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Chronicling Untold Stories of Accessing Maternal Healthcare Services among Low-Income Residents of Chitungwiza, Zimbabwe

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ABSTRACT: The study explores women's lived experience regarding maternal health care services and the challenges women face in accessing maternal health care services at Chitungwiza Hospital in Zimbabwe. The researchers adopted a qualitative case study research design to answer the research questions. The target populations were women of childbearing age and the staff at Chitungwiza Hospital. A sample of 25 participants was targeted using convenience and purposive sampling techniques. Data was collected using focus group discussions, in-depth interviews, and documentary analysis. Based on these findings, this study concluded that women in Chitungwiza face a lot of sociocultural and economic challenges when accessing maternal healthcare services. They face several challenges, including distance, education level, economic hardships, and sociocultural and administrative challenges. Patriarchal has also led some women to be voiceless; hence, there is a need for relevant institutions such as the government to spearhead gender mainstreaming to counteract such challenges. A multi-stakeholder approach is recommended for service provision in low-income towns such as Chitungwiza.

KEYWORDS: Maternal Health Care, Low-Income Residents, Women

1. INTRODUCTION

Maternal health care access is a fundamental human right that must be integrated into the city plans and development. Maternal health encompasses physical, psychological, and emotional wellbeing during pregnancy, childbirth, and postpartum (Ojong, Wamakima, Moyer & Temmerman, 2023). This is evident from World Health Organization policy, which stipulates the adoption of primary healthcare services in every country. This scenario is also supported by a new urban agenda that points out the importance of maternal healthcare among residents in urban communities. However, it would appear there is a limited maternal facility in most urban areas, especially the low-income resident's suburbs of African cities where people with low incomes reside. Only 33.7% of women in low- and middle-income countries (LMICs) effectively utilize maternal health services (Shanto, Al-Zubayer, Ahammed, Sarder, Keramat, Hashmi, Haque & Alam, 2023). Improving maternal health literacy is crucial for low-income pregnant women, empowering them to seek timely care (Ningrum, Lusmilasari, Huriyati, Mathias & Hasanbasri, 2024). The unequal distribution of health services in most African cities is derived from the colonial legacy. Maternal health services are essential as they reduce the risks of maternal death, pre-natal death, unwanted pregnancies, and neonatal death (WHO, 2012). There are more than seven (7) million infant deaths per year worldwide (Joyce, 2004) that are attributed to poor maternal healthcare. There is an urgent need to provide maternal health services in urban areas, as failure to do so will result in women's lives being compromised and sustainable development not being achieved (McIntyre, 2009). Therefore, this study examines women's challenges in accessing maternal health care services in a low-income suburb such as Chitungwiza in Zimbabwe. The study will also look at the effects of failure to access maternal healthcare services on low-income residents. This study is vital as it sets the tone for policy implementation in maternal health care services in low-income residents, particularly women of childbearing age. Moreover, the study will benefit stakeholders such as community members, the Ministry of Health and Child Welfare, women of childbearing age, and NGOs as they work tirelessly to bring community development in Zimbabwe and other developing countries.

2. STUDY AREA-CHARACTERIZING CHITUNGWIZA

Chitungwiza is a high-density dormitory town in Zimbabwe. The city is approximately 30 km south of the capital city, Harare. It was formed in 1978 from three townships, namely Seke, Zengeza, and St Mary's. Chitungwiza is the largest high-density suburb in

Zimbabwe. The town began in the late 1970s, with most black people living in the oldest high towns, such as Highfield, migrating to Chitungwiza (Musemwa, 2008). The town has several suburbs, and the oldest suburb is St Mary's, which is divided into two sections, namely Manyame Park (New St Mary's) and Old St Mary's. Chitungwiza gained full municipal status in 1996 and is Zimbabwe's third largest and growing urban center. According to ZIMSTAT (2013), the 2012 census revealed that Chitungwiza had a population closer to one million, with 52,85% females and 47,2% males. To date, Chitungwiza has 25 wards. Most residents work in Harare Central Business District as the township has very little industry. As the country's economic challenge deepens, the majority of the residents are poverty-stricken and live below the poverty datum line.

3. METHODOLOGY

This qualitative study explores women's ideas, views, and opinions about accessing maternal healthcare services in the low-density suburbs of Chitungwiza. As such, it adopts a case study research design. To achieve the objectives, the researchers utilized various data collection methods, including focus group discussion, in-depth interviews, and documentary analysis. A sample of 15 participants of women in their childbearing age was selected using convenient sampling. Using purposive sampling, the researchers also targeted 7 participants from maternal health care personnel (ward attendants) and three key informants.

4. RESEARCH FINDINGS AND DISCUSSIONS

4.1 Distance

The study revealed that Chitungwiza General Hospital is the largest hospital in Chitungwiza. Being the largest hospital, it offers its services to the surrounding communities. The study indicates that most women live more than 5km from the nearest healthcare service. These women bear commuting costs from Makoni, Dema, and other faraway areas. Furthermore, the study reveals that long distances and commuting expenses cause women to opt for home delivery using traditional birth attendants and healers. The use of unqualified health personnel, such as traditional birth attendants and healers, exposes their lives to danger. Through focus group discussion, one of the women had this to say:

Transport is so expensive from Seke South to Seke North. When an ambulance is called, you pay the cost yourself. The ambulance is very expensive, and at one point, it was about $580 bond per day.

The Zimbabwean government claims it has made tremendous achievements by reducing the distance to healthcare facilities by constructing them around the country. Surprisingly, the average distance to the nearest healthcare facility is between eight and ten kilometers (MoHC, 2010). The Access to Health Care Services Study of 2007 found that most communities live within a 5 km radius of their nearest health facilities, whilst 23% live between 5 to 10 km and 17% are over 10 km from their nearest health center (Muchabaiwa, 2012). As such, the majority of women with low-income status are, in most cases, marginalized in the use of healthcare services in Chitungwiza Town.

4.2 Quality care

The study has found that low-income residents surrounding Chitungwiza suburbs are in short supply of proper health infrastructure. Women are forced to seek help elsewhere and even opt for home delivery. Poor quality of facility-based care is a major contributor to high maternal morbidity and mortality rates among low-income women (Austin, Langer, Salam, Lassi, Das & Bhutta, 2014). Low-income residents of Chitungwiza experience persistent shortages of essential equipment, medications, and fundamental healthcare supplies, worsened by limited access to adequate health facilities.

Furthermore, women from low-income backgrounds may encounter mistreatment and discrimination within these facilities, potentially discouraging them from seeking necessary care. This situation includes being judged for their appearance or inability to provide gifts to healthcare providers, which creates unwelcoming environments (Sacks & Peca, 2020). The study has shown that health personnel staff are often poorly trained, may lack essential clinical skills, and may not observe hygienic practices. Furthermore, health workers may be rude sometimes, unsympathetic, and uncaring; thus, women prefer to use the services of traditional birth attendants and healers. An expected woman had this to say:

To go to labour, you need to buy methylated spirit, razor blades, and gloves, and they do not attend to you without these items. Sometime back, these items were provided for us. Moreover, nurses are always going on strike; hence, no one can attend to you. Student nurses who have just graduated are the ones serving us. Some maternity wards have been privatized at the Chitungwiza General Hospital. The privatized wards are expensive and can only be afforded by middle-income residents.

What it shows is that women are not getting quality care when they go for maternal treatment at Chitungwiza Hospital. Elsewhere, some researchers, Dahlin (2010), Hansson (2015), and Mutambirwa (2016), have argued that healthcare in Zimbabwe has been categorized

as pluralistic due to the existence of both traditional and biomedical systems. Customer care services, drug provision, and health infrastructure systems are much better off in low-density suburbs. Disparities in Person-Centered Maternity Care (PCMC) are evident, with wealthier, employed, and literate women reporting higher quality care compared to their poorer, unemployed, and illiterate counterparts. Poor women, especially those who are unemployed or deliver in higher-level facilities, receive the lowest quality PCMC (Afulani, Sayi & Montagu, 2018).

Deprivation to the access of maternal health care services by low-income residents is embedded into poverty backgrounds (UNICEF, 2010). The quality of maternal care is often lower in facilities located in impoverished areas, and the poorest women have significantly less access to minimally adequate delivery care. This inequity in care quality further marginalizes low-income women, contributing to poorer maternal and newborn health outcomes (Sharma, Leslie, Kundu & Kruk, 2017). Key informants also highlighted that these poor services have resulted in a high neonatal mortality rate in the town. Similarly, within India, nationwide surveys detected a neonatal mortality rate of 34.9 deaths per 1000 live births within low-density income suburbs like Chitungwiza, which was more significant than high-income suburbs of 25.5 deaths per 1000 live births and the average urban 28.7 deaths per 1000 live birth (Tornui, 2013). The 2015 State of the World's Mother Report finds that where child survival gaps are most prominent in Bangladesh, Cambodia, Ghana, India, Kenya, Peru, Rwanda, Vietnam, and Zimbabwe, poor urban children are 35 times as likely to die as their affluent peer (Wagle, 2014). In Sub-Saharan African countries, many childbearing women are still attended by traditional birth attendants and relatives at deliveries (Jamison et al., 2006; Crowell et al., 2012). Literature shows that birth without skilled personnel and access to life-saving drugs is the most standard practice for millions of mothers in the poorest countries where mortality rates and morbidity of the mothers are highest (Crowe et al.; WHO, 2012).

4.3 Culture and religion

What prevents some low-density residents from utilizing maternal health services does not lie in affordability only but also in other issues such as culture and religion. It is revealed in the study that factors contributing to the avoidance of formal health institutions by low-income residents are lack of privacy, run-down physical facilities, inconvenient operating hours, and restrictions on who can stay with a woman at the health facility. Cultural beliefs and lack of family support can deter women from seeking maternal healthcare, particularly in communities with low income (Dahab & Sakellariou, 2020). Religious beliefs often dictate health-seeking behaviors, with some women preferring spiritual healers over medical professionals, which can lead to inadequate care during pregnancy (Mustafa, Batool, Fatima, Nawaz, Toyama & Raza, 2020). Some religious sects, such as apostolic faith, are not fond of using medical services as they believe in spiritual healing processes. As such, they prefer home delivery by the midwives. A woman from the apostolic faith had this to say:

Some nurses are harsh and emotional, and you would wish to deliver on your own. That is why we end up shunning hospitals for home delivery. The nurses can be different somehow, as one can be lucky to be attended to professionally. However, traditional elders would encourage us to take traditional medicine to facilitate an easy delivery. According to them, it is the way to safeguard the lives of both the baby and the mother.

To this end, culture and religion are contributing to the challenges faced by these women. Key informants also agreed that culture and traditional beliefs significantly influence the decision to seek antenatal care. Many families opt for the traditional birth attendant as their first line of call for delivery services unless they believe labour is not normal (Wagle, 2014). Engaging community leaders and family members in health education can help address cultural barriers and promote better maternal health practices (Sumankuuro, Crockett & Wang, 2018). Key informants also highlighted that women from apostolic households and those who believe in traditional healing are less likely to make antenatal visits and deliver healthcare facilities than women from other religious affiliations. Research participants also showed that religious affiliation is thus a substantial source of exclusion from antenatal care and delivery at healthcare facilities. Traditionalists do not believe in modern-day medicine and prefer cleansing and traditional herbs. Thus, religious and cultural beliefs are a strong determinant of women's place of birth and accessing maternal health care services. Healthcare workers must understand and integrate cultural and religious contexts into maternal health programs to improve effectiveness and reduce maternal mortality (Rahayu, Hartiningsih, Herawati, Hernawati, Kartika, Rahmawati, Sari, Suryani, Risyanti, Syafrullah, Lestari, Danismaya, Ermiati & Arifin, 2023). Religion is considered a significant constraint on demographic transition and fertility change, particularly in several historical and contemporary populations, and this constraint can operate at a national level (Cleland & Wilson, 2016; Grada & Walsh, 2015). In some instances, minority groups maintain strict and sometimes separate lifestyles against backgrounds of widespread social, economic, and demographic change (Eaton & Mayer, 2016; Hostetler, 2015). Commonly held beliefs and norms that could be religious or cultural shape individuals' perceptions of their health and the health services available.

4.4 Gender dynamics

Gender equality and access to maternal health care services are the goals of sustainable development that will be achieved by every nation by 2030. In many settings, women often lack decision-making power in families, communities, and societies. Thus, social taboos and unequal power relations between men and women often affect the use of contraceptives by women. One of the most prevalent barriers to contraceptive use among women is opposition from their husbands. Findings show that men are in control in most families and have the final say regarding all family issues. Women's financial independence can improve maternal health outcomes by easing marital tensions and enhancing decision-making capacity. However, men often remain the primary decision-makers, which can still restrict women's autonomy in health matters (Cornish, Walls, Ndirangu, Ogbureke, Bah, Tom-Kargbo, Dimoh & Ranganathan, 2021). Gender violence is also a determinant of maternal health. Women are at a high risk of unwanted pregnancies and other sexual and reproductive health problems. Similarly, women complained that they do not have funds to register at the local clinics for monthly checkups. Women in low-income settings frequently face restricted access to financial resources, limiting their healthcare access (Sule, Uthman, Olamijuwon, Ichegbo, Mgbachi, Okusanya & Makinde, 2022). Through focus group discussion, one woman said:

The challenge we face as expecting women is that of polygamy. When you are in polygamy and at the same time expecting, the husband will spend most of his time away, seemingly forgetting that this is the best time you need him most. However, when you deliver, they get so excited about the baby. Some other challenges are menmonopolies decisions on access to maternal health care services. The problem worsens when the husband is unemployed and cannot afford recommended food items like bananas, oranges, apples, etc.

Evidence from the study reflects that gender dynamics are also contributing to the challenges faced by these women in Chitungwiza town. Gender norms and societal expectations can inhibit women's access to maternal healthcare. Traditional norms often place men in control of reproductive health decisions despite their lack of comprehensive maternal health knowledge (Kalindi, Houle, Smyth & Chisumpa, 2023). Key informants agreed that it is culturally unacceptable for women to receive midwifery/obstetrical care without the acceptance of the husband, and this can partly explain why home births vastly outnumber those occurring in health facilities. Most of the decisions are made by male members of the households. Muchabaiwa (2012) also observes that women do not have decision-making power or the opportunity to move outside the family for purposes, including seeking care services. A woman can only exercise choice of birth site if she has unrestricted access to maternity providers in all settings (Tornui, 2013). Women in polygamous households are less likely to deliver at a healthcare facility compared to those from non-polygamous households.

4.5 Living standards

Global health policies increasingly prioritize maternal health, recognizing its role in achieving sustainable development goals, which aim to improve living standards globally (Ojong et al., 2023). Access to quality maternal health services correlates with improved wellbeing for mothers, which can enhance their economic productivity and household stability (Adejoorin, Salman, Adenegan, Obi-Egbedi, Dairo & Omotayo, 2024). The study found that a lack of antenatal and postnatal care and assistance during delivery can lead to maternal death. Maternal deaths have both direct and indirect causes. This study further revealed that maternal deaths are due to direct causes, which include obstetric complications such as severe bleeding, infection, unsafe abortion, hypertensive disorders (eclampsia), and obstructed labor. Women die of indirect causes, such as diabetes, hepatitis, heart disease, and anemia. These diseases or causes of ill health can be exacerbated during pregnancies. These maternal mortality deaths are a result of poor living standards. Low-income residents often lack the financial capacity to afford the recommended medications and nutritional foods advised by healthcare providers during pregnancy. A research participant had this to say:

Being economically disadvantaged leads to stress. The nurse advises us to eat different types of foods, which nowadays are so expensive that one ends up vending to afford the necessities. You are supposed to buy vitamin supplements to sustain your health status.

Access to maternal health care services among the urban poor in developing countries has become a development concern (UN,2012). Every state's right is to provide essential services and access to maternal health services among its citizens. Empowering women through better maternal health services can lead to greater community engagement and development, fostering equity and social justice (Ojong et al., 2023). Sociocultural and economic challenges have affected access to maternal health services in most cities in developing countries. Despite being the world’s least urbanized region, Sub-Saharan Africa has the fastest urban growth rate (UN, 2012). Urban poverty has been linked to substantial deterioration of key urban health and social indicators. Conversely, inadequate maternal health services can perpetuate cycles of poverty and inequality, as seen in regions with high maternal mortality rates, where the lack of care leads to broader socioeconomic challenges (Chauhan, Narayanan & De Souza, 2017). The new face of urban poverty has been linked to adverse outcomes for the urban poor, such as high rates of unwanted pregnancies, higher fertility, sexually transmitted infections, and poor maternal and child health outcomes. Maternal health directly influences the health of newborns and children. Better maternal health care, including access to skilled birth attendants and antenatal care, reduces maternal and infant mortality rates and crucial indicators of living standards (Mangiaterra, Bucagu & Sabbatucci, 2023). There is a need to consider the socio-environmental and economic

conditions that heighten vulnerability to poor health in urban contexts (Mselle, 2013). Poverty, in particular, must be recognized as a key hindrance to sexual and reproductive health in urban poor communities. Poverty is proven to be the enemy of development, especially when it comes to women. A good relationship exists between access to health services and poverty (MoHC, 2010).

4.6 Education

Findings from the study indicate that education is one of the key determinants of access to maternal health care services. Women with no more than an incomplete primary education level have more than triple the odds of non-facility delivery compared to those with at least secondary-level education. Increased years of schooling for women are associated with a reduction in maternal health complications. For instance, extending women's education reduced the probability of several maternal health complications by up to 29%. This improvement is attributed to better cognitive skills, economic resources, and autonomy, leading to healthier behaviors and increased antenatal healthcare use (Weitzman, 2017). Another important observation from the study relates to the effect of the desirability of pregnancy on maternal health care. The study indicates that there is a high neonatal death rate in women who have no basic education as compared to their counterparts. Women with higher education levels are more likely to utilize maternal health services, including antenatal care and skilled birth attendance. This utilization is crucial for reducing maternal and infant mortality rates (Amwonya, Kigosa & Kizza, 2022). As such, those who did not have basic education opted for home delivery. A participant from a focus group discussion said:

Educated mothers are better off in terms of capacity and resources. It saves many problems; for example, you do not depend upon your husband for all requirements, such as maternity fees and pregnancy registration. You can do that on your own, especially when you are working. When you are educated, you know how to care for your child. When it comes to food, educated women have a better understanding of the quality of foods for both a baby and herself. When a child is dehydrated, we recommend that more minerals be given. Low levels of educated women end up in traditional practices to cure dehydration, which has proven detrimental and risky to the life of a child.

Gendered educational barriers also affect health-related choices, as the education level affects people's capacity to make exemplary health choices. Women and adolescent girls' choices and ability to make choices in favor of their health are jeopardized by the production and reproduction of gender inequality at the household and community level. For instance, men generally make health-seeking decisions (Olesen, 2012). Moreover, a significant obstacle is a lack of male knowledge and understanding (Olesen et al., 2012). A woman's education and wealth are strong determinants of whether or not deliveries happen in institutions. Empowering women through education and economic opportunities is essential to improve maternal health outcomes in these contexts (Omer, Zakar, Zakar & Fischer, 2021).

4.7 Administration

The study noted that access to maternal health care services is not limited to sociocultural and economic factors but also extends to administration challenges. Effective leadership in healthcare facilities significantly influences maternal health outcomes. For instance, supportive and innovative hospital leadership practices can lead to better quality of care and motivated staff. In contrast, authoritarian leadership can result in poor communication and demotivated staff, negatively impacting maternal health services (Mathole, Lembani, Jackson, Zarowsky, Bijlmakers & Sanders, 2018). The study has revealed that a massive brain drain hardly hits the health sector. Such circumstances have created shortages of skills that are hard to replace. More so, the study unraveled that the few remaining are in short supply, and some of them are not qualified, thus putting the lives of expecting mothers in danger. Low labor motivation has affected maternal healthcare services by low-income residents. The availability and accessibility of maternal health services, especially in low-income areas, is critical. Initiatives to enhance maternal care training and improve transitions from training to practice in underserved areas are essential to address workforce shortages and improve maternal health outcomes (Owens, Whittaker, Galt, Stoesser, Spiess, Mervis, Curtin, Gardner & Ose, 2023). Low remunerations, lack of drugs, and poor working conditions are some factors pushing workers away to other countries such as Botswana, South Africa, and the UK, where they are highly demanded. Most nurses and doctors are often on labor strikes, demanding a pay rise. At some point, these challenges pose a threat to the lives of expecting mothers and unborn children as they are neglected during that period. One of the nurses had this to say:

The truth is that there is nothing here in terms of facilities. The problem is that decisions are made by some people who did their degree in the United States and came to sit in an office in Harare. Such people have no idea of what is happening on the ground. All they see is a piece of white paper with figures. We go there for meetings; we make recommendations, but nobody puts them into action because they do not see what we see or know what we know.

Key informants agreed that unemployment has been rampant, and an exodus of young, skilled professionals has been happening for many years. Many nurses and doctors have migrated to neighboring countries for better employment and affordable living standards. Zimbabwe has been affected by a brain drain, and several health personnel have left the country for greener pastures. However, it is an

expense for the government to replace such skills. Birth attendance by unqualified health personnel has led to massive maternal mortality rates (Muchabaiwa,2012). Lately, massive labor strikes in the health sector have seen doctors and nurses in the streets demonstrating for a pay raise. This situation has affected the department as most women have been neglected during such operations (Muchabaiwa, 2012). The involvement of community health workers in providing maternal health services at the community level has shown positive impacts. However, challenges related to resources and training need to be addressed to ensure the sustainability and effectiveness of these programs (Tuyisenge, Hategeka, Luginaah, Cechetto & Rulisa, 2020). Social security is one of the determinants of access to maternal health services. Having supportive friends and families that support you when you are in need is one of the elements of poverty alleviation. Social protection in Zimbabwe is scarce as most relatives and friends are in an economic meltdown. Furthermore, the main objective has been social security as the panacea for accessing maternal health, which remains a dream (Olesen, 2012). Developed countries such as the United States of America, the United Kingdom, and other middle-income countries such as the United Arab Emirates are better positioned to cope with the challenges of accessing maternal health care services as they have the capacity and resources to do so (Mselle, 2013).

4.8 Lack of people's participation in policy

The Ministry of Health and Child Welfare is responsible for providing maternal health care services across the country, including the urban poor. Deprivation of access to maternal health care services is not limited to poverty by the urban poor but also issues about consulted policies. Most policies are done without baseline surveys and assessments. The study reveals that the introduction of user fees through economic adjustment programs by the 1970s was the first stage of crippling the health services sector. The policy led to the marginalization of the urban poor in utilizing health services as they were expensive and could not afford them. One participant had this to say:

Just imagine: long ago, we were not paying anything for those services, and suddenly, we have just been told to pay for them. It is disturbing. You end up opting for home delivery because the maternity fees are not affordable. Moreover, nowadays, the polio vaccine is being injected directly into the mother rather than into the child. Just imagine: if I could not afford such a vaccine, it automatically entails that the child would be deprived.

Key informants agreed that the communities are not considered regarding health policy formulations. The lack of participation in decision-making highlights women's powerlessness and hinders their access to crucial health services (Sahu & Mehta, 2023). For instance, key informant 2 highlighted that the introduction of economic adjustment programs in the early 1990s saw a decline in the number of women accessing maternal health services. Another key informant reported that the cost of health facilities was relatively small before introducing user fees. Research participants also highlighted that introducing user charges for health services meant that some people were automatically excluded because of poverty and unwillingness to pay. 1980 free health care was introduced for low-income people (MoHC, 2010). Removing user fees can have mixed effects on the quality of care. Some studies report high satisfaction levels among women due to better birth outcomes and improved care processes. However, concerns about decreased provider motivation and the availability of necessary inputs can negatively affect service quality (Ajayi, 2019). The policy position on user fees has been that those who can afford to pay for services should do so, but implementation of the principle has been mixed.

Managing exemption from fees has been challenging and costly, with some consequent injustices in who is exempted. In 1990, emphasis was placed on fee collection. However, after evidence of high dropout rates from services, user fees in urban primary care services were suspended in 1995. Even with fee exemptions, out-of-pocket expenses for maternal healthcare can still be significant, covering costs like transportation and medications. This suggests that fee removal alone may not fully alleviate the financial burden on families (Shawel, Ayele, Dessie, Tura, Dinsa, Tekola, Mandefro, Masrie, Tamire & Tefasa, 2023). The National Health Strategy for Zimbabwe 1997–2007 targeted free treatment for the majority but stated that the free health policy creates a disincentive for people to join medical insurance schemes. Poor people thus faced various de facto cost barriers: the falling real value of the threshold for free care, transport costs, private purchases of medicines due to drug stockouts, and poorly functioning exemption schemes (MoHCW, 2010).

5. CONCLUSION

Based on these findings, this study concludes that women in Chitungwiza face many sociocultural and economic challenges when accessing maternal healthcare services. Determinants in accessing maternal health care services are interwoven into many factors, including distance, level of education, economic hardships, and sociocultural and administrative challenges. It was also discovered that through family setups, some women do not have the final say when deciding the choice for maternal health care services. Patriarchal leadership has led women to be voiceless. Hence, there is a need for relevant institutions such as the government to spearhead gender mainstreaming to counteract such challenges. There is a need for a multi-stakeholder approach when it comes to service provision for

low-income residents. For instance, health-related NGOs are included to improve service delivery, such as clinics, drugs, and empowerment programs to eliminate poverty among poor urban women. Having such a vision will make sustainable development goals achievable.

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