0(0)	0(0)
Maternal health message has been translated into local language for understanding by the community.	134(74.4)	46(25.6)	0(0)	0(0)	0(0)
Nurses and clinical officers teach reproductive health at the health facilities	151(83.9)	29(16.1)	0(0)	0(0)	0(0)
Grassroots advocates collaborate with women and men in Vihiga County to create demand for maternal health	155(86.1)	23(12.8)	0(0)	0(0)	0(0)
CHVs conduct household assessments and make referrals to ensure that pregnant mothers visit health facilities for checkups	96(53.3)	63(35)	16(8.9)	3(1.7)	2(1.1)
Grassroots advocates are organized in groups in the 25 wards of Vihiga County	114(63.3)	50(27.8)	6(3.3)	10(5.6)	0(0)
Grassroots advocates plan and facilitate in chief barazas on maternal health	116(64.4)	42(23.3)	14(7.8)	4(2.2)	4(2.2)
Grassroots advocates are registered at the social services as self-help groups at the ward level	124(68.9)	44(24.4)	8(4.4)	4(2.2)	0(0)

From Table 1, the respondents were asked whether grassroots advocates at the community level had sensitized the pregnant mothers on importance of visiting the clinic in pregnancy early enough. The distribution of findings showed that 68.9 percent of the respondents strongly disagreed, 21.1 percent of them agreed, 8.9 percent of the respondents were not sure on the statement that the grassroots advocates at the community level had sensitized the pregnant mothers on importance of visiting the clinic in pregnancy early enough, 1.1 percent disagreed while 0 percent of them strongly agreed. These findings implied that grassroots advocates at the community level had sensitized the pregnant mothers on importance of visiting the clinic in pregnancy early enough. Awareness creation ensures social accountability to the communities as the organized

grassroot advocates through social movements hold the individuals in charge of service delivery responsible even if it means storming their places of work (World Bank, 2016). Advocacy requires partnerships from the grassroots to the health professionals to ensure that all the actors in the MNH are held socially accountable for decreased maternal mortality which is evident in some countries in Africa. Researchers have related communities and government as key parties in increasing services in MNH and accountability (Ray, Madzimbamuto & Fonn, 2012).

The respondents were also asked whether the information about maternal health was well disseminated through the IEC materials. The distribution of the responses indicated that 81.1

percent strongly agreed to the statement, 16.7 percent of them agreed, and 2.2 percent of them were not sure, while 0 percent disagreed and strongly disagreed respectively. These findings implied that the information about maternal health was well disseminated through the IEC materials.

The respondents were also asked whether the maternal health message had been translated into local language for understanding by the community. The distribution of the responses indicated that 74.4 percent strongly agreed to the statement, 25.6 percent of them agreed while 0 percent of them were neither not sure, disagreed nor strongly disagreed. These findings implied that maternal health message has been translated into local language for understanding by the community.

The respondents were further asked whether Nurses and clinical officers taught reproductive health at the health facilities. The distribution of the responses indicated that 83.9 percent strongly agreed to the statement, 16.1 percent of them agreed, while 0 percent were not sure, disagreed and strongly disagreed to the statement respectively. These findings implied that majority of the respondents agreed nurses and clinical officers teach reproductive health at the health facilities.

The respondents were further asked whether grassroots advocates collaborated with women and men in Vihiga County to create demand for maternal health. The distribution of the responses indicated that 86.1 percent strongly agreed to the statement, 12.8 percent of them agreed, 0 percent of them were neutral, disagreed and strongly disagreed to the statement respectively. These findings implied that grassroots advocates collaborate with women and men in Vihiga County to create demand for maternal health.

The respondents were asked whether the CHVs conducted household assessments and made referrals to ensure that pregnant mothers visit health

facilities for checkups. The distribution of the responses indicated that 53.3 percent strongly agreed to the statement, 35 percent of them agreed, 8.9 percent of them were not sure, 1.7 percent disagreed while 1.1percent strongly disagreed to the statement respectively. These findings implied that CHVs conducted household assessments and made referrals to ensure that pregnant mothers visit health facilities for checkups. Past studies revealed that speaking for the voiceless in the society had been a tool used in both DRC and Kenya which required strengthening where availability of data was not evident in DRC, however in Kenya, community health strategy through the CHVs whose community units were attached to the health facilities ensured that community data was availed. Support had been garnered on the grassroots demonstrations for social accountability both at the local and national level through clearly formulated (Garba, 2014).

The respondents were further asked whether the grassroots advocates were organized in groups in the 25 wards of Vihiga County. The distribution of the responses indicated that 63.3 percent strongly agreed to the statement, 27.8 percent of them agreed, 3.3 percent of them were not sure, 5.6 percent of them disagreed while another 0 percent of them strongly disagreed to the statement respectively. These findings implied that grassroots advocates are organized in groups in the 25 wards of Vihiga County.

The respondents were further asked whether the grassroots advocates were registered at the social services as self-help groups at the ward level. The distribution of the responses indicated that 68.9 percent strongly agreed to the statement, 24.4 percent of them agreed, 4.4 percent of them were not sure, 2.2 percent of them disagreed while another 0 percent of them strongly disagreed to the statement respectively. These findings implied that grassroots advocates are registered at the social services as self-help groups at the ward level.

The current research findings were in line with several past studies. Research revealed that improving maternal and new born health quality of care and outcomes is seen as dependent not only on commitments and investments generally, but also increasingly on the strength of awareness creation for accountability for investments in relevant, evidence based strategies (WHO, 2014). Health practitioners had been held responsible over service delivery in health facilities over a period of time which did not have an in depth consideration on the lives of mothers and children in the third world countries (Bhutto *et al.*, 2016). Parties who did not operate as stipulated in the guide face resilience from the

grassroots who create awareness apart from focusing on changing the operating system as a whole thus changing the direction of people who are answerable to the service delivery and use of mother and child services at the health facilities (Freedman, 2004).

### Correlation of Awareness Creation and Maternal Health

The correlation between awareness creation and maternal health was calculated using Pearson's Correlation in order to establish the relationship between the two variables. The results were as shown in the Table 2.

**Table 2: Correlation between Awareness Creation and Maternal Health**

Variable		Awareness creation	Maternal Health
Awareness creation	Pearson Correlation	1	.801**
	Sig. (2-tailed)		.000
	N	180	180
Maternal Health	Pearson Correlation	.801**	1
	Sig. (2-tailed)	.000	
	N	180	180

\*\*Correlation is significant at the 0.01 level (2-tailed).

The correlation between awareness creation and maternal health was 0.801 ( $p = 0.000$ ). This meant there was a positive relationship between awareness creation on maternal health. The study thus failed to accept the null hypothesis and state that there is a significant relationship between awareness creation and maternal health.

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have an in depth consideration on the lives of mothers and children in the third world countries (Bhutto *et al.*, 2016). Parties who do not operate as stipulated in the guide face resilience from the grassroots who create awareness apart from focusing on changing the operating system as a whole thus changing the direction of people who are answerable to the service delivery and use of mother and child services at the health facilities (Freedman, 2004).

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is evident in some countries in Africa. Researchers have related communities and government as key parties in increasing services in MNH and accountability (Ray, Madzimbamuto & Fonn, 2012).

### Regression Analysis of Awareness creation and Maternal Health

The study used simple regression analysis to establish the influence of awareness creation on maternal health. The results of the model summary were as shown in Table 3.

**Table 3: Model Summary of Awareness Creation on Maternal Health**

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.801 <sup>a</sup>	.641	.601	3.25498	2.1223

a. Predictors: (Constant), Awareness Creation  
b. Dependent Variable: Maternal Health

From the results, the R coefficient was 0.801 while R square was 0.641. That meant 64.1 percent variance in maternal health was explained by awareness

creation. The study therefore failed to accept the null hypothesis. The ANOVA summary results were as shown in Table 4

**Table 4: ANOVA results for Awareness Creation on Maternal Health**

Model		ANOVA <sup>a</sup>				
		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	4747.429	1	5747.429	642.472	.000 <sup>b</sup>
	Residual	3792.971	178	10.595		
	Total	8540.400	179			

a. Dependent Variable: Maternal Health  
b. Predictors: (Constant), Awareness Creation

From the results in Table 4, the F test value was 642.472 and it was significant at p=0.000. That implied that the model nicely fitted and there was a

probability of 0.0 percent to accept the null hypothesis. The student t test summary was as shown in Table 5.

**Table 5: Coefficients of Awareness Creation on Maternal Health**

Model		Coefficients <sup>a</sup>				
		Unstandardized Coefficients		Standardized Coefficients Beta	t	Sig.
		B	Std. Error			
1	(Constant)	2.972	1.199		6.8124	.000
	Awareness Creation	.518	.041	.801	20.891`	.000

a. Dependent Variable: Maternal Health

Awareness creation has no significant influence on maternal health in Vihiga County. From the results, the R coefficient was 0.801 while R square was 0.641. That meant 64.1 percent variance in maternal health was explained by awareness creation. The study therefore failed to accept the null hypothesis.

## CONCLUSION

The study concluded a high correlation between awareness creation and maternal health which made the study to fail to reject the hypotheses in the study. The grassroots advocates had created awareness in Vihiga county which had translated to more community members visiting the health facility to have a reproductive with the health practitioners at the health facilities. Awareness creation carried out by the grassroots advocates at the community level had contributed to the increased maternal health access as relevant information is disseminated where the CHVs conducted household visits and referrals.

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## RECOMMENDATION

The study findings showed that CHVs were trying their level best to make referrals to health facilities which were not yet fully covered under their areas of jurisdiction. The study recommended that there is need for CHVs to proactively conduct household assessments and make referrals to ensure that pregnant mothers visit health facilities for checkups. The study findings showed that grassroots advocacy groups carry out sensitization meetings at the community which are not evenly distributed in the wards. The researcher recommended that grassroots need to plan and facilitate in chief barazas on issues maternal health at the location level so as to reach each and every community member contributing to the advocacy and empowerment theory used in the study.

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