The Impact of Government Supported Maternal Health Programs on Maternal Health Outcomes in Kenya

_Hits, Misses and Lessons_
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>AMREF</td>
<td>African Medical Research Foundation</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<td>CBOs</td>
<td>Community Based Organizations</td>
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<td>CHV</td>
<td>Community Health Volunteer</td>
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<td>CSO</td>
<td>Civil Society Organization</td>
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<td>FGD</td>
<td>Focus Group Discussions</td>
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<td>GoK</td>
<td>Government of Kenya</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IAGAS</td>
<td>Institute of Anthropology, Gender &amp; African Studies</td>
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<tr>
<td>IPT</td>
<td>Intermittent Preventive Treatment</td>
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<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
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<td>KNBS</td>
<td>Kenya National Bureau of Statistics</td>
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<td>KNUT</td>
<td>Kenya National Union of Teachers</td>
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<td>MCA</td>
<td>Member of County Assembly</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOMs</td>
<td>Ministry of Medical Services</td>
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<td>MOPHS</td>
<td>Ministry of Public Health and Sanitation</td>
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<td>MPDSRC</td>
<td>Maternal and Peri-Natal Death Surveillance and Response Committee</td>
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<td>NCPD</td>
<td>National Commission on Population and Development</td>
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<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>NHIF</td>
<td>National Health and Insurance Fund</td>
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<td>OBA</td>
<td>Output-Based Assistance</td>
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<td>OOP</td>
<td>Out of Pocket</td>
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<td>OSIEA</td>
<td>Open Society Initiative for Eastern Africa</td>
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<td>PMMN</td>
<td>Prevention of Maternal Mortality Network</td>
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<tr>
<td>PRB</td>
<td>Population Reference Bureau</td>
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<td>PSRI</td>
<td>Population Studies and Research Institute</td>
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<td>SDG</td>
<td>Sustainable Development Goals</td>
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<td>TBAs</td>
<td>Traditional Birth Attendants</td>
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<tr>
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<td>United Nations Children’s Fund</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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We acknowledge the mothers who volunteered information freely to the team and the health care providers who accommodated us despite their busy schedules. We also thank other key informants who found time to share with the team their experiences and predicaments regarding the free maternity services. It is our hope that this report will enrich the provision of maternal health care services and ease the burden on our women.

Finally, we thank the Open Society Initiative for Eastern Africa for the financial and technical support that was valuable in enabling us to undertake this study.
EXECUTIVE SUMMARY

Introduction

This study set out to review the impact of free maternity services on maternal mortality in three counties in Kenya: Nairobi City, Kilifi and Migori. The study team utilized a variety of methods to gather information concerning free maternity services in each county. First, the team conducted in-depth interviews in three facilities with health care providers including medical superintendents, nursing officers-in-charge, matrons-in-charge, midwives, and quality control officers. The team also held focus group discussions with lactating mothers who had utilized maternal health care services at the facilities before and after the coming into effect of the free maternal health care declaration. Additionally, the team held key informant interviews with program officers and managers of non-governmental organizations (NGOs) implementing programs in the three counties. The research team also reviewed maternal health care records with the following indicators: new antenatal care (ANC) clients, ANC revisits, total ANC clients, clients receiving Intermittent preventive treatment (IPT), IPT1 and IPT2, total deliveries, number of maternal deaths—both pre-partum and post-partum.

Goal

The overall goal of the study was to explore the effects of free maternity services in addressing the runaway maternal mortality. The specific objectives of the study were as follows:

- To examine the disconnect between the policy pronouncement and resource allocation regarding the current state of maternal health in Kenya.
- To find out the factors responsible for the apparent lack of accountability and inaction by civil society organizations (CSOs) and citizens to challenge the poor quality of maternal health services provided.
- To investigate and document the efficacy of selected models of maternal health financing and services delivery.
- To determine the effects of devolution and devolved health sector on maternal health outcomes.

Results

The findings indicate several key gaps in the implementation of the free maternal health care declaration in the three counties as follows:

- Lack of involvement of stakeholders due to the top-down nature of the policies in Kenya;
- The Free Maternity declaration was a political decision that was made at the apex of political leadership and all public health facilities were expected to provide services regardless of their capability in terms of personnel and resources.
- The Free Maternity declaration has been seen by the implementers as focusing mainly on reduction of financial barriers without considering other important impediments like culture, distance to the health facilities, authority to make decisions on utilization of health services, staff attitude and motivation, as well as the availability of adequate equipment and supplies, as key factors in accessing maternal health services.
- In all the health facilities visited, it was noted that there is a problem of resource flow. In all the cases, there was no proper accountability for the flow of resources and more particularly the rebit1 Health facilities reported to have provided services without promised re-imburements. Since the re-imburements were not forthcoming as expected, facilities provided poor quality services and lack of basic supplies forced providers to refer clients to private health facilities where they were expected to pay for the services rendered.
- The increased utilization of health facilities, as a result of the free maternal health services, has also overstretched the providers, hence lowering the quality of services due to increased work load which is further reflected in health care staff attitudes.

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1 Rebit (Recurring Earnings before Interests and Taxes) are resources that the central Government ought to refund each health facility based on the number of deliveries conducted every month at an agreed rate of KShs. 2,500 for level 3 and 4 and KShs. 5,000 for level 5 for both normal deliveries and C-sections.
In terms of the apparent lack of accountability and inaction to challenge maternal mortality, the following were the findings:

- There is a general lack of access to sufficient information at the community level that can influence demand for quality services. Those with information do not feel empowered enough to take action in demanding for proper maternal health care.

- The low public participation in the policy development and structures that guide maternal health care has impacted the provision of maternal health services.

- The centrality of culture in maternal health sometimes makes pregnancy a private affair and childbirth a family issue. Women are therefore blamed for any bad outcomes. The husband and the immediate family members are sometimes blamed for not having acted on time. This self-blame makes the accountability around the deaths and morbidity difficult since the cases are not reported.

- In some cases, women are attended to by the traditional birth attendants (TBAs) whose role is not properly recognized in the formal health care system. Others use traditional medicine and prefer home deliveries which make them feel ashamed to reveal the un-favorable birth outcomes.

- Some facilities already have a maternal and peri-natal death surveillance and response committee (MPDSRC), which reviews and audits each maternal death and recommends measures to address the noted problems and to reverse the trend.

- The facilities have extended this surveillance to the surrounding communities where, through the Reproductive Health Coordinator (RHC) and the Community Health Volunteers (CHVs), they conduct verbal autopsy liaising with the community to document and understand the reasons behind deaths at home and recommend remedial measures.

Impact of devolution and devolved health sector on maternal health outcomes:

- Devolution has been touted as a great idea that has enhanced health care provision and brought services closer to the people. More hospital-based deliveries are being recorded. Most facilities have doubled the number of mothers giving birth monthly. For instance, Migori County Referral Hospital reports an increase from 120 to 300 deliveries per month, while Kilifi has seen an increase from 300 to 500 deliveries per month.

- Because of devolution, each of the sub-county hospitals now has ambulances to attend to emergency issues.

- Devolution has strengthened the position of the CHVs and enhanced local level consultations with the community. The community level health care has enabled communities to voice their concerns and opinions about maternal health services.

Efficacy of maternal health financing models:

- Noted funding sources included the government, the donors, insurance companies, National Hospital Insurance Fund (NHIF), out of pocket (OOP) and merry go rounds in the community. Other funding sources include M-TIBA2 and top-up bonus for savings.

- Output Based Aid (OBA), which was an initiative of the German and the Kenyan Governments, has been seen by mothers as the best financing model. A pregnant mother could purchase a card for KShs. 100 and the card would take care of all the maternal health care costs for up to six months after delivery.

- Free maternity services have been lauded by women utilizing maternal health services and stakeholders as having enhanced accessibility, availability and affordability of health care services to the low and middle-income populations. It has reduced maternal mortality and morbidity within populations and enhanced equity in maternal health care services.

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2 M-TIBA is a “health wallet” on the mobile phone that allows your patients to set funds aside for health care, thereby improving their financial capability to access your services. M-TIBA will be regularly updated with new products. Once you are selected to become part of the M-TIBA network of health care providers, you will be the first to receive information on these new products and how to become eligible to offer them to your patients.
Staffing and local level hiring of staff has in some facilities been politicized with some incompetent staff getting hired, compromising quality of services. The increased staff strikes have further compromised the quality of services as patients are left unattended.

The major problems with the devolved health system revolve around the availability of finances and the mode of financing health care. Allowances that were previously given to staff by the central government have been scrapped by county governments. This has demotivated health workers and led to poor services provision.

Maternal health care is underfunded. Each delivery whether “normal” or caesarean section attracts a refund of KShs. 5000 at level 5 health facilities. This rate is not commensurate to the cost of providing the service. At the same time, the money does not reach the facility as recommended and when the refund is made, the money goes into other budget lines within the county and not necessarily channeled to maternal health services.

There is need to modify the existing policies and guidelines for health care financing. The program by NHIF has been lauded by many as a preferred method, where the government enrolls all pregnant women by paying KShs. 500 and then the mother receives all the services funded by NHIF. NHIF then directly reimburses the facilities for the maternity services rendered, thus reducing the bureaucratic bottlenecks and the inefficiencies at the county level and also checks the tug of war between the Ministry of Health, treasury, counties and the health facilities.

The county governments should be empowered to guide and coordinate the identification of the maternal health care needs in the various counties to avoid duplications of interventions by development partners and related programs.

Counties and national government need to work together in a complimentary manner rather than being antagonistic as if they are competitors. The standoff and the centrality of control of resources flow currently being witnessed hurts health care provision more than any other sector. The health sector strife that lasted a record 256 days could be avoided if the two levels worked together.

County governments must ensure that professionalism is sustained in the hiring of staff and incentives where applicable, should be maintained to motivate staff to sustainably deal with the increased workload.

Normal deliveries should be refunded at a rate of KShs. 8,000-10,000 per delivery while the caesarean section should be refunded at the rate of KShs. 15,000-20,000. A provision should be made to cover stillbirths and pre-mature births that require extensive hospitalization.

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The government and its agencies should involve stakeholders in the policy formulation and implementation to enhance uptake of maternal health care services and for accountability mechanisms to take root.

There is need to invest in measures to enhance information availability, accessibility and sensitization of the population on the available health products and opportunities that can improve access to health care.

The proposed NHIF approach, that seeks to ensure that every pregnant mother is enrolled and receives every available services to ensure safe motherhood, should be recommended in financing maternal health care. Nevertheless, mothers, their care givers, therapy managers as well as the providers should be sensitized and given information regarding NHIF services. There is also need to ensure transparent and accountable management of the NHIF funds.

Community level accountability mechanisms should be enhanced, and all maternal deaths reported and documented and where possible, corrective measures taken to avoid repeat occurrences.

Recommendations

- The government and its agencies should involve stakeholders in the policy formulation and implementation to enhance uptake of maternal health care services and for accountability mechanisms to take root.
- There is need to invest in measures to enhance information availability, accessibility and sensitization of the population on the available health products and opportunities that can improve access to health care.
- The proposed NHIF approach, that seeks to ensure that every pregnant mother is enrolled and receives every available services to ensure safe motherhood, should be recommended in financing maternal health care. Nevertheless, mothers, their care givers, therapy managers as well as the providers should be sensitized and given information regarding NHIF services. There is also need to ensure transparent and accountable management of the NHIF funds.
- Community level accountability mechanisms should be enhanced, and all maternal deaths reported and documented and where possible, corrective measures taken to avoid repeat occurrences.
A woman dies every minute in childbirth around the globe and almost half of these deaths occur in sub-Saharan Africa (Africa Progress Panel, 2010). Despite the progress made in many countries to increase the availability of maternal health care, most women across Africa remain without full access to this care.

East Africa has a maternal mortality rate that stands at about 500/100,000 live births. In Kenya, it is estimated that 6,300 women die each year during pregnancy and childbirth (NCPD, PSRI and PRB, 2015). According to the World Health Organization (WHO), Kenya is among the 10 countries that comprised 58 percent of the global maternal deaths in 2013, contributing two percent of these deaths (WHO, UNICEF, UNFPA and the World Bank, 2015). Despite the notable progress made in several maternal health indicators such as the reduction in maternal mortality ratio from 414 in 2003, 488 in 2008-2009 to 362 in the 2014 Kenya Demographic and Health Survey, a lot still needs to be done to save women from dying during pregnancy and childbirth (Central Bureau of Statistics (CBS) Ministry of Health (MOH) & ORC Macro, 2004; KNBS, 2010, KNBS 2014).

It is noted that the target to reduce Maternal Mortality Ratio (MMR) to 147 would not be met due to the slow progress at reducing maternal mortality (it has remained high at 400-600 deaths per 100,000 births). Currently, 62% of births are attended to by skilled personnel and 61% of births take place in a health facility (KNBS, 2014). Generally, Kenya has made steady progress in improving reproductive health outcomes in the last decade despite her inability to achieve the set Millennium Development Goal target of reducing maternal mortality by 75%. Today, many women continue to experience morbidity or deaths from preventable causes, such as hemorrhage (severe bleeding), obstructed labor, and eclampsia (hypertension), which have proven to have cost effective interventions. Access to quality reproductive maternal health services remains a challenge across all levels of care and inequities continue to persist among population sub-groups and between the rich and the poor (KNBS, 2014; World Bank, 2013; NCPD et al., 2010 and MoH, 2014).

Preventing maternal deaths is possible with existing knowledge and technology. It involves preventing unintended pregnancies, monitoring women during their pregnancies and managing medical complications that arise during pregnancy and delivery (NCPD et al., 2015). Thus, the four most critical interventions are family planning, antenatal care, skilled delivery care and postnatal care, which must be expanded and improved.

The KDHS 2014 survey shows major supply and demand side gaps and challenges in coverage of health services that result in continued disparities between counties, urban and rural residents and different population groups. Reports indicate that out of the 32,021 women of reproductive age who were reported to have died, 6,632 died of pregnancy related causes. About 15 out of 47 counties account for 98.7% of the total maternal deaths in the country with Mandera accounting for 2136, Wajir 581, Nairobi 533, Nakuru 444, Kakamega 364, Kilifi 289, Nandi 266, Bungoma 266, Homabay 262, Migori 257, Kisumu 249, Siaya 246, Transzoia 234, Kwale 203 while the remaining 32 counties accounted for only 85 maternal deaths (UNFPA, 2014).

The county with the highest population of women dying from pregnancy related causes is Marsabit. Siaya, Kisumu and Taita-Taveta counties have the highest proportion of women dying in the postnatal period. The implication here is that various factors influence the risk to maternal deaths in different counties. UNFPA further observes that Kenya is among the top 10 countries with the highest number of HIV associated maternal deaths with about 20% of maternal deaths being indirectly related to HIV (UNFPA, 2014).
Several challenges have been noted by the Ministry of Health as being responsible for poor maternal health outcomes. The key supply side challenges include sub-optimal functioning of the health system with uneven distribution of the health workforce as well as constraints in competency and motivation of the healthcare providers to provide quality care; insufficient financing and weak supply chain management, resulting in missing critical inputs required for services delivery, especially essential commodities; and poor quality and utilization of routine data for services delivery, especially essential commodities; and poor quality and utilization of routine data for evidence-based decision making (MoH, 2016). It is also noted that socio-cultural and economic barriers and constraints in physical access to health services continue to limit demand.

This study sought to interrogate the relationship between the different policy pronouncements regarding health financing and the actual outcome of maternal mortality and morbidity. The findings indicate the need for proper consultations before a policy is suggested and mass awareness of the populace on suggested changes for proper services utilization.

3 The recent doctor’s and nurses’ strike are testimonies to the problem and the government attitude towards the providers. The official attitude is wanting and the level of civil society agitation demanding for accountability has gone down over the years.
Access to skilled delivery remains a challenge and it is due to these challenges that on June 1, 2013, the Government of Kenya took action to address this problem by making a policy pronouncement that would ensure provision of free maternity services in all public health facilities. This was effective immediately and in July 2013, the government committed KShs. 3.8 billion to fund the free maternal health care program in the 2013/2014 national budget (Bourbonnais, 2013).

Under the Constitution of Kenya, 2010, the health function was devolved to the county governments with distinct functions being assigned to the national and county governments. The national government is responsible for leadership in health policy development, management of national referral health facilities, capacity building and technical assistance to counties and consumer protection, including the development of norms, standards, and guidelines (Okech, 2016). The county governments are responsible for county health services and pharmacies; ambulance services; promotion of primary health care; licensing and control of establishments that sell food to the public; cemeteries, funeral parlors, and crematoria; and refuse removal, refuse dumps, and solid waste disposal (Ibid). With regard to their functions, the county governments have undertaken new strategies and initiatives to address the health needs of their populations, including the construction of more health facilities, the acquisition of new equipment and medication at these facilities, and the addition of ambulances and more medical staff (KNBS, 2014).

Kenya Demographic and Health Survey (KDHS), 2014 shows a maternal mortality reduction from 488 in 2008 to 362 in 2014. This is still high compared to the MDG target of 147 per 100,000 that was supposed to be achieved by 2015. Some of the reasons advanced for the persistent high maternal mortality rates include hemorrhage (severe bleeding), obstructed labor, and eclampsia (hypertension), lack of access to quality maternal health care services including antenatal care, delivery and postnatal services.
2.2 Government Initiatives and Rights to Adequate Health Care

Globally, there is a renewed momentum and support for reproductive health as part of the Sustainable Development Goals (SDGs) and the updated Global Strategy for Women’s, Children’s and Adolescent Health (2016-2030). It aims to achieve the highest attainable standard of health for all women, children and adolescents, and ensure that every newborn, mother and child not only survives, but thrives. The new Global Financing Facility creates a new platform for collective action at the country level and is one of the main funding streams for the ‘Every Woman Every Child Movement’.

The Ministry of Health observes that improving coverage for maternal health services is its priority as is reflected in Vision 2030, the Constitution of Kenya, 2010 as well as the Health Sector Strategic and Investment Plan 2014-2018. To this end, the Government is noted to have introduced new policies and initiatives such as Free Maternity Services, Elimination of User Fee for Primary Care and the Beyond Zero Campaign to address critical barriers.

The Ministry of Health’s investment framework envisions a Kenya where there are no preventable deaths of women, newborns or children and no preventable stillbirths; where every pregnancy is wanted, every birth is celebrated and accounted for, and where women, babies, children and adolescents are free of HIV and AIDS, survive, thrive and reach their full social and economic potential (MoH, 2016).

In the Health Financing Strategy of 2010, the Government of Kenya committed itself towards universal health coverage (UHC) by emphasizing social health protection for all Kenyans. The Government introduced a social solidarity mechanisms founded on the principles of social health insurance and tax financing for purposes of financial protection of the poor and other vulnerable groups (Okech, 2016).

In order to achieve the set objectives, the government reiterated its commitment to amend the National Health Insurance Fund (NHIF) Act to enhance access, and broaden benefit package. In the Constitution of Kenya, 2010, the government provided the necessary legal framework for ensuring a comprehensive and people driven health care delivery system aimed at enhancing access to quality and affordable health care. The Constitution introduced a devolved system of governance with two tier-government systems namely the county and national government. The goal was to enhance utilization and geographical access to quality care by all Kenyans.

The Constitution further provides for the right of access to health care including emergency health services by all including children and persons with disabilities as key areas of focus in health services delivery. In 2013, the government announced the abolishment of user fees at primary health care facilities and introduced free maternal health care services in public health facilities. This initiative may be considered as a policy meant to enhance access to quality care, especially among the poor and other vulnerable groups; its implementation has however been replete with technical challenges and financial shortcomings (Okech, 2016).

The measure was envisaged to help all pregnant mothers to access maternal health care and consequently reduce maternal deaths. User fees at public health facilities were introduced in the late 1980s during a period of national structural adjustment programs to supplement government health allocations, which at the time no longer covered the full cost of many services. However, lower-income citizens, especially in rural areas, could not afford to pay these fees, leading to poor health outcomes for women in particular (Mwabu, 1995).

With the new policy pronouncement, the National Government is required to reimburse health facilities for free maternity services and for every delivery that they handle, at the rate of KShs.2500 per birth at health centers and dispensaries, and KShs.5000 for every birth at level 4 and 5 hospitals. This covers normal deliveries as well as caesarean section and other related complications. These funds are supposed to be paid directly to the facilities. In addition, no fee is to be charged for antenatal and post-natal care up to six weeks after delivery, or for referrals made in the case of complications related to pregnancies. All fees charged for all types of health care services at dispensaries and health centers were also abolished (MoH, 2015).
The main assumptions towards achieving this milestone are that supply side interventions will improve service delivery and strengthen the health system. This should effectively be coupled with innovative demand side approaches for scaling up coverage and utilization for high impact reproductive health interventions. The framework also highlights need for a multi-sectoral approach to address key social determinants that impact maternal health outcomes such as education, safe water and sanitation, transport, communication, food security as well as gender equality. It is against this backdrop that the study explored the accountability mechanisms inherent in the health sector approach to the provision of adequate reproductive health care in Kenya and to tease out the progress thus far in the provision of quality maternal health care services.

2.3 Noted Approaches in Maternal Health Financing

There are known cost effective interventions that can dramatically reduce maternal mortality: The following are some noted interventions:

- Maximizing services of health workers: Addressing costs, access and information challenges.
- Tackling barriers through increased budgets for maternal health, health systems interventions i.e. community health volunteers.
- Efficient financing mechanisms: Subsidies and payment exemptions, health insurance programs, donor funding and harnessing the power of the private sector.

Borghi (2001) observes that funds for health care can be generated by four main sources (most of which are currently applied in Kenya):

- Direct government financing
- Donor financing
- Private user charges
- Third party payments (health insurance, community financing among others).

Community Health Volunteer (CHV): It is noted that CHV programs can improve maternal health and have successfully reduced maternal mortality in both Ethiopia and Nepal (Africa Progress Panel, 2010). Countries have provided subsidies, abolished user fees, implemented national and community health insurance schemes, utilized performance-based financing and built partnerships to improve maternal health. The Africa Progress Panel notes that while donors can provide much needed funding, it is important for countries and donors to work together to ensure that programs are cost effective and in line with the national priorities. Governments must also leverage the resources of the private sector to improve maternal health.

Political Will: Further, the Africa Progress Panel (2010) noted that political will and strong leadership make innovative, cost-efficient interventions possible. Since women are often marginalized economically, politically and socially, sustained leadership on gender equality is required to advance maternal health. Strong leadership at the highest levels promotes accountability within ministries as well as counties and enables them to find reliable partners to drive and champion progress in maternal health.

Community Financing: Community financing is effective in enabling many low-income populations who would otherwise have no financial protection against the cost of illness (Jacob and Krishnan, 2017). Literature indicates that there are successful projects, which have been initiated through this model of financing. For example, in Nigeria and Sierra Leone, the programs were run by the Prevention of Maternal Mortality Network (PMMN) and the aim was the provision of fund for emergency care (transport to hospital, drugs and supplies, general treatment) for women during pregnancy, with no pre-payment required. In Tanzania, the example is of a health card for reproductive health services funded by households and subsidized by the government (Borghi, 2001).

Maternal Voucher: Bangladesh experimented with the Maternal Health Voucher Scheme which was a specialized form of demand side financing program implemented by the Government. It was concluded that in poor developing countries, a demand side strategy may not be very effective without significant expansion of the service delivery capacity of the health facilities at the local levels (Ahmed and Khan, 2010). The Government of Kenya, with

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*One wonders how corruption in the health sector can be handled to ensure donor and private sector confidence in the midst of low accountability.*
Proper and sustainable maternal health care financing must take into account the different aspects of the needed services. These include ANC visits, normal vaginal delivery, caesarean section, abortion, post-abortion care, eclampsia, hemorrhage and sepsis. It is however noted that insufficient funding for health services is nearly a universal problem in developing countries. In many low-income countries, the percentage of government revenue that has gone into financing health care has declined since the early 1980s (Krasovec and Shaw, 2000).

Even though most populist governments have attempted to provide free maternal health care services, community based programs have been noted to have a vital place in emergency obstetric care, because they can ensure women’s access to such care when needed. In general, Borghi (2001) observes that costs are lowest and sustainability greatest in programs that make use of existing capacity.

In some countries, there are numerous non-governmental organizations (NGOs) working with or in parallel to government in the provision and/or financing of maternal health care services. In Malawi and Brazil for example, the government provides subsidies to the NGOs in full or in part for the provision of reproductive health services and in Guatemala, the NGOs are contracted by the government to extend basic services to the poor rural populations (Borghi, 2001). In general, the study looked at the different scenarios and teased out whether the model being politically adopted in Kenya provides a sustainable way of ensuring safe motherhood.

Borghi (2001) in an analysis of the cost of maternal health care and how it can be financed noted that in order to achieve good maternal health outcomes in developing countries, the model of health financing must facilitate access and guarantee service quality. The, above she noted, can be achieved through a variety of methods such as general taxation and social insurance.

Household or Out of Pocket Financing: Health sector financing is largely covered by the household or out of pocket. Its contribution however, to the total health expenditure has declined over the years partly due to increased donor funding and increased poverty at the household level. The public sector (government) contribution to the total health expenditure has been constant for several years despite dire need for increase (MoMS and MoPHS, 2010). The first comprehensive report by Ministry of Health on the status of implementation of free maternity services notes that 28% of pregnant mothers seeking delivery services had reported to have paid some fees to access care (Ministry of Health, 2015). This implies that there are still hidden costs which a pregnant mother need to pay for despite the government declaration of free maternity services. This has been explained as resulting from the lack of re-imbursements by the central government hence necessitating providers to refer mothers to private clinics and for the antenatal care and lab tests where they pay for the services.
2.4 Free Maternity Services and its Challenges

The initiative to offer free maternity services was mooted after the devolution of most of health services in Kenya in 2013. Currently, health care is run by the 47 County governments (Republic of Kenya, 2015). The organization of the health care services delivery at present is based on a six-level structure. At the very bottom is the community which is level 1 followed by the primary care services which are provided at the dispensaries (level 2) and health centers (level 3). These two levels are followed by county referral health services (levels 4 and 5) and level 6 consists of the national referral health services (Republic of Kenya, 2014).

As a result of the free maternity declaration, Kenya recorded an increase in proportion of facility-based deliveries from 44% in 2008 to 61% in 2014 (KNBS, 2015). A recent article by Njuguna, Kamau and Muruka (2017) on the impact of free delivery policy on utilization of maternal health services indicates that the number of deliveries and antenatal care attendance increased by 26.8% and 16.2% respectively in county referral hospitals and decreased by 11.9% and 5.4% respectively in low cost private hospitals between 2013 and 2014. They note that counties with level 5 hospitals recorded more deliveries compared to those with level 4 hospitals partly due to their higher level of staffing and better facilities.

Recent statistics compiled by Okeyo (2017) indicate that for the period 2013-2017, 4665 women died while giving birth compared to 6200 in 2008. During this period, a total of 3,637,097 women delivered in hospitals in Kenya out of which 448,971 deliveries were in Nairobi City County alone. The report further indicates that 743 mothers died in Nairobi while giving birth, 263 in Mombasa, 248 in Mandera, 239 in Kisumu and 188 in Nakuru during the same period. In terms of complete antenatal care visits during the same period, 2,815,391 women completed their recommended four antenatal care visits of which 385,506 were in Nairobi, 149,235 women were in Kiambu, 132,090 were in Kakamega, 124,008 women were in Nakuru and 97,791 women were in Mombasa counties.

The above increase has been attributed to the free maternity services introduced in 2013. The sudden increase in the number of pregnant women seeking maternal health care services because of the free maternity services has strained the health facilities especially the physical infrastructure, and human as well as financial resources.

Introduction of the free maternity services resulted in a 22% increase in the utilization of maternity services (Ministry of Health, 2015). Minimal input by the government in terms of new physical and organizational resources could have compromised the quality of maternal care, reducing confidence in the system hence lower utilization of the facilities (Murima, 2016) in the long run.

A study by Lang’at and Mwanri (2015) in Malindi Kenya demonstrates that the policy has had both positive and negative contributions to health. For instance, before the introduction of the policy, the maternity departments were overcrowded with mothers who had not yet cleared their bills. The free service policy has alleviated this problem as women can go home immediately upon their discharge.

Caregivers noted that women who never visited the facilities before, during pregnancy and delivery as a result of the user fee, were now able to seek skilled care services. There was a rise in the number of antenatal care services visits as well as number of facility-based deliveries following the introduction of the policy. The timing of the women seeking these services had also improved. Following the initiation of the policy, women were seeking maternal health services sooner than they used to. Other service providers stated that the free maternal health care service had already impacted the maternal health outcomes including a reduction in the number of maternal mortalities (Ibid).

Reports indicate that the initial attempts to eliminate fees for maternal care were less than successful due to funding, distribution, budgeting and overall program management challenges (Ministry of Health, 2015). The transition to a devolved system has not been smooth. The turf wars between counties and national government, the level of mistrust and absence of positive intergovernmental relations has severely undermined services provision with the health sector being the hardest hit (Bosire, 2017).
Workload has increased because of increased utilization of the services. For example, a national referral hospital reported a 26% increase in deliveries, 22% increase in caesarian sections and 50% increase in antenatal care attendance, yet staffing was inadequate (One nurse taking care of 15 patients). An approval by Ministry of Health to provide staffing had never been implemented (Ministry of Health, 2015). Many a times, post graduate doctors who are not compensated do the work and in addition, part time nurses are hired to mitigate the overwhelming work. Two referral hospitals reported that maternal mortality had increased because there was a tendency to focus more on the complicated referral cases.

To make the situation even worse, from the outset, health workers did not like the hurried and unplanned devolution of health care without appropriate structures. They went on a nationwide strike in 2013. Subsequent years have seen multiple county-based strikes take place at the expense of poor patients. 2017 was the worst year for the health sector, with about 256 days spent on strike that paralyzed operations in public health care system. In December 2016, doctors went on strike for 100 days, closing down every public health facility in Kenya. As patients died, the health custodians at all levels played hard ball and ignored the silent suffering of patients. The strike eventually ended but the respite was short. A few weeks later, nurses went on strike, paralyzing service provision in every health facility in Kenya. Bosire (2017) refers to the 2017 as the year when public health died in Kenya.

Okech (2016) points out that currently, a number of health facilities have acquired specialized machines and equipment through the National Government’s Managed Equipment Scheme. However a number are lying idle and gathering dust, despite costing the county governments millions of shillings every month in lease fee. This is attributed to lack of necessary personnel to operate the machines and equipment as well as lack of proper infrastructure for their installation. Similarly, there is limited investment in maintenance of physical infrastructure although investments in medical equipment are ongoing in selected hospitals. Of concern however, is lack of comprehensive, coordinated investment leading to gaps in some facilities and limited investment in maintenance of medical equipment. Reports show that purchase of ambulances is ongoing at hospitals and model health centers, though there still exist significant gaps in utility vehicle availability (some ambulances also used as utility vehicles as a result) (GoK, 2015).

Failure of the government to involve health providers and administrators in the development of this policy was also perceived as a barrier to the effective implementation of the program in specific facilities. On the other hand, facility in charges expressed concerns about the quality of the services provided, which they felt were compromised by the high patient volumes amidst shortage of staff and supplies. The studies also noted that most dispensaries in Kenya (the main facilities serving rural areas) are poorly staffed and lack adequately trained skilled workers. This limits the functioning of the facilities, including the operation times of the facilities, which were perceived as a challenge to maternity service provision and utilization (Lang’at and Mwanri, 2015).

Overall, the free maternity services pronouncement led to an increase in the demand for services but with limited capacity to provide the services. At the same time, the strikes and the confusion prevalent in the health sector have further eroded would be gains. At the moment, the much-touted free maternity care is in limbo as maternity wards across the country are closed, with the burden of service delivery shifted to the private and faith-based health facilities (Bosire, 2017).
BEYOND ZERO INITIATIVE

The First Lady, Mrs. Margaret Kenyatta launched a campaign dubbed “Beyond Zero Campaign” on January 24, 2014 to improve maternal and child health outcomes in the country. The new initiative also aimed at accelerating the implementation of the national plan towards the elimination of new HIV infections among children. Mrs. Kenyatta noted during the launch that she was deeply saddened by the fact that women and children in our country still die from causes that can be avoided. She observed that the initiative would bring prenatal and postnatal medical treatment closer to women and children.

This initiative received major support from donors and private sector players. Immediately after the launch, Donors and private sector organizations pledged funds to purchase mobile clinics that were to provide integrated HIV, maternal and child health outreach services in the country. For example, James Mwangi, the Chief Executive Officer of Equity Bank in Kenya, pledged US$ 580,000 during the launch event. The Ministry of Health also promised to invest in 2014 an estimated US$ 400 million towards initiatives to reduce HIV transmission and maternal and child mortality, to increase the number of skilled health care providers and to equip the existing facilities with relevant supplies.

The strategic framework for which the Beyond Zero Initiative is anchored focuses on five key areas: (i) Accelerating HIV programs; (ii) Influencing investment in high impact activities to promote maternal and child health and HIV control; (iii) Mobilizing men as clients, partners and agents of change; (iv) Involving communities to address barriers to accessing HIV, maternal and child health services; and (v) Providing leadership, accountability and recognition to accelerate the attainment of HIV, maternal and child health targets. In essence, this initiative appears part of the uncoordinated approaches that lack the capacity to sustain themselves. Thus far, the initiative has donated 47 mobile clinics to the 47 Counties.

Anecdotal information indicates that some of the mobile clinics are gathering dust where they have been donated owing to several shortcomings among them lack of staff and supplies. In addition, the initiative appeared only geared at providing the mobile ambulances to the counties and nothing more. So far, in the counties visited, the mobile clinics were parked at the referral facilities. For Nairobi, it is parked at Pumwani Maternity Hospital, for Migori it is at the County Referral Hospital while for Kilifi, it is parked at the County Referral Hospital.
3.0 STUDY METHODOLOGY

The study adopted a cross-sectional-descriptive approach combining both qualitative and quantitative (trend analysis on health care service utilization from health records office) approaches. Three counties were purposively selected for this study.

3.1 Target Population and Data Collection

The study was conducted at the various facilities within the selected counties. For Nairobi City County, the three facilities visited were Pumwani Maternity Hospital, Mbagathi District Hospital and Mama Lucy Kibaki Hospital. For Migori County, the study was conducted at the Migori County Referral Hospital, Kehancha Level IV Hospital and Rongo Sub-County Hospital. For Kilifi County, the facilities visited were Kilifi County Referral Hospital, Bamba Sub-County Hospital and Malindi Sub-County Hospital.

In each facility, the researchers reached out to three key informants who included the doctor in charge, the nursing officer in charge and the person in charge of the maternity. The records office was important for the extraction of existing data on utilization of maternal health care services at the facility. Lactating mothers who have interacted with the health care system before and after the free maternal health care policy were also interviewed to share their experiences. Other cadre of informants included organizations working on maternal health care at the national as well as county levels.

In total, the following informants were interviewed after having been selected through purposive sampling:

Ten (10) Focused Group Discussions were held with women of varied ages in the three counties. Age categories included 15-24 years (3 FGDs); 25-34 years (3 FGDs) and 35-49 years (4 FGDs); Six Key Informant interviews, consisting of two for each county and Twenty-three (23) In-depth interviews.

From the lactating mothers in the FGDs, the study teased out their awareness of the free maternity services, the quality of care and availability of the necessary supplies, accountability of maternal deaths at the community level and the effects of devolution on access to maternal healthcare among other issues. From the maternal health care providers in the facilities, the study teased out the effects of free maternity services on health care delivery in terms of quality and availability, health financing and the effects of devolution on their services.

The Key Informants, who included actors such as NGOs and CBOs staff were asked about their involvement in maternal health care, forms of health care financing, best practices and lessons learnt over the years in this sector as well as their participation in the area of policy formulation. From the health records in each facility, the study teased out antenatal and delivery care coverage, trends in utilization of the facility, trends in maternal mortality and morbidity, services provided and the level of coverage and catchment areas of the facilities. The results of the above exercise are shown in section 4 of the report.

3.2 Study Recruitment Strategy and Procedures

Breastfeeding mothers were recruited while exiting health facilities after utilization of postnatal care services. To ensure that the women were not kept long as the study waited to get the required number of participants, interviews were organized during clinic days when many women visited the facility. In other situations where the nurses’ strike had disrupted the services, the recruitment was done through the CHVs in the community but within the catchment area of the facilities.

As already noted, the key informants were purposively selected by virtue of being the personnel in the selected health facilities and NGO/CBO staff implementing maternal health care programs in the three counties. The actors in the Civil Society world were those suggested by the facilities as being partners or organizations that are known to work in reproductive health such as AMREF among others.
The process began with desk review of the various policies and financing options of maternal health globally, regionally and in the East African countries before looking at what is available locally in Kenya.

In terms of the counties selection, the study purposefully settled on Migori, Nairobi and Kilifi based on the reported burden of reproductive health and maternal health indicators. These counties represent regional diversities, with Migori being in western Kenya region where the HIV and AIDS burden has had devastating effects; Nairobi County is the capital city and home to many slums where health care access poses certain challenges. Nairobi is also centrally located with the presence of many actors including civil society organizations that hold government accountable besides providing maternal health care services to the poor segments of society. On the other hand, Kilifi County is at the coast region which has other challenges including religion, poverty and cultural obstacles to proper access to maternal health care services.

Quantitative data has been provided by analyzing the maternal health trends over the years and documenting the shortcomings and the players at the local levels.

3.3 Ethical Considerations

The research sought and obtained an ethical approval from the KNH-UON ERC (P377/07/2017). Besides the overall approval, each county had its own research committee which also approved the study. The same process was replicated in the specific facilities visited. In the protocol, the research observed all the relevant provisions that concern research on human subjects. All the informed consent and assent were obtained from all study participants after due explanations of the research. All participants did so voluntarily and were at liberty to disengage at any point in the process.

Due regard was paid to the timing so as not to interfere in their daily chores and where possible, transport reimbursements made to ensure that participants were not disadvantaged in anyway. The detailed consent form was duly signed by all participants and those who could not append their signatures, were allowed to have a thumb print.

3.4 Challenges Faced

Several challenges were faced by the study team that led to the delay in completing the assignment. They included:

- The ethical approval process was slow and even when the approval had been granted, each county still expected to approve the protocol and even still, each facility had to sit and take the proposal through its research committee. All these levels of approval led to delay in the commencement of fieldwork.

- During fieldwork, the nurses’ strike made work very difficult since the services were at a standstill and the mothers could not be easily recruited. In some of the facilities, the recruitment was in the community through the assistance of the CHVs.

- Some of the targeted informants were unable to honor their appointments. Three in-depth interviews in Kilifi, one in Mbagathi and one in Mama Lucy Kibaki Hospital could not be conducted owing to the inability by the informants to honor their promise. Most of them were either maternity in charges who were on strike and in two situations, the medical superintendents.

- The records review had its own challenges. In some facilities, it was not easy to access the records while in others, some summaries were missing hence difficult to understand the trends in the use of services over time.
4.0 KEY FINDINGS

In this chapter, we present the key findings of the study. The quotations from survey participants illustrate their perceptions regarding the area of study. The data is presented in this chapter to demonstrate trends in health services utilization.

“We conduct up to 15 deliveries per day and about 10 per night with only less than three nurses to cover a 24/7 schedule. We at times have only two nurses on duty and even have an average of two C-sections” (Health provider, Kilifi County Referral Hospital).

“Free services have enabled women to come to the facilities and this has provided an opportunity for the health care sector to provide comprehensive services to women to reduce instances of maternal mortality. This is proving to be a very noble initiative despite its various shortcomings” (Senior administrator, Pumwani).

Despite the challenges, the free maternity services have enabled women to access other services such as health talks, antenatal as well as postnatal care information, information on importance of family planning and birth spacing, importance of maternal nutrition and the advantages of facility-based deliveries.

Women who previously avoided going to hospital for fear of being detained for lack of money to pay for the services can now visit the facilities without fear. This can be summarized by the views expressed by the FGD participants across the three counties who noted that:

“The free maternity services have really decongested the hospitals since women who would be previously detained after delivery are now allowed to go home after delivery. This not only makes the process easier but also respects the rights of the women and their children and saves their families from agonizing over the bills” (FGD participant in Kilifi County).

“At Pumwani here, we used to pay between KShs. 7000-8000 for normal deliveries and this was too much and most women could not afford. The free services have saved many women and I can tell you for sure, this was God sent” (FGD participant at Pumwani Maternity Hospital).

“Apart from the strike that paralyzed services, free maternity services have enabled us poor women to enjoy health services that previously were not possible. We feel very happy and hope that the County government will ensure that quality is sustained and that nurses are paid in time” (FGD participant in Migori County).
Overall, the providers reported that the increase in number of women seeking maternity services was not accompanied by the necessary infrastructural development to cope with the demands. Women on the other hand noted that the services are replete with several shortcomings, among them lack of essential supplies and negative attitude of the providers. In some instances, they wondered what aspect of the free maternity services was really free since they were asked to pay for many of the services they received such as the cotton wools, blades and other essentials. Both providers as well as the service seekers were in agreement that the increase in those seeking services had compromised quality.

Worse still and of great concern to quality is the continued strike in the health sector that took 256 days in 2017. Immediately after the doctor’s strike, nurses in public hospitals went on strike that lasted a total of 156 days. This grounded the public health system to a halt and the custodians seemed to be totally unprepared to deal with such crises in future. What has been witnessed is the blame game between the national Ministry of Health and the county governments. The national government was uncharacteristically silent, with the President only expressing optimism that the impasse would end soon. For stability of the health sector, more sustainable solutions need to be sought to the challenges facing the sector. More importantly, the impasse between the national government and county governments must be addressed as a matter of urgency to forestall future strikes that cause paralysis in the health sector.

4.1 Free Maternal Health Policy Formulation, Pronouncement and Resource Allocation

The health care providers as well as the other actors in the health sector noted that the policy pronouncement led to an increase in utilization of maternal health care services at the health facility level. However, the implementation process was not well coordinated from the time of policy pronouncement to commencement of provision of free maternal health care services as noted below:

“The biggest problem regarding the pronouncement is that after the declaration, all public hospitals started providing free services without due regard to whether they had the necessary resources and capacity to do so. When an important policy issue becomes part of the political bickering, then the whole process gets muddled up. We needed to do background inquiry on the services seekers and answer questions such as who needs what, where and at what level of assistance. Lumping all services seekers together was a political process and not policy based. Translating political statement to policy can sometimes be a nightmare” (Health Programme Manager at AMREF).

In general, the services providers and other actors in the health sector noted that the pronouncement needed to be translated into a policy statement and a clear process of resources allocation needed to have been thought through. They are of the view that the minimal involvement of the actors meant that there was no buy in. The policy instead of addressing maternal health holistically, focused more on funds as a barrier to access without considering other related barriers such as culture, distance to facility, staff attitudes and workload among others. Some stakeholders noted thus:

“This free maternity initiative does not clearly take care of the entire process of pregnancy. It should be renamed “free pregnancy and delivery care”. The process of pregnancy goes beyond childbirth and is not about the numbers. Where do we classify those who miscarry? How do you budget the same amount as reimbursement for all forms of deliveries such as cesarean section, breech delivery, assisted vaginal deliveries among others? Generally, this thing was not well thought out” (Reproductive Health Program Officer at AMREF).

“Free maternity should be called free gynecology and obstetrics care since free reproductive health is broad and goes beyond delivery. It should include everything from the very time a girl experiences her first menses” (Senior administrator, Pumwani).

“There are too many hidden costs and the idea of free maternity services should either be expanded or the name changed to reflect the limited services it entails. As providers, we get blamed for not providing comprehensive services yet our financial capacities are limited. When you ask a woman to go for certain services in the private clinics, they always think that we are being unfair and corrupt” (Quality control personnel, Rongo Sub-County Hospital).
4.1.1 Financing of the free maternity program

Providers noted that there is a complete disconnect between what is expected to happen and what happens in reality. First, health care facilities are expected to be reimbursed for every facility-based delivery at the noted rates: KShs. 2500 for the level 2 and 3 facilities and KShs. 5000 for level 4 and 5. Most facilities noted that initially, they received some money as reimbursements, but the resources became unavailable with time. The facilities provided the services as required but were not reimbursed. Funding from the Ministry of Health or national government was sometimes channeled through the county governments and not directly to the facilities. As a result, county governments allocated the resources based on the priorities of the county bureaucrats. Quality maternal health care did not seem to be part of the priorities for a majority of counties and the allocations did not reflect the number of deliveries conducted each month. This was summed up by one of the reproductive health coordinators in one of the counties who noted:

“We conduct about 300 deliveries in our county referral hospital every month and we should then by their own estimate receive a total of 1.5 million shillings monthly as reimbursement for maternal health care services alone. Instead, we are allocated one million to cater for all the health services provided in the facility for the whole month. This is just a drop in the ocean and we have to make good with such resources. It was even better when we charged 2000 shillings for normal deliveries and 5000 shillings for caesarean section since the money would be available to buy the necessary supplies”.

This lack of maternal rebit has compromised the quality of care to a level that the services seekers are wondering what aspect of the services are free since they are forced to pay for some of the services or are asked to buy supplies from the private clinics and pharmacies. The providers also noted that they have been accused by the mothers of not being responsible in discharging their duties. A provider in Kehancha level 4 hospital noted thus:

“Mothers are accusing us of being corrupt and eating the money that is meant for free maternity services. This is because, whenever they come to the clinic and we do not have the supplies because of the lack of reimbursements, we ask them to go for the anti-natal profiles at the private clinics and they think that we are colluding with the private providers. This is really frustrating and some people with some means are now not coming to the public facilities”.

The other challenges mentioned by the providers included infrastructure, financial, human resources as well as information technology which are the pillars of health. A senior administrator at Pumwani Maternity Hospital noted that they are paid for delivery and not for maternity services. Some women have complications or face risky pregnancies during antenatal care and after delivery and have to stay for more than 24 hours in hospital yet they are not covered. In addition, anyone who undergoes caesarian section should be discharged by the 4th or 5th day even though the additional days are considered non-medical in the free maternity package.
On their side, the mothers in the focus group discussions noted that besides the negative staff attitudes, they also do not understand how free the free maternity services are since they have to pay for many of the services received. One of the FGD participants noted thus:

“It would be important to tell us what the facilities require from us. Coming here with the knowledge that the services are free and then you are asked to pay for the profiles is not fair. It is also inconveniencing and leaves us confused. The providers also keep reminding us that we are getting free services and have no reason to complain. We receive what is available instead of what is necessary”.

The presumption that all people value free things also came into sharp focus. One actor in the health care system noted that people rarely value free things and Kenyans are ordinarily very suspicious of what is provided to them for free. They always think that there are strings attached which may also hamper the proper utilization of services. He observed that he has heard services seekers making comments such as:

“For my community, we do not go for free things. A valued pregnancy cannot be free”.

The provider also noted that the middle-class women saw free maternity services as meant for the poor and those who do not value pregnancy. On this basis, there is need to rethink the entire process if we are to make the maternal health care services to work for the entire population. The number of poor women still being detained in private facilities for non-payment of maternity services should also be a cause for worry since it implies that even some poor women doubt the quality of services provided in the public health system and opt to seek for services in private facilities where they are expected to pay.
At the same time, a number of stakeholders expressed their frustrations with the way the services are provided. The pregnant mothers were of the view that the providers take them for granted and provide services in ways that do not inspire confidence. The complaints ranged from staff laxity, unavailability, harshness, timing of services, and incompetence among others. The following are some of the views expressed in the FGDs:

“Services are good but during clinics, the nurses are really harsh on us, they complain that women are so many at the facility because they are just getting pregnant without planning because the services are free. So, we use the services for lack of options” (FGD 35-49 year olds in Kilifi County).

The Same sentiments were expressed by the FGD of the 24-34 year olds in Mbagathi Hospital.

“Women now go to hospital as early as 5am to be the first in the queues so as to be attended to. At times, the health education is given only to the first 10 mothers, the rest are chased away irrespective of how far they have come from. If you come at 10 am, you will not be served. This free is good but really hurting us” (FGD 25-34 year olds in Kilifi County).

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“Nurses in the public hospitals should be taught how to relate with their patients” (FGD 18-24 year olds in Nairobi County).

“In a number of instances, we have been attended to by nurse students instead of the qualified nurses because of the absenteeism of the doctors as well as the nurses. There is just a general lack of a caring attitude among the providers” (FGD 25-34 year olds at Kilifi referral Hospital).

“At times, you get the watchmen as well as cleaners scolding the mothers. The whole health care system seems to lack respect for the patients and more so, during these free maternity times” (FGD in Migori County).

“In fact, I gave birth at 12pm, it was a normal birth and at 4pm, I was discharged because I could not sit on the floor and there was no bed because of the congestion” (FGD of 25-34 year olds in Kilifi).

The above challenges indicate that a sober discussion with the various stakeholders in maternal health has not taken place. The providers are facing challenges providing the services while service seekers are frustrated with the way and quality of services being provided.

Stakeholders made recommendations on how to strengthen the services to make them work:

- There is need to revisit the whole policy on free maternal health with strategic involvement of the stakeholders right from the formulation to the implementation stage to ensure that the needs of all stakeholders are taken into consideration.
- There is need to invest in reproductive health information availability to both the service providers and the mothers. In addition, the media should be in the forefront in sensitizing the population on available products that can improve accessibility of healthcare services.
- The already developed policies, for instance the maternal health protocol of 2002 should be put into use instead of being left to gather dust in the shelves or drawers of bureaucrats. The country is known to spend a lot of money in developing service charters, protocols, guidelines yet no reference is ever made to them and the patients who they should serve are not even aware of their existence.

The best functional health care system must take into account not only the cost component or the built environment. It must ensure availability of supplies, improve infrastructure, enhance the quality of the human resources and above all, ensure sound leadership and governance.
4.2 Lack of Accountability and Inaction to Challenge Maternal Mortality

The research teased out issues regarding the apparent lack of accountability and inaction in the communities as well as the health care systems to challenge maternal mortality. The findings indicate that some of the inaction results from the various cultures in which individuals are socialized and the interaction with the health care facilities in which the patients are seen as little knowledgeable to question “technical” processes.

Health care, and more so pregnancy, has been seen as a personal challenge not affecting anyone else. The individual, family and immediate relatives suffer in silence without telling anyone what they are going through. In this regard, individuals struggle on their own by calling on friends to assist, selling their property— for instance land— to finance health and people feel guilty when they lose a life. Most people end up blaming themselves for not having done enough to save one of their own. This self-inflicted guilt then mars any action that may enhance accountability of the systems to remedy the situation. The secretary general of the doctor’s union noted thus:

“Unless people begin telling their stories of how they sold their land, their belongings to finance maternal health or any other health problem, of how they lost their wives, sisters, mothers and daughters in avoidable circumstances, we may not take action. We must be able to call upon those who are the duty bearers to know that something is wrong. We must start demanding the full implementation of the constitution and observe the right to life”.

In many cultures, maternal health is still regarded as an aspect that must be experienced within a culturally closed system. Pregnancy and childbirth are replete with cultural metaphors and women prefer seeking services among traditional birth attendants while others prefer traditional medicine to ease their pain. Since most of the traditional practices are not accepted in the official health system, individuals get into self-pity and blame themselves hence limiting their capacity to take remedial measures to change the environment they find themselves. Giving birth alone in the garden, the house or on the way to the market is seen as being courageous and brave, the dangers notwithstanding. An individual in the FGD in Rongo sub-county noted thus:

“PREGNANCY AND CHILD BIRTH IS AN ASPECT THAT MUST BE EXPERIENCED WITHIN THE CULTURAL CONTEXT. All pregnancies can be death sentences and when one dies, you cannot blame anyone. The nyamrer was (TBAs) are very good and they try to assist and we cannot report them to authorities since it is never their wish to see any of their clients die”.

One informant overseeing health care programming in several countries in Africa noted that in one community in Ghana, there is a saying that “A pregnant woman has one foot in the grave”. In every African community, there is a justification to allow some women to die during delivery. This pedagogy of the oppressed has led to the justification and acceptance of maternal deaths in larger parts of Africa.

On the services delivery front, the system has been framed in such a way that individual services seeker is a recipient of generosity of a government or the services providers. You hear people making comments like this government or this minister is so good for allowing these services to be provided to us. In the interaction with the health care system, the patients lose their ability to question anything. One is directed to very many tests and they lack the courage to ask what all the tests are about or why they should cost the amount that you are asked to pay. This was aptly captured by a human rights defender who noted thus:

“Stepping into the doctor’s office, all patients even the most educated ones lose the WHY part in our vocabulary. The ability to ask why the tests are being done, why the handwritings cannot be read and why the type of medicine is being dispensed is lost to the patient. At times, even the watchmen in the facilities behave like doctors to interpret the prescriptions”.

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The FGD participants noted how powerless they are once in facilities and the fact that their proper treatment is at the mercy of the providers. They noted thus: “My mother used to tell me that if you go to the hospital and do not get along well with the nurse, the chances of coming back in a coffin are very high. This perception is still common here in Kilifi. Patients are at the mercy of health care providers” (FGD in Bamba, Kilifi County).

“In most communities, people are fatalistic and see maternal death as inevitable. They do not blame themselves. If it happens in the facility, they would rather blame the providers for not having acted in time with very many ‘if only’ i.e. if only they had admitted her, if only they received her in time, if only they diagnosed the real problem or provided timely treatment among others” (FGD in Kehancha, Migori County).

“Any hospital death becomes the burden of the immediate family. The doctors just say that ‘she died from excessive bleeding, high blood pressure’ and we do not know whether they are telling the truth since they are the experts. How do we even make follow-ups?” (34-49 years olds FGD in Kilifi).

“So, I cannot go to follow up why they died. In my village, I have like 10 women who have died and left their children. So, as a woman, you just go and contribute to the funeral. When they die, then that is their day and when mine comes, I will just die too and that will mark the end of my existence in this world” (FGD with 25-34 year olds at Mbagathi Hospital).

It is recommended that Kenyans must adopt a ‘rights-based approach’ to health care. These are entitlements and not gifts. The rights holders as well as the duty bearers must desist from the colonial hangover, which presented public services as favors. Behaviors that impede individual's capacity to demand for services must be dealt with through concerted efforts to enhance public awareness. Resulting from such attitudes, patients face abuses, maltreatment, lack of proper infrastructure, lack of accountability in government circles, unions at all levels defend their own without regard to the rights of the patients and individual citizens do not know that what they face in reality is unconstitutional. The ignorance and continued marginalization of the citizens in services delivery has become the norm and entitlements are seen as favors. Deaths and subsequent funerals are only places to politick and not question the structural inefficiencies that lead to those deaths.

The apparent lack of public participation in developing policies and structures that guide maternal health care; the lack of access to sufficient information that can influence demand for quality services and the ignorance on the part of rights holders to take appropriate action to demand for quality maternal health care services has been blamed for the low level accountability.

Most of the facilities observed that they have put in place mechanisms to ensure that all maternal deaths are duly investigated and appropriate actions taken. The hospitals have the Maternal and Perinatal Death Surveillance and Response Committees (MPDSRC) which do the inventory, review and audit all maternal deaths in the facilities and recommend measures to be taken to ensure that the problem does not recur. At the community level, the hospitals noted that they have partnered with the Community Health Volunteers (CHVs) and the community members to conduct verbal autopsies to understand deaths at home and recommend measures to address the same at the community level or at the facility.

Despite the existence of such committees and good initiative at the facilities, civil society actors noted that individuals cannot effectively monitor themselves and that no legal action has ever been recommended against any of the health care providers for negligence:

“Has anyone been prosecuted as a result of the findings of MPDSRC? The point is that individuals cannot investigate themselves and at the same time take punitive and corrective actions for their own failures. Someone very independent must take note of the systemic failures and do the necessary”.

“IN MOST COMMUNITIES, PEOPLE ARE FATALISTIC AND SEE MATERNAL DEATH AS INEVITABLE. THEY DO NOT BLAME THEMSELVES. IF IT HAPPENS IN THE FACILITY, THEY WOULD RATHER BLAME THE PROVIDERS FOR NOT HAVING ACTED IN TIME WITH VERY MANY ‘IF ONLY’ I.E. IF ONLY THEY HAD ADMITTED HER, IF ONLY THEY RECEIVED HER IN TIME, IF ONLY THEY DIAGNOSED THE REAL PROBLEM OR PROVIDED TIMELY TREATMENT AMONG OTHERS” (FGD IN KEHANCHE, MIGORI COUNTY).
A senior administrator at Migori County Referral Hospital added their voice to the need for an independent external audit for appropriate action. They noted thus:

“There is need for external audits to validate self-based audits so as to take remedial measures in maternal mortality. Someone independent must follow up on the implementation of both internal and external recommendations and see to it that they are done as per the audit outcome. The county needs to be answerable to a third party who can question issues of accountability at all times”.

It is important for the Kenyan people to be empowered to demand to be treated well at all times. Recently, in one facility in Mount Elgon, the community after a long spell of being treated with disdain by the providers, armed themselves and stormed the health facility to demand for better treatment. They demanded that all the providers be transferred if they are not ready to provide respectful services to the community. This led to mass transfer of the providers and the new people who came in have been treating the community respectfully. They now report to work in time, listen to the concerns of patients, provide the necessary referrals in time and conduct outreach program in the community. This they noted is unlike the previous set of health workers who were arrogant and opened the facility late, closed early and could abuse services seekers.

In summary, Kenyans need to realize that health care is not just the responsibility of a health care worker or the patient but the responsibility of every human being. This calls for public participation to reduce health care workers’ strikes, like the 256 days strike witnessed in 2017. However, the strike was reduced to an exchange among the nurses, the county and national governments. The public have not seen it fit to create platforms through which they can demand for accountability among the political class and the custodians of the health sector. We need to ask ourselves individually or collectively what role we have played to ensure that the patients are treated with respect and that the frequent strikes by providers do not recur. The citizens must demand better services from the government whether county or national.

4.2.1 Utilization of maternal health care services

Review of records of the nine facilities visited showed a systematic increase in the number of women seeking maternity services as a result of the free maternity policy. However, the information also shows the effects the nurses as well as the doctors’ 256-day strike had on utilization of the health services.

4.2.1.1 Utilization of maternal health services in Kilifi County

Data was extracted from the health records in three health facilities in Kilifi County. The three health facilities targeted in the County were Kilifi County Referral Hospital, Malindi Sub-County Hospital and Bamba Sub-County Hospital. The results are presented below.

“There is need for external audits to validate self-based audits so as to take remedial measures in maternal mortality. Someone independent must follow up on the implementation of both internal and external recommendations and see to it that they are done as per the audit outcome. The county needs to be answerable to a third party who can question issues of accountability at all times”.

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Utilization of antenatal care services

Data extracted from health records showed the utilization pattern of antenatal care services for the period between 2011 and 2016. The results showed a similar pattern where there was a decrease in utilization of services between 2011 and 2013 for new ANC clients, ANC revisits, total ANC clients, total pregnancies registered and women who received both IPT1 and IPT2 at the Kilifi County Referral Hospital.

However, after 2013, there was an increase in the number of women utilizing these services with a slight decrease between 2015 and 2016 as shown in Figure 1 below. These trends signal the rush to utilize services. However, the reducing numbers could be an indication of dissatisfaction with the services offered as a result of low quality due to large numbers seeking services beyond the capacity of the available health care personnel.

Figure 1: Utilization of antenatal care services at Kilifi County Referral Hospital
Data on utilization of antenatal care services at Bamba sub-County Hospital (Figure 2) showed an increase in the percentage of pregnancies registered, out of the total pregnancies registered during the period 2011 and 2016. There was a dip in the number of women who received IPT1 and IPT2 in 2014 compared to the period between 2011 and 2013, however, there was a steady increase in the number of women who received IPT1 and IPT2 in 2014 and 2016. While there was a decrease in the percentage of women who revisited the ANC clinics and total ANC clients in 2015, it sharply increased in 2016.

Figure 2: Utilization of antenatal care services at Bamba sub County Hospital
Utilization of antenatal care services at Malindi sub-County hospital increased in 2014 after the declaration of the free maternity services compared to earlier years of 2011, 2012 and 2013. This increase was for new ANC clients, ANC revisits, total ANC clients, total pregnancies registered and the number of women who received IPT1 and IPT2. However, a dip in the utilization of all these services was recorded in 2015 and a slight increase in 2016.

This pattern is likely due to the rush to utilize the free maternity services in 2014 after the government policy came into effect. However, due to the overwhelming numbers, it is likely that the quality of services went down, leading to a decrease in the number of clients using the services before delivery. These are shown in Figure 3 below.
Data on utilization of delivery services at the Kilifi County Referral Hospital showed an increase in the total number of births between 2011 and 2016. As shown in Figure 4, there was a sharp increase in the number of total births attended to at the facility between 2013 (3379) and 2014 (4941) representing a 46% increase in births attended to at the facility. The increase in births by skilled attendants at the facility has been maintained at over 4900 between 2014 and 2016.

Figure 4: Total deliveries assisted by year at Kilifi County Referral Hospital
Data on deliveries assisted by skilled health providers shows a steady increase from 2011 (481) to 2016 when 1185 deliveries were assisted at the facility representing a 146% increase between 2011 and 2016 in Bamba sub-County Hospital as shown in Figure 5 below.

![Utilization of Delivery Services at Bamba Sub-County Hospital](image)

*Figure 5: Utilization of delivery services at Bamba Sub-County Hospital*
The number of women who utilized delivery services at Malindi sub-County hospital sharply increased from 2366 to 4221 between 2013 and 2014 when the free maternal health policy came into force. This represents a 78% increase between 2013 and 2014. In both 2015 and 2016, the total deliveries assisted at the facility were still over 4,000. These findings are illustrated in Figure 6 below.

![Utilization of Delivery Services at Malindi Sub-County Hospital](image)

*Figure 6: Utilization of delivery services at Malindi Sub-County Hospital*
Maternal deaths

There was a drop in maternal deaths from 11 deaths to four between 2011 and 2012, and a slight increase to six deaths was reported between 2012 and 2013. However, after the introduction of free maternity policy, the number of maternal deaths increased sharply to 20 in 2014 probably due to the increase in the women who were seeking skilled deliveries at facilities, but perhaps seeking the services when it was too late. The deaths however, decreased to seven between 2014 and 2015 and remained the same (seven) in 2016.

Figure 7: Maternal deaths in Kilifi County Referral Hospital

Figure 7: Maternal deaths in Kilifi County Referral Hospital
There were no maternal deaths recorded during the period 2011 and 2016 at the Bamba sub-County Hospital.

Overall, the number of maternal deaths in Malindi sub-County Hospital dropped from 17 to 12 between 2011 and 2012 and dropped further to 10 in 2013. In 2014, maternal deaths increased to 14 but dropped again to eight in 2015 then more than doubled to 20 in 2016 as shown in Figure 8 below.

*Figure 8: Maternal deaths at Malindi Sub County Hospital*
4.2.1.2 Utilization of maternal health services in Nairobi County

Data was extracted from the health records of three health facilities in Nairobi City County. The three health facilities were Pumwani Maternity Hospital, Mbagathi sub-County Hospital and Mama Lucy Kibaki Hospital. The results are as presented below.

Utilization of antenatal care services

Figure 9 below shows an increase over time in the number of women who utilized antenatal care services in Mbagathi sub-County Hospital. This was true for total ANC visits, number of first time ANC clients and ANC clinic revisits during the period 2011 and 2016.

![Antenatal Care Visits at Mbagathi Sub County Hospital](image)

*Figure 9: Antenatal care visits at Mbagathi Sub-County Hospital*
There was an increase in the percentage of women utilizing antenatal care services at Mama Lucy Kibaki Hospital between 2012 and 2013 for new ANC clients, total ANC visits, and ANC revisits. However, the number of women who returned to the facility for a fourth ANC visit decreased between 2012 and 2013 despite the increase in utilization of services. In 2013, 2014 and 2015 this facility recorded a drop in uptake of antenatal care services that continued in the subsequent years as shown in figure 10 below.

![Utilization of Antenatal Care Services at Mama Lucy Kibaki Hospital](image)

*Figure 10: Utilization of antenatal care services at Mama Lucy Kibaki Hospital*
The figure below shows that the number of women seeking antenatal care services sharply decreased after the declaration of free maternity services. Additional interviews from this hospital confirmed that the hospital started charging women KES 1,500 for attending ANC clinics after realizing that money from the central government to manage the free maternity care would be received late, this later led to a sharp decrease in the number of women seeking ANC services in 2015 and 2016.

Figure 11: Utilization of antenatal care services at Pumwani Maternity Hospital
Utilization of delivery services increased from 2820 to 5187 between 2013 and 2014 after the free maternity policy declaration representing, 84% increase in use of these services. The use of skilled delivery assistance further increased between 2015 (6564 deliveries) and 2016 (6710 deliveries) at Mbagathi sub-County Hospital as shown in Figure 12 below.

Figure 12: Total deliveries by year of delivery at Mbagathi sub-County Hospital
There was an increase in utilization of delivery services at Mama Lucy Kibaki Hospital as shown in Figure 13 below. There was an increase in utilization of delivery services from 3490 in 2012 to 5901 in 2013. This further increased to 7354 in and 8104 in 2015. However, between 2015 and 2016, there was a slight decrease in utilization of delivery services from 8104 in 2015 to 7858 2016.

Figure 13: Total deliveries per year at Mama Lucy Kibaki Hospital
Utilization of delivery services at Pumwani Maternity Hospital increased sharply from 15,821 to 23,697 representing a 50% increase between 2013 and 2014 due to the free maternity policy. However, in 2015, due to the fees levied by the hospital due to the delays in receipt of money from the central government, the number of deliveries at the facility reduced to 14,931 but slightly increased to 15,225 in 2016 as shown in figure 14 below.

Figure 14: Total deliveries per year at Pumwani Maternity Hospital
Maternal deaths

The number of maternal deaths at Mbagathi sub-County Hospital increased from 4 to 7 between 2013 and 2014 when the free maternity policy came into force. This could be because of the increase in the number of hospital deliveries, with some presenting to the facility when it was already too late for any intervention to save their lives. In 2015, there was a drop in maternal deaths by one and it remained the same in 2016. These results are as shown in Figure 15 below.

Figure 15: Maternal deaths at Mbagathi sub-County Hospital
There was a sharp increase in maternal deaths at Mama Lucy Kibaki Hospital from six in 2012 to 19 in 2013. However, there was also a sharp decrease in maternal deaths to six in 2014, but this increased again to 16 in 2015 then slightly dropped to 12 in 2016 as shown in Figure 16 below.

![Figure 16: Maternal deaths at Mama Lucy Kibaki Hospital](image)
The figure below presents maternal deaths in Pumwani Maternity Hospital between 2011 and 2016. It is evident that there was an increase in maternal deaths from 11 to 14 between 2011 and 2012 but this decreased to five in 2013. However, there was an increase in maternal deaths to 11 between 2013 and 2014 after the declaration of the free maternity services, although, in 2015 and 2016 the total maternal deaths dropped by one from eight and seven as shown in Figure 17 below.

Figure 17: Maternal deaths at Pumwani Maternity Hospital
4.2.1.3 Utilization of maternal health services in Migori County

Data was extracted from the health records of three health facilities in Migori County including Migori County Referral Hospital, Rongo sub-County Hospital and Kehancha Level IV Hospital. The results are presented below.

Utilization of antenatal care services

The use of antenatal care services at the Migori County Referral Hospital varied with the total number of ANC visits remaining relatively the same even after the free maternity services pronouncement. It is surprising to note that the number of women who received both IPT1 and IPT2 sharply decreased in 2015 even though this is a malaria endemic county, signaling the risk of malaria to mothers and their unborn children. We however note that there was an increase in the number of women who received IPT1 and IPT2 in 2016. These results are presented in Figure 18 below.

![Utilization of Antenatal Care Services at Migori County Referral Hospital](image)

*Figure 18: Utilization of antenatal care services at Migori County Referral Hospital*
Utilization of antenatal care increased in Rongo sub-County Hospital after the declaration of free maternity care for total ANC clients, ANC client revisits and first ANC visits. However, the percentage of women who received IPT1 and IPT2 sharply decreased in 2015 which is worrying given that this is a malaria endemic zone, but there was an increase in the percentage of women who received IPT1 and IPT2 in 2016. These results are further illustrated in Figure 19 below.

![Utilization of Antenatal Care Services at Rongo Sub County Hospital](image)

*Figure 19: Utilization of antenatal care services at Rongo sub-County Hospital*
There was an increase in the utilization of antenatal care services at Kehancha sub-County Hospital. The percentage of women who attended ANC clinics increased over the years even after the declaration of the free maternity care services. A similar trend was observed for ANC revisits and those visiting the facility for ANC for the first time as shown in Figure 20 below.

*Figure 20: Utilization of antenatal care services at Kehancha sub-County Hospital*
There was a steady increase in the total deliveries assisted by skilled attendants at the Migori County Referral Hospital after 2014 which means that the free services increased access and use of skilled assistance for delivery among women as shown in Figure 21 below.

Figure 21: Total deliveries assisted by year at Migori County Referral Hospital
Rongo sub-County Hospital witnessed an increase in deliveries assisted by skilled professionals at the facility in the period 2011 to 2015 and then a drop in the number of deliveries was recorded in 2016 from 1666 to 1379 deliveries as shown in Figure 22 below.

Figure 22: Total deliveries by year at Rongo Sub-County Hospital
The use of delivery services at the Kehancha sub-County Hospital increased over the years, since 2011, but the increase was more after the free maternity policy declaration, with an increase from 937 in 2013 to 1234 in 2014, representing a 32% increase. It is worth noting that the utilization of delivery services at the facility started to drop in 2015 with 1071 deliveries assisted, which further dropped to 748 deliveries in 2016.

*Figure 23: Total deliveries by year at Kehancha sub-County Hospital*
Maternal deaths

Maternal deaths in Migori County Referral Hospital dropped from a high of 15 to four between 2011 and 2012 but increased to five maternal deaths in 2013. However, after the declaration of free maternity care, the number of maternal deaths at the facility increased from five to 13 representing a 160% increase. In 2015, maternal deaths dropped to seven but increased again in 2016 to 11 as illustrated in Figure 24 below.

Figure 24: Maternal deaths by year at Migori County Referral Hospital
There was only one maternal death in both 2011 and 2012 at the Rongo sub-County Hospital. However, this increased to three in 2013 but dropped again to one in 2014, again only one maternal death occurred at the facility in 2015 and there was no maternal death recorded at the facility in 2016 as illustrated in Figure 25 below.

Figure 25: Maternal deaths at Rongo sub-County Hospital
Generally, low maternal deaths were recorded at the Kehancha sub-County Hospital; in 2011 there were three maternal deaths, but this increased to four in 2012. However, there was a sharp drop in maternal deaths from four to one in 2013, which was sustained through to 2014, 2015 and 2016. These results are illustrated in the Figure 26 below.

![Maternal Deaths at Kehancha Sub County Hospital](image)

*Figure 26: Maternal deaths at Kehancha sub-County Hospital*
4.3 Health Care Financing and Maternal Mortality

From the free maternity services instituted in 2013, it is apparent that the most controversial issue has been how the whole financing is conducted. It is now apparent that reimbursement by the Ministry of Health to the facilities has been problematic and continues to compromise quality.

The research investigated what constitutes the best practices in maternal health financing. Several financing mechanisms were noted among them government funding, donor funding, insurance and out of pocket (OOP).

The informants noted that any funding that takes money out of the pocket of consumers directly is not likely to be sustainable and may lead to poverty and misery in the long run. The problem in Kenya has been that the government budget for health care is a paltry 4% of the overall budget. The donor contributions have accounted for over 30% and the biggest problem today is that this support is dwindling and reproductive health has been most affected by the United States of America president Donald Trump’s administration policy and the pro-life thinking. Many safe motherhood initiatives have been lumped together as supporting abortion and related women’s rights. Funding to programs for reproductive commodities has been cut and this has led to unmet needs (United States has over the years heavily supported reproductive health programs).

The government is said to be currently considering possibilities of enrolling all the pregnant women into NHIF so that they can all be insured to receive comprehensive services at all facilities, be they private or public. If this initiative takes effect and succeeds, then the free maternity services as we know it today will be radically transformed for the better. Most of the providers note that if this new initiative succeeds, then the facilities will be able to offer quality services since reimbursement will be done by the NHIF directly to the facilities unlike the practice today. One provider noted thus:

“If maternal health care is taken up by the NHIF as is being suggested, this would lead to massive improvement in the provision of services. We will be able to get the reimbursements in time and this will enable us to purchase all the necessary supplies to plough back to the system. In addition, the process will decongest the public health care system since the private facilities will also be included in the scheme”.

The NGO actors noted that several forms of health insurance have been experimented in different jurisdictions. Some of the insurances include commercial insurance that is common in Kenya, government driven insurance for majorly people in the public sector such as National Health Insurance Fund (NHIF) and community insurance like the one in Rwanda. The Rwanda experience is touted to be the best for Africa where resources are scarce. This form of insurance will at the very onset require belief in government, elimination of corruption and a system that works for the people. In this form of insurance, three entities are important to its success. The individual person organized in a community-based grouping contributes; the government also contributes as well as the donor community. The kitty then provides a basis for health financing to the individuals. Support is then provided to health workers to come up with facilities where quality of care is monitored and the services provided are paid for through the group insurance.

“If maternal health care is taken up by the NHIF as is being suggested, this would lead to massive improvement in the provision of services. We will be able to get the reimbursements in time and this will enable us to purchase all the necessary supplies to plough back to the system. In addition, the process will decongest the public health care system since the private facilities will also be included in the scheme”.
Some providers noted that the Canadian system of health financing provides a perfect means of ensuring good health of the population. This is premised on a public health system with a single payer system and price controls where no provider is allowed to charge crazy fees. The system is based on a universal health coverage where everyone is covered and the provinces manage the services provision. Everyone is entitled to quality health care and ensures the economies of scale as well as the economies of impact. The system works for everyone to an extent that Canadians remark that “they do not know their health care system” simply because it works.

Going forward, a majority of the informants noted that a reformed NHIF would be the best form of health financing for Kenya. This is compared to the existing situation in Germany and France where insurance is available to everyone and the individual chooses where to go for health care, whether public or private, who are in competition. In the competition, all the health care providers will only remain afloat if they provided quality services. The better the services provided, the higher the chances of survival as a provider.

The providers suggest that financing a system that creates competition is a very efficient. Since most Kenyans pay taxes and all the employed people are already automatic members of NHIF, the government will need to simply provide little resources to pay for the most vulnerable members of the society but encourage those in the private sector to enroll as a matter of policy. Once everyone becomes a member of NHIF, the proportionate saving in costs gained by an increased level of utilization of services then comes into play. The next level is to ensure certain quality regulations and price controls. There is completely no reason why an operation should cost KShs. 5000 at Kenyatta National Hospital while the same costs over KShs. 200,000 at the Nairobi Hospital. Since the payments for the health services will be from the same source, prices will be regulated and quality ensured via blacklisting all the services providers who are after exploiting patients while offering low quality services. This will also ensure that the out of pocket payments that are currently in place as top-up to the NHIF contributions come to an end. An individual will only need NHIF card to access health care.

Private health facilities charge exorbitant fees for bed per night, some as high as KShs. 22,000 per night, higher than high class hotels that are equipped with many amenities. For example, Gertrudes children’s Hospital and Nairobi Hospital charge high bed fees ranging from KShs. 9,000 to 22,000.

Some argue that once the NHIF takes charge of all Kenyans, regulations will be put in place to ensure that this level of exploitation comes to an end.

In essence, the new outfit must be participatory and ready to engage all the stakeholders in ensuring its success. At the same time, the outfit will engage the citizens, the county governments as well as the national governments to prioritize primary health care and have CHVs at the local levels to provide the necessary feedback for continuous improvement of the services provided. It will involve the training and integration of the CHVs into the official health care system and as part of the community referral system. This will require that they are also funded to enhance accountability.

The new system must ensure that the following challenges inherent in the present system are duly addressed:

- Inadequate staffing
- High attrition among health care workers through continuous replacement
- High brain drain resulting from poor pay and the unending strikes in the health sector
- Low investment in maternal health and sustainable options
- Building trust in NHIF
- Improvement in technical knowledge among the populations
- Increased accountability by health care financing organizations to the financiers as well as the services seekers
- Implementation of the various health care policies, charters and protocols that ensure quality
- Insulating health care staff hiring from local politics and protecting staff from political interference.

If this new thinking is supported and given the political will that accompanied the pronouncement of the free maternity care, it will be a game changer in health care financing in Kenya and probably in Africa as a whole.
4.4 Devolved Health Sector and Maternal Health

Kenya devolved most health functions immediately after the 2013 general elections. General management of the health system was devolved to county governments, with national government retaining the policy development function.

For many, devolution of health provided an opportunity for county governments to identify the needs in the counties and coordinate their solutions without duplication of the several interventions. However, funding challenges that have characterized the devolved health system weakened the system. This is attributed to the contests between the ministry of health and the county governments that have impeded the transfer of resources to counties for health services delivery. The central government has been accused of not letting go of the health functions to enable the county government to undertake their duties. There are reports of ministry of health engaging in procurement of equipment for the counties even where such are not needed. The lack of reimbursement to the facilities for services provided has made it difficult for counties to perform their roles, hence making devolution of health seem more of a failure than a useful initiative.

The various facilities visited were unable to offer quality services because they lacked supplies and are overstretched. The recent sustained health workers strike further worsened the situation of health care in counties, with the maternity wings of the hospitals literally closed. One provider lamented about the present funding arrangements thus:

“Before devolution, the exchequer gave money to the facilities with clear expenditure lines where maternal health was clearly flagged out. Today, we have a kitty at the county called medical and in there lies the problem. It seems that the whole health devolution is set to fail”.

There are those who believe that devolution was a political undertaking and devolution of health should not be based on political boundaries. An expert notes as follows:

“On the face value, devolution has done wonders and Turkana, Mandera, Marsabit, Wajir and other far-flung counties can now have a doctor and boast of a functional health system that they have never known since independence in 1963. However, the details are not that simple since the interns there have little training, procurement of essential supplies is still a major issue, the machines forcefully bought by the national government are dumped there without people with requisite skills to maintain them, CT scan machines are bought without the necessary rooms to put them. Ambulances are being bought; buildings constructed and yet there is minimal investment in the staff. Strikes have become the order of the day. The whole system is a real mess”.

There are those who believe that devolution has brought services closer to the people and in the process improved the facilities. The following comments illustrate this further:

“Devolution of health care has brought services closer to the people. More facilities have been constructed, equipment improved, new machines bought and more ambulances purchased” (Nurse in Kilifi).

“The new maternity wing was built by the county government to expand services and it has been of help ever since. The only problem is that it was not fully facilitated” (Senior nurse at Mbagathi sub-County Hospital).

“We have had tremendous improvements in the facilities including direct assistance by several development partners who have refurbished maternity wings and bought necessary equipment” (Kilifi health care provider).
Despite the above positives, there are those who believe that some governors have taken advantage of devolution to invest in things that do not enhance value. So many facilities are being constructed without consultation on the ground.

“There was the construction of a structure meant to be a theatre without the requisite knowledge and technical knowhow in Rongo. We were not consulted but only saw someone come from the county that he had been awarded a tender to construct a theatre” (Stakeholder at the Rongo sub-County Hospital).

In all the three counties, there was real-time impact resulting from the collaboration with the many health care-based NGOs. These include support by UNFPA, UNICEF, AfyaJijini, MSF, Save the Children, USAID, Coca Cola Foundation as well as capacity building by the University of Nairobi. These useful collaborations should be enhanced and improved on by the respective counties. Efforts should be made to ensure proper and accountable utilization of the resources provided by the donors so that corrupt practices do not compromise the good will.

Those surveyed were also of the view that several changes have taken place that have undermined the proper provision of health care and demotivated the health care personnel. The following are some of the comments that came from the various stakeholders regarding this:

“The previous allowances that health care providers received such as night outs were scrapped by the Migori County Government even when the same is still being provided by the Kisumu and Kisii County governments. This has killed the morale of nurses” (Quality assurance personnel, Rongo sub-County Hospital).

“A number of locals have been politically employed due to their connections with county government officials yet some of them are technically unqualified. This is compromising quality of services. They are not answerable to the technical wing of healthcare within the facilities but to the political bosses hence difficulties in supervising them and quality control” (Quality assurance Personnel, Rongo Sub-County).

“Previous resources such as the Facility Improvement Money (FIM) are no longer available from the central government to facilitate outreach programs as it was before. This has hampered the services that were available to the outlying areas and the facilitation of the workers in terms of allowances” (Nurse in Kilifi County).

“Looks like the nurses paid by the county governments are under-paid, overworked and their salaries delay since they complain a lot hence poor services. They always make us believe that they are not comfortable with their situation and that we should not complain about their poor services. It also seems like they are not adequately supervised” (34-49 year olds FGD in Kilifi County).

“The problem of the failure to reward success and the problems of promotion of the nursing staff where someone can be in the same grade for up to 10 years has demotivated workers under devolution. In some instances, even the donor support has been channeled to the county coffers hence not reaching the facilities” (Stakeholder in Migori County).

There are also indications that the Members of County Assemblies (MCAs) who are responsible for passing county budgets are already questioning why doctors working under them should earn more money than them. This could potentially be the next war front that would cripple health care delivery system at the devolved units.

In the recent past, corruption has taken center stage in the health sector at the national level with purchase of containers for instance being made at a cost of 10 million each. The same containers are still gathering dust at a warehouse at the port of Mombasa (Jacob and Agutu, 2018). Similar accusations of corruption and mismanagement have been made at the county levels and the development partners in the health sector are reviewing their support (Gitonga, 2018a). Resources that should be used to buy medicines, used in customer care and quality monitoring are all misdirected by governors to finance the physical infrastructure, which in most cases does not contribute directly to quality services (Gitonga, 2018b). An example is given of the construction of a maternity wing at the Mbagathi District Hospital by the then Governor of Nairobi County without any equipment to make the unit functional. Equally, the national government does purchases for counties for items not needed and not based on priorities (Oruko, 2018) which smacks of corruption and underhand deals.

Besides other positives realized through devolution, some counties have employed additional nurses to cope with the challenges of increased utilization of the maternal health care services. Respondents from Migori County indicated that they employed three additional nurses at the height of the increased demand for maternal health care services. This increased the number from nine to 12 and they were able to cope with increased demand. However, this gain was heavily eroded by the prolonged health workers’ strike.
From the findings, the uptake of free maternity services was greatly compromised by the 256-day strike by the doctors as well as the nurses. Stakeholders in the health sector must prioritize resolution of the grievances of the health care workers to forestall their escalation to an industrial action has been the case. There is an urgent need to link the free maternity health declaration to a deliberate effort to strengthen the health system as well as effective financing mechanisms for it to adequately respond to the felt needs.

The provision of free maternity services has been lauded as a timely undertaking and most of those utilizing the services have praised the initiative even though there are glaring shortcomings in the delivery of services. It is however important to ground the pronouncement in policy and to re-think the best ways and means of funding the same.

It is clear that issues of funding, facilitation, personnel and the general infrastructure need to be revisited for sustainability and quality provision of services. It is important to ensure that the facilities offering the services are re-imbursed in time and in accordance with proper and realistic costing. The present KShs 2,500 for levels 2 and 3 facilities and KShs 5,000 for levels 4 and 5 facilities are not just unrealistic but completely undervalued. The costing of services such as caesarean section should be reviewed to reflect actual cost of providing such services. A normal delivery should cost about KShs 16,000 while caesarean section should be about KShs 30,000 depending on the level of complications.

It important to devise means to motivate the services providers and their services rewarded accordingly. At the moment, the problems of over-working, underpayment and under-staffing are making the provision of the services difficult and compromising quality.

### 5.0 CONCLUSION

From the findings, the uptake of free maternity services was greatly compromised by the 256-day strike by the doctors as well as the nurses. Stakeholders in the health sector must prioritize resolution of the grievances of the health care workers to forestall their escalation to an industrial action has been the case. There is an urgent need to link the free maternity health declaration to a deliberate effort to strengthen the health system as well as effective financing mechanisms for it to adequately respond to the felt needs.
6.0 RECOMMENDATIONS

The following key recommendations are important in ensuring that the free maternity services declaration is sustainable and takes care of the several aspects of reproductive health beyond just antenatal care and delivery:

Health workers’ training and reward system

- Capacity building of the nursing staff based on continuous medical education and the staff training must be instituted. The training must include issues of attitude change, customer care or patient-nurse relationship.
- At the community level, the health care sector should constitute a standardized package for the training of CHVs across the country to strengthen the community level initiatives and primary health care.
- The whole hospital staff from the watchman at the gate, the cleaners in the facility, the nurses, medical officers and doctors must all be trained on customer care. It is important that the watchman be privy to the services provided in a facility since they are the first line of contact.
- There is need for a reward system for CHVs who refer the highest number of mothers and make follow-ups of their health for the entire pregnancy period and immunization of the child.
- A clear promotion criteria and reward system to the providers will be necessary to motivate them.

Policy

- The relationship between the counties, the national government, the Ministry of Health and the respective health facilities should be harmonized and clear hiring policy guidelines developed.
- The oversight role of the ministry must be revived and the counties must institute proper mechanisms for quality control and provider supervision. A multi-sectoral approach should be instituted to check on accountability at all levels and to ensure quality provision of services.
- There is need for the providers to be consulted and their input considered in the process of improving the services. This translation of the declaration into policy must also have a clear logical frame with complete monitoring and evaluation matrix incorporated.

Financing

- The NHIF approach is considered the best form of maternal health care financing. To this end, the government should consider enrolling all the pregnant women into NHIF and ensure that the re-imbursement to the facilities is done in real time. The provision of other services should also be included and mothers need not worry whether they have pre-term delivery or caesarean section. In the long run, all Kenyans must be enrolled into NHIF based on universal health coverage with quality and equity at the center of the services provision.
- The cost of health care services must be regulated and the exploitation that has been witnessed through private health care insurance checked. Quality of care, equity and dignity for services users must be observed.
- The free maternity package must include basic necessities such as food, basin, sanitary towels, baby shawl, diapers as well as baby clothes. These will encourage women to deliver in facilities in the long run.

Community awareness and accountability mechanisms

- The role of the CHVs must be strengthened and community awareness enhanced so as to improve on accountability mechanisms at the community level and at the same time, increase the demand for quality services by the providers based on community cross-referrals. This should be accompanied by a wider reach out that brings on board the adolescents as well as persons with disabilities.
- There is need for each facility to have mentor mothers who can talk to fellow women on the importance of having healthy babies as well as the importance of facility-based delivery.
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<th>• Awareness campaign at the community level must be instituted to bring about attitudinal change regarding maternal health, demand for quality services and to embrace universal health care. This will empower women to delay pregnancy, have comprehensive check-up and understand all that is involved in the delivery of a healthy baby and to maintain a healthy mother. It will also enhance community awareness of self-care rights and health entitlements.</th>
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<td>• Women must be reminded and taught on birth preparedness and where the facilities are far away from the community, the provision of maternal shelters, especially in the 36th week considered in counties that are expansive and with limited facilities.</td>
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<td>• In situations where the role of men and mothers-in-law in the pregnancy and delivery process hinders real time decision making for instance the “Mwenye Syndrome” in Kilifi, efforts must be made to ensure that repugnant cultures are reviewed and dignity of women observed.</td>
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<td>• The strength of the CSOs and other actors must be harnessed to promote accountability and reach out to the most vulnerable and marginalized sections of society in regards to services delivery.</td>
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