NGEC
National Gender and Equality Commission

STATUS OF MATERNAL HEALTH IN KENYA

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"With respect to health, my government has made adequate budgetary arrangements to enable all pregnant mothers to access free maternity services in all public health facilities, with effect from 1st June, 2013,"
Uhuru Kenyatta.

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Foreword

The implementation of the June 2013 Presidential Directive on Free Maternity Services was a commendable and timely intervention that the Government of Kenya has taken to expand access to quality and affordable maternal health care for women and girls in Kenya. It is a demonstration of Kenya's commitment to her domestic and international obligation to promote universal access to quality and affordable health care for her citizen. Access to affordable and quality maternal health care as an integral part of sexual and reproductive health care is undermined by the prohibitive costs of maternity services. The right to sexual and reproductive health care which is guaranteed in article 43 of the Constitution of Kenya 2010 and other international and regional treaties to which Kenya has ratified. The treaties impose on Kenya the obligation to ensure that women and girls are able to survive pregnancy and childbirth as part of their enjoyment of sexual and reproductive health rights and to live a life of dignity.

In line with its legal mandate, the National Gender and Equality Commission conducted an audit of the implementation of the presidential directive on free maternity services in samples health facilities. The objectives of the audit were to among other things explore contribution of the free maternity services (FMS) program to delivery and realization of rights to reproductive health of the highest attainable standards and to identify coverage and utilization of FMS by Special Interest Groups (SIGs) in particular couples and persons with disability, minorities and marginalized communities.

The audit established that there has been notable improvement in access to quality and affordable health care for many women and girls in Kenya despite the many challenges that have emerged in the course of implementing the program. It is our sincere hope that the findings of this study will contribute to the strengthening of the FMS program and to the on-going national and global dialogue on sexual and reproductive health and rights. The findings will also be used to inform NGEC's coordination strategy towards mainstreaming issues of SIGs, and in the development of minimal standards for realization of the right to health at National and county and levels.

Commissioner Winfred Lichuma, EBS
Chairperson,
National Gender and Equality Commission.

Acknowledgement

The National Gender and Equality Commission wishes to extend special appreciation to all the women and girls who took part in the audit for their invaluable contribution to the study. We are also grateful for the contribution made by health staff at National and County level, county government officials, and other independent bodies.

We are truly indebted to the Ministry of Health and want to recognise Dr. Mary Anne Ndonga for the technical support accorded during the design and data collection of the assessment and in the validation process of the report.

We would also wish to thank various independent offices and regulatory bodies for their invaluable input; Former Commission for the implementation of the Constitution (CIC) and Transitional Authority (TA), Controller of Budget (COB), Commission on Administrative Justice (CAJ),Kenya National Commission on Human Rights (KNCHR), Commission on Revenue Authority (CRA), Kenya Medical Practitioners and Dentists Boards (KMPDB), County Executive Committee Members of Health, and County directors for Health.

The study was undertaken with financial support from the Government of Kenya, and additional funding from UNDP through Governments of Finland and Sweden. Many non-state actors were involved in the conception of this study. To state a few; IPAS, HERAF, AMREF, LVCT Health and Lexlink consulting for the lead in data analysis and drafting of the report.

Finally, we extend our special thanks to Commissioner Winfred Lichuma, Chairperson, NGEC for providing overall leadership and technical support to the process. We recognize the enthusiasm, dedication and commitment of Margaret Muthee, Dona Anyona, Stephanie Mutindi, and all technical staff who were involved in the audit, data collection and writing of this report.

Paul Kuria
Ag. Commission Secretary
National Gender and Equality Commission.

Acronyms

FMS	Free Maternity Services
FY	Financial Year
HSMF	Hospital Service Management Fund
HSSF	Health Sector Services Fund
ICDP	International Conference for Population and Development
KDHS	Kenya Demographic and Health Survey
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
NGEC	National Gender and Equality Commission
NHIF	National Hospital Insurance Fund
PMTCT	Preventing-Mother-To-Child-Transmission
SDG	Sustainable Development Goals
SIG	Special Interest Groups
UNFPA	United Nations Population Fund

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Executive Summary

From December 2014 to March 2015, the National Gender and Equality Commission (NGEC) conducted an audit of implementation of presidential directive on free maternal health care program in selected public health facilities in Kenya with a view to establish the application of principles of equality and inclusion in the program. Specifically, the objectives of the audit study on the Free Maternity Services (FMS) program were:

1. To explore contributions of free maternity services program to delivery and realization of rights to reproductive health of the highest attainable standards.
2. To identify coverage and utilization of FMS by Special Interest Groups (SIGs) in particular couples and individuals who have disability, minorities and marginalized groups.
3. To explore the opportunities available for FMS to reduce inequities in access to reproductive health services in Kenya.

The audit which was conducted across 4 counties namely, Laikipia, Nyeri, Kilifi and Busia established that:

1. The FMS has led to increased access to quality maternity services to women and girls in Kenya as evidenced by the upsurge in number of deliveries in public health facilities. About 43% of all public health facilities reported a doubling of daily deliveries following the presidential directives.
2. There was a high level of awareness of free maternity services program among respondents in all the four counties.
3. A high number of women and girls were able to access maternity services for free. However, a significant number of respondents were not certain about the cost elements covered by the program or lacked clarity about the scope of the FMS program. Further about 33% of clients in the selected public health facilities reported to have made payment to health facilities in order to access maternity services.
4. The FMS program has not adequately mainstreamed the needs of special interest groups especially persons with disability and marginalized communities.
5. Challenges relating human resources and financing framework for the FMS program may undermine effectiveness of FMS program.

In order to enhance the effectiveness of the FMS program, the report makes the following key recommendations:

1. The Ministry of Health should issue clear policy guidelines to all health institutions and

existing oversight mechanisms at local and national level to clarify the scope of coverage and cost elements of the free maternity program.

2. The Ministry of Health should institutionalize the Free Maternity Services by undertaking a review of existing policies, in particular Kenya Health Policy 2012 – 2030, National Reproductive Health Policy and National Adolescent Sexual and Reproductive Health Policy with a view to integrating it into all existing policies.
3. The National parliament should enact into law the Reproductive Health Care Bill 2014 and the Health Bill 2015 in order to provide a sound legal basis for implementing the free maternity services directive at the national level. Similarly, county assemblies should consider enacting laws that recognize the right to safe motherhood and entrench provision of free maternity services.
4. Counties Governments should establish an effective referral and evacuation programs, backed by standby ambulances, and well linked to all public and private health facilities from dispensary level to the national referral level.
5. The Ministry of Health should also undertake a comprehensive maternity care needs assessment for special interest groups including adolescents and youth, persons with disability and women and girls living in marginalized areas in order to design appropriate and targeted interventions inclusive of special interest groups. In particular, the Ministry should expand disability friendly infrastructure and services in all public health facilities.
6. The national and county governments should draw an implementation and funding framework for the FMS program.
7. Kenya should give consideration to put measures to implement target 8 of Goal 3 of the SDGs. The call is to ensure healthy lives and promote well- being for all at all ages. This will ensure universal health coverage including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. There is urgent need to end preventable deaths and put measures that will finance comprehensive health care that is affordable to the vulnerable especially the special interest groups categorized to include women, persons with disabilities, children, youth (adolescents) older members of society and marginalized groups and communities.
8. To the greatest extent possible the Ministry of Health should forge partnership with private facilities to expand the program to private health facilities under a government waivered or subsidized program.
9. NGEC and other stakeholders to finalise and launch the standards on the right to health for its immediate application in audits, assessments and increase with input to health at county and national level and in the private sector.

1. Introduction

1.1 About the National Gender and Equality Commission (NGEC)

The National Gender and Equality Commission (NGEC) is a Constitutional Commission established pursuant to Article 59(4) and (5) of the Constitution and the National Gender and Equality Act 2011 with the overall mandate of promoting gender equity and freedom from discrimination as per Article 27 of the Constitution. Pursuant to Section 8(b) of the NGEC Act, the Commission is mandated to monitor, facilitate, and provide advisories on integration of the principles of gender equality and freedom from discrimination in all national and county policies, laws and administrative regulations in all public and private institutions. In addition, the Commission has the responsibility of conducting audits on the status of special interest groups (SIGs) including minorities, marginalized groups, persons with disabilities, women, youth and children. Through the audits, the Commission gathers data on the implications of policies, laws, directives and interventions on the lives of SIGs and the extent to which the principles of inclusivity and gender equality are adhered to.

Pursuant to its mandate, NGEC conducted an audit of implementation of presidential directive on free maternal health care program in selected public health facilities in Kenya with a view to establish the application of principles of equality and inclusion in the program. The study documented the benefits of the program to SIGs, assessed the challenges faced, opportunities available on both the supply and demand sides and their implications on scaling up the program. Findings of the study will be used to inform NGEC's coordination strategy towards mainstreaming issues of SIGs, and in the development of minimal standards for realization of the right to health at county and national levels. The audit will also contribute to the ongoing national and global dialogue on sexual and reproductive health and rights and the deliberations on Sustainable Development Goals (SDGs) and the post 2014 International Conference for Population and Development (ICPD).

1.2 Objectives of the Study

The objectives of the audit study on the Free Maternity Services (FMS) program were:

1. To explore contributions of free maternity program to delivery and realization of rights to reproductive health of the highest attainable standards.
2. To identify coverage and utilization of FMS by Special Interest Groups (SIGs) in particular

couples and individuals who have disability, minorities and marginalized groups.

3. To explore the opportunities available for FMS to reduce inequities in access to reproductive health services in Kenya.

1.3 Methodology

The audit was commissioned through the Economic, Social and Cultural Rights (ECOSOC) and Gender and Women departments of the NGEC and was conducted from December 2014 to March 2015.

The commission organised an inception meeting to launch the assessment bringing together government representatives, non-state actors, members of parliament, development partners and county representatives. The inception meeting held on 14 October 2014 in Nairobi made several recommendations that informed the design of the study including; the need to increase diversity of counties to be covered, and the expansion of the scope of study instrument to include questions on county preparedness to manage the FMS program. Upon conclusion of the data collection in the first two counties, the commission organised a technical meeting with key stakeholders including National Treasury, Controller of Budget health regulatory bodies such as Kenya Pharmacy and Poisons Board, Ministry of Health, Transition Authority, Commission for the Implementation of the Constitution, and county officials in charge of health from Kiambu, Nairobi and Kajiado. The objective of the meeting was to share the preliminary findings of the study before expanding the assessment into other counties.

During the assessment, semi-structured interviews were conducted with facility clients, health facility staff and health policy officials across 4 counties namely, Laikipia, Nyeri, Kilifi and Busia. Kilifi County is one of the counties with worst maternal health indicators while Nyeri County has one of the best indicators. National data indicate that in Kilifi, Laikipia and Busia counties, 46%, 51% and 40% of deliveries take place at home respectively[1]. Nyeri County has one of the lowest home deliveries at 9.6%[2]. In Laikipia County, slightly less than half of all deliveries (49.5%) are assisted by a skilled provider while in Nyeri, the reported figure was 88.1%[3]. Kilifi (52.3%) and Busia (58.5%) reported above average proportion of birth attended by skilled providers[4].

Semi structured questionnaires were administered to 4 categories of respondent namely: a) in-

[1] KDHS 2014, p 129
[2] Kenya Demographic and Health Survey (KDHS) 2014, p 129
[3] KDHS 2014, p 131
[4] KDHS 2014, p 131

facility clients b) out-facility clients, c) health facility staff and d) health policy officials at county level. A total of 513 in-facility clients, 508 out-facility clients, 62 health facility staff and 17 health policy officials were interviewed in 55 public health facilities. About 85% of in-facility respondents were women ages 18-35 years. Almost 10% of them were below the age of 18. Less than 10% of the women were employed and almost 90% did not have education beyond secondary school. A similar pattern emerges from the out-facility respondents. Tables 1 to 9 give a breakdown of the respondent groups by county and age group and number of facilities visited per county.

a) In-facility interviews

Table 1: Client age group (in facility)

Age	Busia	Kilifi	Laikipia	Nyeri	Total
Not Indicated		2	1	7	10
<18	5	21	13	4	43
>35	2	1	8	12	43
18-35	26	181	93	137	437

Table 2: Client employment status (in-facility)

Employment	Busia	Kilifi	Laikipia	Nyeri	Total	Percentage
Not indicated	1	4	0	8	13	2.5
Employed	2	16	13	16	47	9.2
Not employed	19	130	75	57	281	54.8
Self employed	11	55	27	79	172	33.5
Total	33	205	115	160	513	100

Table 3: Client education status (in-facility)

Education level	Busia	Kilifi	Laikipia	Nyeri	Total	Percentage
Not indicated	1	15	1	9	26	5.1
None	0	13	7	1	21	4.1
Primary	20	115	36	35	206	40.1
Secondary	8	51	51	86	196	38.2
Tertiary	4	11	20	29	64	12.5
Total	33	205	115	160	513	100

b) Out-of-facility interviews

Table 4: Client employment status (out-of-facility)

Employment	Busia	Kilifi	Laikipia	Nyeri	Total	Percentage
Not indicated	0	6	0	0	6	1.2
Employed	2	10	23	16	51	10.0
Not Employed	22	107	93	39	261	51.4
Self Employed	14	38	48	90	190	37.4
Total	38	161	164	145	508	100

Table 5: Client education status (out-of-facility)

Highest education level	Busia	Kilifi	Laikipia	Nyeri	Total	Percentage
Not indicated	0	9	0	9	18	3.5
None	1	12	14	0	27	5.3
Primary	27	91	50	36	204	40.2
Secondary	9	40	82	82	213	41.9
Tertiary	1	9	18	18	46	9.1
Total	38	161	164	145	508	100

c) Health facility staff interviews

Table 6: Number of health facility staff interviewed

County	Number of Staff
Busia	13
Kilifi	22
Laikipia	4
Nyeri	22
Total	61

Table 7: County health officials interviewed

County	Department represented
Nyeri	Health
	Clinical Services
	Health
	Health
	Occupational Therapy (Rehabilitation)
	Health
	Rehabilitation Unit
Total	7
Kilifi	Health Services Department
	Health Services Department
	Health Services Department
	Health Services Department
	Kilifi Sub – County Hospital
Total	5
Laikipia	Health Services Department
	Health Department,
	Health and Sanitation
	Health Department
Total	4
Busia	Reproductive Health
	Health Services Department
Total	2

e) Distribution of facilities audited by county

Table 8: Distribution of facilities

County	Dispensary/Clinic (Level 2)	Health Centre (Level 3)	Hospital (Level 4)	Total
Nyeri	7	11	4	22
Kilifi	6	6	5	17
Laikipia	1	-	3	4
Busia	3	7	2	12

2. Background

2.1 Introduction

With a growing population of approximately forty four (44) million people[5], the Government of Kenya ("the Government") has endeavoured to create a health care system that is adequate, effective and equitable to cater for the needs of this dynamic society. Since 2010, reproductive health and more specifically maternal health targeting hard to reach population has received merited attention from the Government particularly with the implementation of the June 2013 presidential directive on free maternity services. This directive is one of the many strategic policy interventions that the government has pursued since independence to promote universal access to health care.

In 1963, universal health care was a major policy plank of the newly formed idealist and independent government of Kenya which abolished two (2) years post colonialism user fees for accessing public health facilities[6]. As a result public health services were primarily funded through general taxation and in a limited sense by the subsequently established National Hospital Insurance Fund (NHIF)[7]. Regrettably, the economy suffered a catastrophic setback in 1988 when donor support was reduced leading to budgetary constraints. User fees were reintroduced in public health facilities from 1989 through to 1992 when a wave of reform hit the nation[8]. The system of waiver and exemptions that was put in place to cushion the poor could not off-set the negative impact of user fees on access to health services leading to poor health outcomes such as declining maternal and neonatal health indicators. In the early years of the 21st century, the Government of Kenya enacted a number of policy and administrative measures to promote equitable access to health care service by reintroducing or enhancing user fees exemptions and waivers as well as implementing financing mechanisms such as health sector services fund (HSSF) and hospital service management fund (HSMF) to help public health facilities maintain quality of services and

[5]United Nations, Department of Economic and Social Affairs, Population Division (2009). World Population Prospects: The 2008 Revision, Highlights, Working Paper No. ESA/P/WP.210

[6] Jane Ochuma, Vincent Okungu, 'Viewing the Kenyan health system through an equity lens: Implications for universal coverage' 2011 In
t J Equity Healthhttp://www.ncbi.nlm.nih.gov/pmc/articles/PMC3129586/ accessed 6.3.2016
www.ncbi.nlm.nih.gov/pmc/articles/PMC3129586/ accessed 6.3.2016

[7]Sessional paper no. 10 of 1965: African socialism and its application to planning in Kenya.

[8] Elkana Ong'uti, 'Health care financing reforms in Kenya'2012

cope with impact of declining revenues resulting from exemptions[9]. Some of these measures such as exemptions for antenatal care services and delivery services at lower level public health facilities positively impacted on access to quality maternal health care services for women. However, their overall impact on maternal health outcomes were largely negligible with key indicators such as maternal mortality ratio and neonatal mortality ratio reporting marginal improvement. Studies on impact of user fees on promoting access to health services have found that poor policy formulation process, lack of adherence to directives and policies and lack of information/awareness about the guidelines undermined the effectiveness of such policies and directives[10].

[9] Chuma & Okungu, Viewing Kenyan Health System through an Equity Lens; Kenya Health Sector Strategic Plan III, 2012-2017, Kenya Vision 2030; the First Medium Term Plan, 2008-2012; Population Policy for National Development, 2012-2030

[10] Thomas Maina & Elkana Ongut, Effective Implementation of the New Health Financing Policy, Ministry of Health Policy Brief, July 2014; Suneeta Sharma et al, Formal and Informal Fees for Maternal Health Care in Five Countries: Policies, Practices and Perspectives, Policy Working Paper Series No. 16, USAID, June 2005; Antony Opwora et al, Implementation of patient charges at primary care facilities in Kenya: implications of low adherence to user fee policy for users and facility revenue, Health Policy and Planning, 2014; pages 1–10; Chuma et al, Reducing User Fees for Primary Health Care in Kenya: Policy on Paper or Policy in Practice?, *International Journal for Equity in Health* 2009, **8**:15

[11] Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in November 2010

2.2 Maternal health care in Kenya: No woman should die giving life

Maternal health refers to the health of women during pregnancy, child birth and the postpartum period[12], i.e. the first six weeks or 42 days after birth. Maternal health care includes access to family planning, antenatal care, delivery, and postnatal health care services[13]. Pregnancy and childbirth, are meant to be positive and fulfilling events in the lives of women but in many cases it can result to suffering, ill-health and death of many women especially poor women and those living in rural areas.[14] Maternal morbidity (complications or health conditions arising from pregnancy and childbirth) and maternal mortality, (death of a woman while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management)[15] are major public health concerns with significant developmental and a human rights impact in Kenya. The Africa Progress panel notes that investing in maternal health is not only a political and social imperative for the government but it is also cost-effective[16]. Healthy mothers lead to healthy

Status of maternal health at a glance:

92%: proportion of pregnant women accessing ANC services

61%: proportion of live births delivered in health facilities

62%: proportion of births assisted by a skilled provider.

But …

For every 100,000 live births, 362 women die during pregnancy, at child birth or within 42 days after child birth

48% of all maternal deaths occur at child birth

37% of all pregnant women give birth at home

Sources: KDHS 2014; UNFPA

[12] http://www.who.int/topics/maternal_health/en/ (Accessed 10 June 2016)
[13] Nicole Bourbonnais, Implementing Free Maternal Healthcare in Kenya: Challenges, Strategies, and Recommendations, 2013 Kenya National Commission on Human Rights
[14] Africa Progress Panel, *Maternal Health: Investing in the Lifeline of Health Societies and Economies,* (September 2010), policy briefs, pages 4 -5; http://www.who.int/topics/maternal_health/en/ (Accessed 10 June 2016);
[15] WHO (World Health Organization), n.d. Health Statistics and Health Information Systems. http://www.who.int/healthinfo/statistics/indmaternalmortality/en/index.html
[16] Africa Progress Panel, *Maternal Health, page 5*

families and societies, strong health systems and healthy economies.[17]

Kenya suffers high rates of maternal mortality and morbidity[18] and has failed to meet the millennium development goal number five of improving maternal health by among other things reducing maternal mortality ratio to 147 of 100,000 live births.[19] According to the Kenya Demographic and Health Survey (KDHS) 2014, there have been notable improvements in some maternal health indicators with estimates indicating that over 92% of pregnant women receive antenatal care, 61 per cent of live births are delivered in health facilities while 62% of births are assisted by skilled provider and about 53% of women receive postnatal care check up in the first two days after delivery.[20] Only about 13% of deliveries nationally were assisted by relatives and friends, 19% by traditional birth attendants and 5% were unassisted.[21]

However, there has been no significant improvements in maternal mortality ratio which is estimated at 362 deaths per 100,000 live birth.[22] This remains one of the highest figures in Africa. Nationally, a significant proportion of women (37%) still give birth at home,[23] while national level data on access to maternal health for special interest groups is largely unavailable. Save for preventing-mother-to-child-transmission (PMTCT) and other services for persons living with HIV/AIDS, there have been limited interventions in favour of other special interest groups such as persons with disabilities, minorities and marginalized groups and adolescents and youths despite the unique challenges that these groups suffer when accessing maternal health care services. The low levels of skilled and hospital deliveries especially in many marginalized regions of the country remain a major health and human rights concern since the major direct causes of maternal morbidity and mortality include haemorrhage, infection, high blood pressure, unsafe abortion,

[17] Africa Progress Panel, *Maternal Health, page 5*
[18] Jane Ochuma, Vincent Okungu, 'Viewing the Kenyan health system through an equity lens: Implications for universal coverage' 2011 In
t J Equity Healthhttp://www.ncbi.nlm.nih.gov/pmc/articles/PMC3129586/ accessed 6.3.2016
www.ncbi.nlm.nih.gov/pmc/articles/PMC3129586/ accessed 6.3.2016
[19] Ministry of Devolution and National Planning, *Millenium Development Goals – Status Report for Kenya* 2013, pages 18 – 20
[20] Republic of Kenya, *Kenya Demographic and Health Survey 2014*, pages 121 – 138
[21] KDHS 2014, p 129 – 130
[22] Republic of Kenya, *Kenya Demographic and Health Survey 2014*, pages 329 – 330
[23] KDHS 2014, p 127

and obstructed labour.[24] In terms of regional data, United Nations Population Fund (UNFPA) estimates indicate that about 15 counties in Kenya have maternal mortality ratio (MMR) that is equal to or above the national average with Mandera reporting the highest MMR at 3795 per 100,000 live births while Wajir, Turkana and Marsabit have MMR that is more than double the national average.[25] According to UNFPA, at national level nearly half of deaths (48 %) occur during delivery.[26]

> A maternity delivery package in a health facility may include several cost elements such as delivery room, nursing charges, delivery bed, drugs and dressings, and immunization costs

Health sector is generally underfunded with reproductive health in particular being given low financial priority. At the national level, the Ministry of Health budget allocation for FY 2014/15 was KShs 47.4 billion, constituting 4 percent of the national budget, compared to 3.4 percent in FY 2013/14. At county level, counties' health sector budgets increased from 13 percent of total counties' budget in FY 2013/14 to 22 percent in FY 2014/15 but substantial variations between counties exist.[27] Services such as family planning are largely donor funded.[28]

[24] http://www.who.int/topics/maternal_health/en/ (Accessed 10 June 2016)
[25] http://kenya.unfpa.org/news/counties-highest-burden-maternal-mortality (Accessed 25 August 2016)
[26] See more at: http://kenya.unfpa.org/news/counties-highest-burden-maternal-mortality#sthash.i8jN3zu4.dpuf
[27] Ministry of Health, 2014/2015 National and County Health Budget Analysis Report, July 2015.
[28] NIDI & APHRC, Reproductive Health and Family Planning Financing in Kenya: A Mapping of the Resource Flows

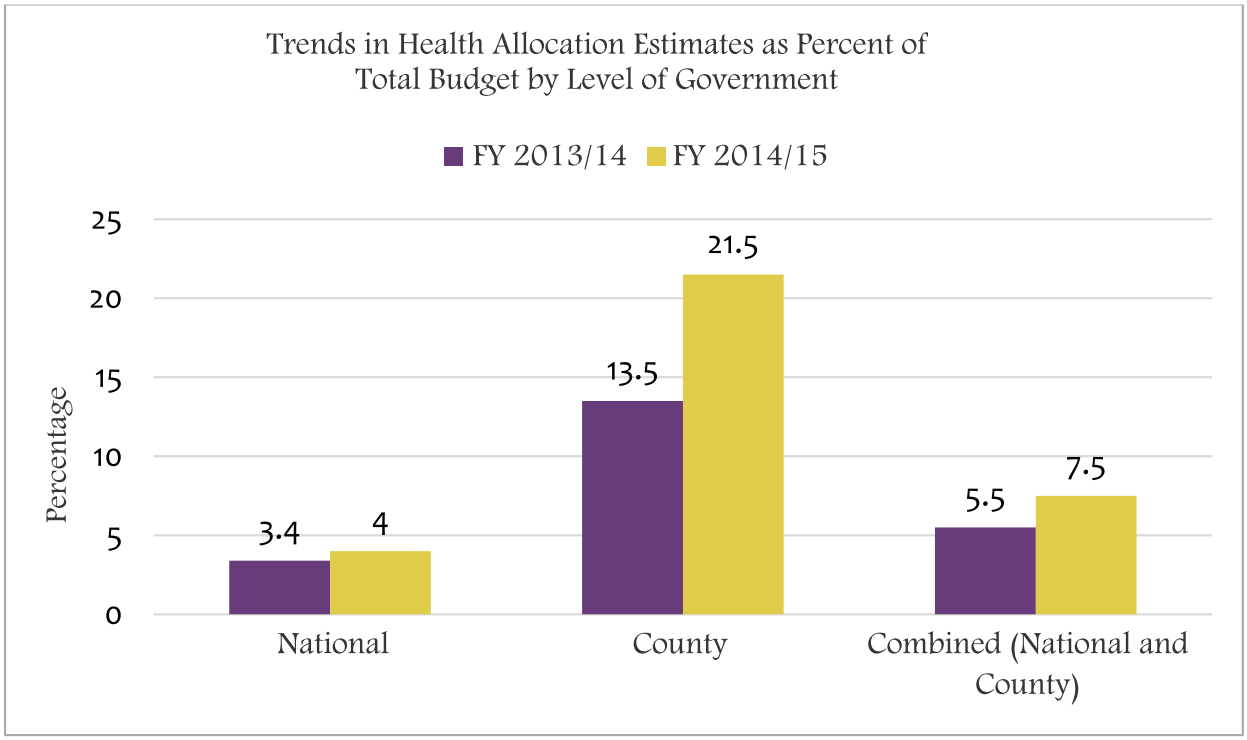

Figure 1: Trends in Health Allocations by Level of Government

Source – MOH

Poor state of financing of maternal health care and the prohibitive cost of hospital delivery are some of the key obstacles that prevent many women and girls from accessing quality and professional maternal health care forcing women to resort to seeking services from traditional birth attendants or to deliver at home. Women and girls seeking skilled and quality delivery services expend significant amount of resources to meet direct and indirect costs A maternity delivery package in a health facility may include several cost elements such as delivery room, nursing charges, delivery bed, drugs and dressings, and immunization costs including user fees, cost of drugs and other supplies, transport costs and cost of taking care of the family. A maternity delivery package in a health facility may include several cost elements such as delivery room, nursing charges, delivery bed, drugs and dressings, and immunization costs. A public inquiry on sexual and reproductive health rights conducted by the Kenya National Commission on Human

Rights in 2012 revealed that user fees charges especially in public hospital were a major barrier to accessing quality maternity care[29] in addition to other 'hidden costs' such as cost of equipment, commodities and select supplies such as cotton wool, gloves, bleach, and surgical blades.[30] Although a system of exemptions and waivers is in place to ensure that women and girls can access certain health care services, in some cases clients are forced to pay for services and supplies meant to be free due to a number of reasons including corruption, need for public health facilities to raise revenue and lack of awareness among users and service providers about exemptions and waivers.

> A maternity delivery package in a health facility may include several cost elements such as delivery room, nursing charges, delivery bed, drugs and dressings, and immunization costs

The prohibitive costs of accessing health care services has a negative and disproportionate impact on the poor and vulnerable groups who are denied access to quality, affordable and equitable health care services. They also face huge financial risk which may plunge them deeper into poverty. With a funding level that has hardly surpassed 10% of the national budget, more than a decade later, Kenya is yet to meet the Abuja declarations target, set in 2001, of allocating at least 15% of the national budget to health sector[31] underlining the challenge facing healthcare financing in Kenya. Admittedly, health sector reforms are exploring ways and means of improving health sector financing in order to ensure universal access to health care including universal access to maternal health care.[32]

[29] The inquiry established that cost of delivery in public hospitals varied between Kshs 3,000 and Kshs 5,000 for normal delivery and Kshs 8,000 for caeserian section in addition to daily bed charges.

[30] KNCHR, Realising Sexual and Reproductive Health Rights in Kenya: A Myth or Reality, April 2012, pages 40 – 73; See also FIDA-Kenya and CRR, Failure to Deliver: Violation of Women's Human Rights in Kenya's Health Facilities, pages 51 – 62; Antony Opwora et al, Implementation of patient charges at primary care facilities in Kenya: implications of low adherence to user fee policy for users and facility revenue, Health Policy and Planning, 2014; pages 1–10.

[31] NIDI & APHRC, Reproductive Health and Family Planning Financing in Kenya: A Mapping of the Resource Flows;

[32] See for instance Gandham RN Varana et al, Improving Universal Primary Healthcare By Kenya: A Case Study of Health Services Fund, UNICO Study Series No. 5, World Bank.

2.3 Maternal health care and human rights

2.3.1 International and regional standards relating to maternal health care

Since 1994, international and regional consensus documents, primarily International Conference on Population and Development (ICPD) Program of Action,[33] and human right frameworks have increasingly recognized the human rights dimensions of reproductive health and acknowledge maternal health care as an integral part of sexual and reproductive health care. The right to reproductive health care is guaranteed in article 43 of the Constitution of Kenya and other international and regional treaties to which Kenya is a State Party[34] including Article 12 of the International Covenant of Economic, Social and Cultural Rights (ICESCR), and Article 12 of the Convention on the Elimination of all forms of Discrimination against Women, (CEDAW).

Human rights are about empowerment and entitlement of people with respect to certain aspects of their lives, including their sexual and reproductive health. They entail fundamental commitments of States to enable women to survive pregnancy and childbirth as part of their enjoyment of sexual and reproductive health rights and living a life of dignity. Reproductive health concerns the capacity of an individual to reproduce and it includes access to a range of reproductive health information, goods, facilities and services to enable individuals to make informed free, and responsible decisions about their reproductive behaviour.[36] In particular, implicit in the right to reproductive health is the right of access to appropriate health care services including delivery services that will enable women to go safely through pregnancy and child birth[37].

One of the key elements for the realization of the right to sexual and reproductive health is affordability of health services as well as access to other underlying determinants of sexual and reproductive health such as access to adequate food and nutrition, access to health related education and information and access to safe and potable drinking waters. In its General

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[33] In 1994, the international community meeting in Cairo under the auspices of the International Conference on Population and Development reached consensus on 3 quantitative goals to be achieved by 2015 one of which was the reduction of infant, child and maternal mortality rates. Subsequently a number of other consensus documents with similar import were adopted including the Beijing Platform for Action and the Africa Union Comprehensive Framework for Sexual and Reproductive Health and the Maputo Plan of Action for Implementing the Framework

[34] As per article 2(5) of the Constitution of Kenya 2010, treaties and convention ratified by Kenya are form part of the laws of Kenya

[35] OHCHR, Technical guidance on the application of a human rights based approach to the implementation of policies and programs to reduce preventable maternal morbidity and mortality, A/HRC/21/22, 2 July 2012

[36] General Comment 22, CESCR

[37] http://www.who.int/topics/reproductive_health/en/ (Accessed 10 June 2016)

Comment No.22 of the right to sexual and reproductive health, the United Nations Committee on Economic, Social and Cultural Rights notes that:

> "17. Publicly or privately provided sexual and reproductive health services must be affordable for all. Essential goods and services, including those related to the underlying determinants of sexual and reproductive health, must be provided at no cost or based on the principle of equality to ensure that individuals and families are not disproportionately burdened with health expenses. People without sufficient means should be provided with the necessary support to cover the costs of health insurance and accessing health facilities providing sexual and reproductive health information, goods and services."[38]

Therefore lack of access to maternal health care resulting from cost or financial barriers undermines equity, violates the right to health care and may also lead to a violation of other rights including the right to life, equality and non-discrimination and freedom from torture, cruel, inhuman and degrading treatment[39]. In order to promote gender equity in the realization of sexual and reproductive health, the committee further notes that 'to lower rates of maternal mortality and morbidity requires emergency obstetric care and skilled birth attendance, including in rural areas…'[40]

In order to expand access to quality and affordable health care, in 2005, the World Health Assembly called on governments to "develop their health systems, so that all people have access to services and do not suffer financial hardship paying for them." Echoing this call, in December 2012, the United Nations General Assembly urged governments to "urgently and significantly scale-up efforts to accelerate the transition towards universal access to affordable and quality healthcare services." Many countries including Kenya have responded to this call and are implementing programs that aim to advance the transition to UHC[41].

Universal access to sexual and reproductive health care including maternal health care is key to meeting UHC goals and realizing human rights. According to the UN Committee on Economic, Social and Cultural Rights, a State is required to aim for ensuring universal access without

[38] Para 17, General Comment No. 22, CESCR
[39] General Comment 22, CESCR and General Comment 14 of the African Commission on Human and Peoples' Rights
[40] See also Para 12, General Comment No. 14, CESCR and Recommendation No 24, CEDAW;
[41] Ramana G et al, Improving Universal Primary Health Care by Kenya: A Case Study of the Health Services Fund, World Bank, January 2013

discrimination for all individuals, including disadvantaged and marginalized groups to a full range of quality sexual and reproductive health care, including maternal health care and to take measures to eradicate practical barriers to the full realization of the right to sexual and reproductive health such as disproportionate costs. States are also required to adopt national health policies and action plan on sexual and reproductive health and to ensure adequate budgetary allocations to finance these policy framework, a theme that is echoed in Abuja declaration[42] as well as a number other human rights and global consensus documents.

Similar provisions exist in regional frameworks including Article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) which Kenya has ratified albeit with reservation to articles 14 and 10. The Maputo protocol explicitly recognizes reproductive rights and commits state parties to establishing and strengthening existing pre-natal, delivery, and post-natal health and nutritional services for women[43] and the African Commission on Human and Peoples rights has issued further guidance on implementation of article 14 through its General Comment No.2. Other relevant global and regional initiatives include, Abuja Declaration on HIV/AIDS, Tuberculosis and Other related Infectious Diseases,[44] the newly adopted Social Development Goals[45], and the African Union, Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) that was launched in November 2010, under the Campaign's slogan that "no women should die while giving life."[46]

2.3.2 National legal and policy framework

Kenya has made significant efforts in legal and policy dimensions towards improved health service provision to her people. The Constitution 2010 provides the overarching legal framework

[42] See below

[43]< http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf> , p15-16, accessed 6/3/2016

[44] At para 26 of the declaration, in 2001, states committed to allocate 15% of the annual budget to the improvement of health sector. 15 years later, Kenya has never met this target

[45] Social Development Goal Number 3 on ensuring healthy lives and promoting well-being for all at all ages sets the targets of reducing maternal mortality ratio to 70 per 100,000 live births and ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs by 2030 - See more at: http://www.unwomen.org/en/news/in-focus/women-and-the-sdgs/sdg-3-good-health-well-being#sthash.JQYKarou.dpuf (Accessed 10 June 2016)

[46] UNFPA African Regional Office on Status of the CARMMA Launch Report March 2011 <http://www.unfpa.org> accessed 6/3/2016

to ensure that there is a comprehensive rights-based approach to health services delivery[47]. According to Article 43(1) (a) of the Constitution, every person has the right to the highest attainable standard of health, which includes the right to health care services including reproductive health care. It further states that a person shall not be denied emergency medical treatment and that the State shall provide appropriate social security to persons who are unable to support themselves and their dependants.[48]

The Constitution further obligates the State and every State organ to observe, respect, protect, promote, and fulfil the rights in the Constitution and to take "legislative, policy and other measures, including setting of standards to achieve the progressive realisation of the rights guaranteed in Article 43[49]." State organs and public officers also have a constitutional obligation to address the needs of SIGs in society[50]. The State has a further constitutional obligation to protect consumer rights, including the protection of health, safety, and economic interests[51]. The Constitution provides the guiding principles and values to be upheld by the state and its officers in the provision and distribution of public services such as health services[52]. The guiding principle is that of equity accompanied by other principles including; public participation, efficiency and mutual cooperation between the two (2) levels of government[53].

The state has the obligation to take appropriate legislative, policy and other measures to ensure that the highest standards of healthcare are progressively realized[54]. This obligation has been conferred to both the national and county governments[55]. The national government is tasked with the duty of providing health policies, national referral hospitals, quality assurance and standards among others[56]. On the other hand, the county government is required to promote primary health

[47] Kenya Health Policy, 2014-2030, Ministry of Medical Services and Ministry of Public Health and Sanitation
[48] Ibid, art.21
[49] (1) Every person has the right—
(a) To the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare;
(b) To reasonable standards of sanitation;
(c) To be free from hunger and have adequate food of acceptable quality; and
(d) To clean and safe water in adequate quantities.
(2) A person shall not be denied emergency medical treatment.
[50] These include couples who have disability, minority and marginalized groups such as persons living with HIV/AIDS, regions with scarce resources and informal settlements and adolescent mothers among others.
[51] The Constitution of Kenya, 2010, art.46
[52] Ibid, art.10, 32, chapter 6, 12
[53] Ibid, art. 189-191
[54] Constitution of Kenya 2010, Art 21
[55] Constitution of Kenya 2010, Fourth Schedule
[56] Constitution of Kenya, 2010, the Fourth Schedule

care, be responsible for county health facilities and pharmacies, ambulance service, public health and sanitation as well as perform other functions[57]. There is a deliberate co-relation between the two levels of government in terms of health service delivery which is also implemented in a graduating scale with the county level being the primary provider and the national government being the highest level source of public health service. The levels have been organized into a four-tiered system for ease of implementation and delivery[58]. The counties are responsible for three levels of care: community health services[59], primary care services[60] and county referral services[61]. The national government has responsibility for national referral [62] services[63].

Kenya is pursuing several legal and policy measures that seek to promote equitable access to quality and affordable health care, including maternal health care for all. The Reproductive Health Care Bill 2014 recognizes safe motherhood as a right and obliges all public hospitals to offer free ante-natal care and delivery services[64]. The Health Bill 2015 also defines the right to reproductive health care to include right to appropriate health-care services that will enable parents to go safely through pregnancy, childbirth, and the post-partum period, and provide parents with the best chance of having a healthy infant[65]. Further it obliges the Ministry of Health to ensure progressive financial access by taking measures that include developing mechanisms for financial and risk pooling to progressively reduce the out of pocket expenditure; developing policies and strategies that ensure realization of universal health coverage; and establishing in collaboration with the ministries responsible for finance, planning and any other relevant department to secure health care for vulnerable groups and indigents[66].

Kenya's Vision 2030[67], National Reproductive Health Policy and National Reproductive

[57]Ibid
[58]Kenya Health Policy, 2012 -2030,Ministry of Medical Services and Ministry of Public Health and Sanitation
[59] This level is comprised of all community-based demand creation activities, that is, the identification of cases that need to be managed at higher levels of care, as defined by the health sector
[60] This level is comprised of all dispensaries, health centres and maternity homes for both public and private providers
[61] These are hospitals operating in, and managed by a given county and are comprised of the former level four and district hospitals in the county and include public and private facilities
[62] This level is comprised of facilities that provide highly specialised services and includes all tertiary referral facilities
[63]KPMG, Devolution of healthcare services in Kenya: Lessons learnt from other countries
[64] Reproductive Health Care Bill 2014, Clauses 2 and 17.
[65] Health Bill 2015, Clause 6(1)(b)
[66] Health Bill 2015, Clause 54
[67] Under the Social Pillar of Kenya's Vision 2030, Kenya aims to provide an efficient, integrated and high quality affordable care for all by prioritizing preventive care at community and household level through a decentralized national healthcare system.

Health Strategy, Kenya Health Policy 2012 – 2030, National Adolescent and Sexual Reproductive Health Policy, Health Sector Strategic and Investment Plan 2013 – 2017 underline, to a varying extent, the need for an equitable health system, adequate resource allocation to ensure universal access to health care for all and prioritize interventions to achieve policy objectives. Although these policies do not specifically address the issue of free maternity services, by implementing the free maternity health program the Kenya government has taken significant steps to implement its human rights obligations under domestic and international human rights frameworks as well as to meet its policy commitments in various international, regional and domestic frameworks. Enactment of the Health Bill 2014 and Reproductive Health Care Bill 2015 into law will create a sound legal basis for implementing these policies and the directive on free maternity services.

2.4 The free maternity services program

In order to improve access to maternal health care and promote gender equity in healthcare provision, in June 2013, HE President Uhuru Kenyatta issued a presidential directive to all public health facilities to provide free maternity service, fulfilling one of Jubilee's key campaign pledge to abolish user charges on maternal health in public health facilities. The FMS program is a national strategic intervention implemented by the national government in partnership with County governments. Under the program, all maternity delivery services including caesarean sections in all public health facilities are offered without any charges while user fee charges under the 10/20 policy have been abolished. Health facilities will be reimbursed by the Government for every delivery that they handle including normal deliveries, delivery through caesarean and complicated deliveries at the rate of Kshs. 2,500 per birth at health centres and dispensaries and Kshs 5000 at public hospitals[68]. The funds are paid directly to the facilities. Furthermore, there will be no charges for antenatal and post-natal care for a period of six (6) weeks after delivery, or for any referrals made during complications related to pregnancies. In 2013/14 fiscal year, Kshs 3.8 billion was allocated to the program increasing to Kshs 4.0 billion in the 2014/2015 budget[69]. The initial phase of the program is financed through conditional grants to health facilities through existing financing mechanisms such as Health Sector Service Fund (HSSF) and Hospital Management Service Fund (HMSF) but progressively and ultimately the government intends to finance the program through the National Hospital Insurance Fund (NHIF)[70].

[68] Ministry of Health, Circular MMS/FIN/1/39 Vol I (35), Free Maternity Delivery Program/Health Centres and Dispensary Services, 1 June 2013

[69] Budget Statement for the Fiscal Year 2014/2015 (1st July – 30th June)

[70] Ministry of Health, Policy Proposal on the President's Initiative on Free Maternal Health Services in Kenya

Many questions have been raised on the feasibility, sustainability and development of the Free Maternity Service program. Some of the challenges put forward include the accessibility of the services, the quality of the service and whether it caters sufficiently for special interest groups ("SIGs"). Health professionals have also expressed concern about the sustainability of the program arguing that public health facilities are ill-equipped to handle the influx of pregnant women seeking free maternity services and attendant complications.

3. Findings

The chapter present findings of the audit of the free maternity services program. The findings relate to awareness level, policy adherence, accessibility of FMS to SIGs, barriers to accessing FMS, adequacy of human resource and funding mechanisms.

3.1 Awareness about free maternity service program

Awareness of free maternity program was high among all clients. 91% of respondents within public health facilities reported that they had heard of the program with Nyeri (90%) and Laikipia (92%) counties reporting the highest awareness levels among respondents.

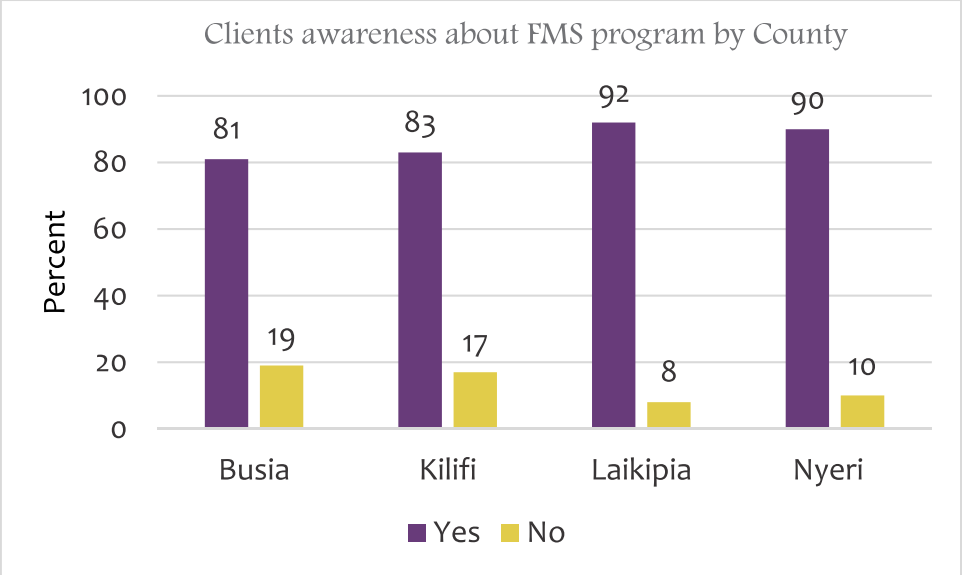

Figure 2: Clients awareness level by county

Media (mainly local FM radio stations) was the leading source of information about the FMS program. Beneficiaries of free maternity services, community health workers and other medical professionals at hospitals and antenatal clinics accounted a small part of the awareness.

In order to create awareness about the program, public health facilities reached out to the communities mainly through community health workers, chief's barazas, traditional birth attendants, and health talks. At least 19 health facility staff cited community health workers as the leading channel of communication followed by chief's barazas. Similar channels were also used to involve communities in the program.

3.2 Adherence to FMS directive: 'The free services'.

In all the counties and facilities surveyed, the clients were aware that the free maternity services program entailed provision of free delivery services. However, it was apparent that a significant number of clients were not certain about the cost elements covered by the program or lacked clarity about the scope of the FMS program. For example, in Busia County some respondent expected the program to cover cost of supplies including drugs, delivery bed, food, gloves, jiks, syringes, mosquito nets and while other respondents thought that clients were expected to meet the costs of many of these supplies. Another respondent in Busia County reported that she was told by a friend that one could give birth for free for five years. However, interviews with healthcare workers in several public health facilities indicated that they did not charge any fees for normal delivery, caesarean delivery, antenatal and post natal care upto six weeks after delivery although there were also concerns among some health care workers on specific cost elements covered by the program.

> I don't know, I was told to buy cotton wool, jik, pegs at Busia District Hospital where I attend clinic – pregnant minor, Busia County
>
> I was told if you give birth for 5 years it is free –pregnant minor, Busia County
>
> Delivery is free but supplies are purchased by the client … like gloves, jik and cotton wool – mother in Busia County

Additionally, about 33% of all clients within public health facilities reported that they had made some payment to the facilities when seeking maternity services. Nearly half of the respondents in Kilifi (47%), 40% in Busia and 27% in Laikipia, had reportedly paid for some services when seeking for maternity services. Nyeri County had the lowest proportion of respondents (16%) paying for services.

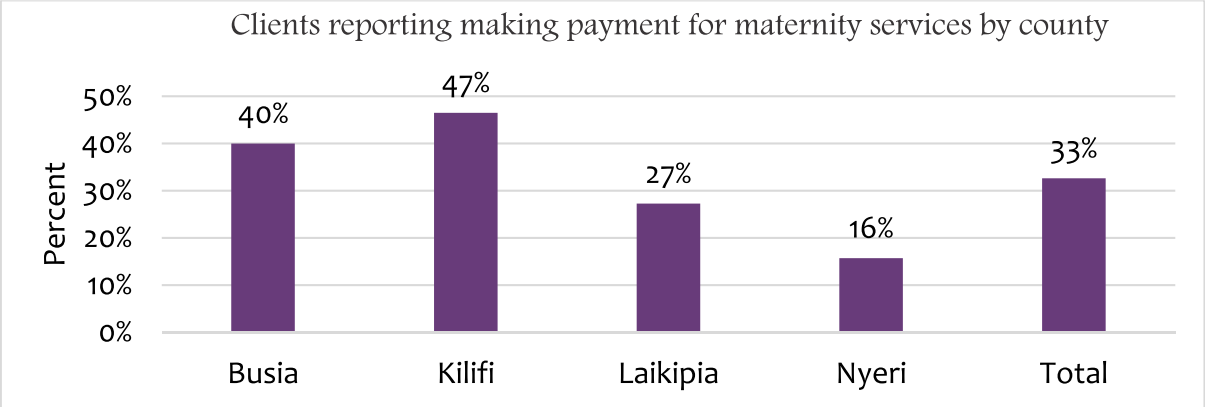

Figure 3: Proportion of clients who paid for maternity services

The payment were mainly related to cards (42%), laboratory tests (34%) and medicines (13%). A very small percentage of the respondents reported that they had paid for delivery services and antenatal care.

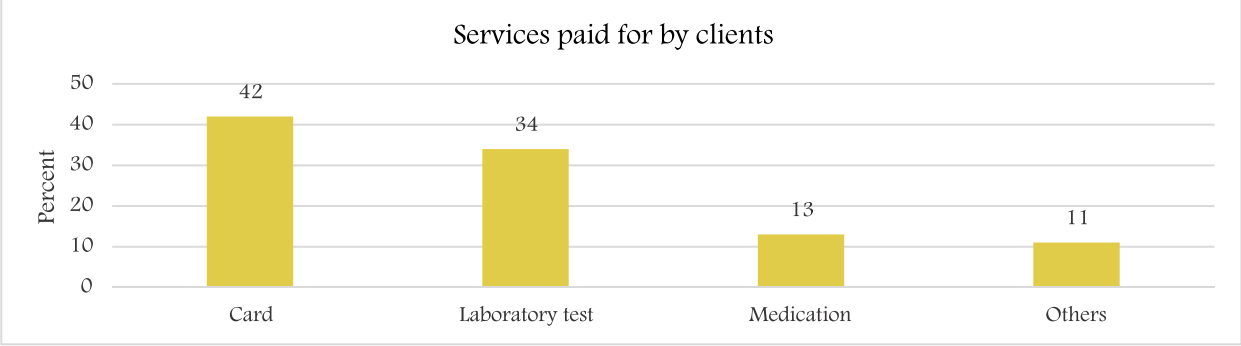

Figure 4: Services paid for by clients

Client perception interview revealed that a low proportion of clients thought that public health facilities charged for maternity services. 11% of all respondents within public health facilities in the four counties thought that public health facilities charged for maternity services with Busia (28%) and Kilifi (15%) having the highest proportion of respondents who felt that public health facilities

in their counties charged for maternity services.

3.3 Inclusion of special interest groups in free maternity service program

90% of all facilities visited reported that they were implementing some measures in the FMS program to address concerns of special interest groups such as persons with disabilities, persons living with HIV/AIDS and young mothers. Whereas programs targeted at PLWHA were already integrated within public health facilities, youth friendly service were available in some public health facilities while a handful of them provided disability friendly services. These facilities had for example adjustable beds. In other public health facilities, PWDs received priority services while in many lower level facilities which lacked disability friendly services and infrastructure, staff indicated that referral services were available for persons with disability. Out of the 51 facilities surveyed, only 7 facilities indicated that they had disabilities friendly services and facilities integrated in their systems. In Kilifi County none of the facilities visited reported on measures being implemented to facilitate access to maternity services for PWDs

The table 10 lists public health facilities that have disability friendly facilities and services.

Table 9: Facilities with disability friendly services

Name of facility	Disability friendly facilities/services
Busia County	Two adjustable delivery couches/disability friendly delivery bed.
Port Victoria District Hospital	
Nyeri County	
Gichiche Health Centre	Wheel chairs Disability friendly maternity beds.
Gakawa Health Centre	Adjustable beds Facility is accessible by ramps
Naromoru Sub County Health Centre	Wheel chair Building is accessible by ramps
Othaya Sub County Hospital	Wheel chair Sign language interpreters
Karatina Sub-County Hospital	Sign language interpreters
Laikipia County	
Likii Dispensary	PWDs receive priority treatment Disability friendly beds

Health care workers cited a number of challenges in attending to the needs of special interest groups with the four leading challenge being staff shortage, delayed reimbursement of funds for services rendered, inaccessibility of public health facilities and low staff morale.

3.4 Drivers for and barriers to accessing free maternity services

3.4.1 Drivers for access

Many women would prefer going to public health facilities to benefit from free maternity services. Over 76% of respondents interviewed outside public health facilities were willing to visit a health facility for delivery. Most clients (63.7%) cited free service as a major reason they would opt to go to deliver in public health facilities while others cited quality of health care, staff qualification, and health safety (19.7%).

Interviews with health facility staff revealed that there has been an upsurge in uptake of free maternity services. About 40% of all public health facilities reported a doubling of daily deliveries following the presidential directives. Port Victoria District Hospital in Busia Count, Bamba Sub-County Hospital and Ganze Dispensary and Kilifi County Hospital in Kilifi County, are some of the public health facilities where number of daily deliveries doubled following the presidential directive. Kilifi County had the highest number of public health facilities recording a significant increase in number of monthly deliveries. Table 10 provides a breakdown of number of deliveries in selected public health facilities prior to and after the implementation of the directive.

Table 10: Number of deliveries in selected facilities

Name of facility	Number of deliveries per day before the free maternity program?	Number of deliveries per day after the free maternity program
Busia County		
Budalangi Dispensary	1	5
Nangina Dispensary	0	1
Mukhobola Health Centre	1	2
Matayo Health Centre	2	5
Kocholya Sub County Health Centre	2	4
Alupe Sub County Hospital	2	5
Port Victoria District Hospital	2	4
Busia District Hospital	3	5
Sio-port Sub county	1	3
Kilifi County		
Bamba Sub -County Hospital	1	3
Ganze Dispensary	1	2
Tsangatsini Dispensary	1	2
Roko Dispensary	1	2
Mariakani Sub County Hospital	3	10
Gede HC	5	5
Malindi Subcounty Hospital	8	12
Vipingo Rural	2	3
Kilifi County Hospital	6	10
Mariakani Sub County Hospital	3	10
Rabai	2	6
Gongoni Health Centre	2	3
Nyeri County		
Gichira Health Centre	0	3

3.4.2 Barriers to access

Socio-cultural factors and challenges relating to poor transport infrastructure and distance to public health facilities are undermining access to free maternity services. It is widely believed in some counties that first-time mothers should have their first child at home. Other respondents also noted that staff shortages, harassment from hospital staff as well as congestion generally deter them from using maternity services. Transport related challenges were the main factors undermining access to FMS in Busia, Kilifi and Laikipia counties whereas in Nyeri County, socio-cultural factors

and poor quality of services were cited as the major impediments. In Busia County, the three major barriers to effective utilization of the free maternity program are lack of transport, distance to public health facilities, and reliance on traditional birth attendants. In Kilifi County, in addition to challenges relating to distance, transport, and cultural beliefs were cited as the major barriers while in Nyeri similar barriers were cited in addition to personal attitudes towards hospital delivery and staff shortage at public health facilities. In Laikipia, major barriers relate to distance, transport, and traditional beliefs.

3.5 Human resources for FMS program

The quality and quantity of staff at health centers is critical for the effective utilization of the FMS program. While staff shortage is an acknowledged fact in many public health facilities, findings from the study suggest that the reality has not changed to reflect uptake of the maternity services or to improve the quality. Only 22% of public health facilities visited reported an increase in staff levels with more than half reporting no change since the launch of FMS program while 24% of them reported a reduction. While 78% of public health facilities surveyed have either lost staff and have maintained their staff levels since the launch of FMS program, demand for additional staff in health facilities has increased particularly in 43% of health facilities that have witnessed a doubling of number of daily deliveries.

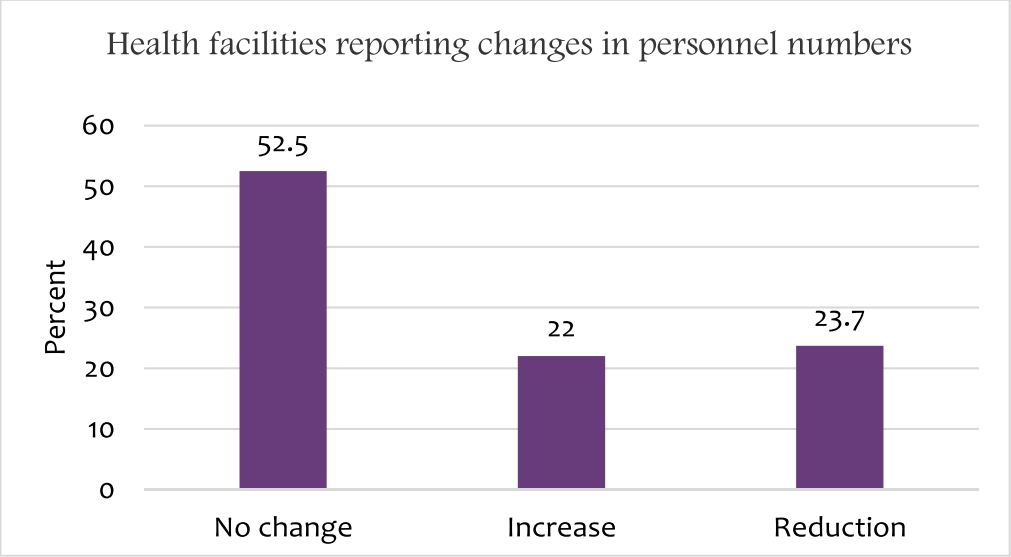

Figure 5: Proportion of public health facilities reporting changes in staff levels

3.6 Financing the FMS program

About 80% of the facilities reported that they had received reimbursement from the national government under the FMS program. However, health care professional and county government officials noted that delays in releasing funds FMS program as a major challenge. The delay is mainly attributed to the change in administrative channels for releasing rebate funds for delivery services to the facilities. According to some health facility staff, the national government channels rebate funds to facilities that are under the mandate of county governments through county revenue funds instead of structures such as HSSF and HMSF.

The introduction of this additional administrative structure has undermined timely release of funds. Further, although counties are responsible for delivery of health services, counties are reluctant to commit additional budgetary allocations to the program because they consider it to be a national government initiative without their involvement. Where counties commit their own resources to the program, they expect timely reimbursement from national government for the funds committed.

In addition, the amounts of reimbursement in some cases did not match the number of deliveries that were handled by the facilities resulting to chronic underfunding of the program. This may be related to inaccurate reporting and recording. Some of the rebate received at the county level is occasionally diverted to pay for other pressing health needs and not necessarily to subsidize cost of supplies and medication used in delivery forcing some public health facilities charge for cost of medicines from other essential supplies. This is perhaps because county government are independent and draw this from their budget and prioritise based on resources available to them.

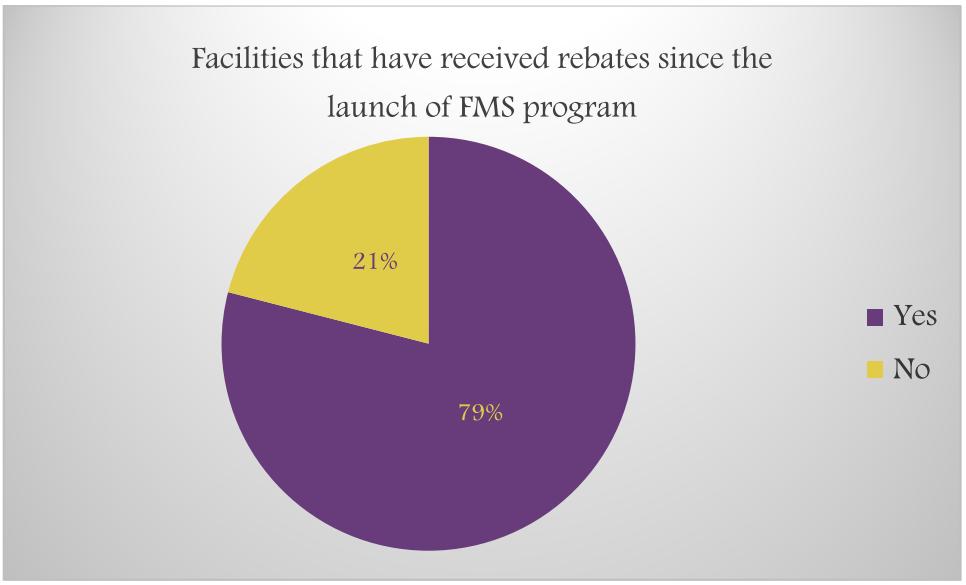

Figure 6: Proportion of public health facilities that have received rebates

3.7 Oversight and supervision of FMS program

Almost all public health facilities reported that there had established quality assurance committees or held regular staff meetings, (usually monthly meetings) to ensure proper oversight and supervision of the free maternity program. There were also periodic visits by external supervisors with frequency of the visits varying from annual visits, to quarterly visits and in some cases on an ad hoc basis. However, many facilities had not received any guidelines on the implementation of the FMS program from the Ministry of Health.

3.8 Benefits of FMS program

The benefits of FMS from clients and health providers' perspectives include reduced cases of child mortality and morbidity, early detection of complications in pregnancy, timely management of pregnancy among child mothers and timely management of incomplete induced abortions. In Teso, health providers noted that since abortion is illegal in Kenya, many women and girls procured abortion from unqualified service providers. Some of the women and girls seek services from public health facilities suffering from complications from incomplete abortion. Under the FMS program, such patients receive comprehensive post abortion care.

4. Conclusions and recommendations

The free maternity services program has resulted into increased uptake of delivery services in public health facilities especially in marginalized areas such as Kilifi and Busia counties. Almost half of all public health facilities have seen the number of daily deliveries double since the program was launched. Women and girls are able to access skilled delivery care at no cost from their nearest public health facility. The program has also resulted to better integration of health service delivery for women and girls as they are able to receive timely treatment for complications arising from pregnancy and child birth including post abortion care and cancer screening. The long run positive impact on health outcomes will be lower rates of maternal morbidity and mortality rates.

The program has also benefited from increased annual budgetary allocations from the national government and increasingly county governments are contributing their own resources including funds, ambulances and recruitment of additional nurses and other health care workers to support FMS despite the challenges relating to financing framework. There is a high level of awareness about the program among clients and the community has embraced the initiative.

However, the audit has revealed a number of gaps that may impact negatively on the success of FMS program and undermine its implementation. There is no clarity among users, health facility staff and policy makers at county level about the specific costs that are exempted. This demonstrates a weakness in the policy formulation process that is undermining adherence to the directive and achievement of FMS objectives, a recurrent problem that has affected similar past initiatives that have adopted a top-down approach to implementing popular health initiatives. Further, a major weakness of the FMS program is that it is not anchored into any specific policy or legal framework. However, there are legislative initiatives to entrench the policy into law and thus institutionalize it.

The FMS directive has failed to adequately address needs of special interest groups in particular persons with disabilities as well as women and girls living in marginalized areas where transport and infrastructural challenges are immense. The directive makes no mentions about how these groups will be facilitated to access maternity services. Furthermore, no adequate resource allocation was made to meet human resource needs, commodities and infrastructure needs of the program. Despite the increased demand for maternity services in many public health facilities, staff levels as well as supplies of equipment and services has not been scaled up commensurate with the increased demand. In some cases staff levels have decreased. Some facilities lacked adequate housing for nurses offering FMS and therefore most mothers could not benefit from FMS programs in most dispensaries due to lack of health providers.

Poor funding framework remains a challenges due to delays in reimbursing public health facilities funds for free maternity services and poor coordination of policy implementation between national and county governments that has resulted to limited or no budgetary allocation to the program by many counties which perceive the initiative as a national government program.

Moreover, while many facilities have put in place oversight and supervision mechanisms, there is no evidence of a comprehensive and structured oversight mechanisms for quality assurance and adherence to the policy from national to county levels. There is also no evidence of structured and informed involvement of community in the program despite measures to promote community involvement in healthcare provision.

Recommendations:

To National and County Governments

1. Policy adherence

The Ministry of Health should issue clear and detailed policy guidelines to all health institutions and existing oversight mechanisms at local and national level to clarify to scope of coverage and cost elements of the free maternity program. The cost elements of the program also need to be reviewed to assess whether they are sustainable to guarantee quality of services as well as whether they meet needs of the poor.

The Ministry of Health should also develop and implement a harmonized supervisory and oversight framework for the free maternity program at the national and county level.

The Ministry of Health, and Council of Governors should enhance coherence in policy formulation, coordination and implementation process. In order to promote broad-based ownership, the National government should involve all stakeholders including county governments, Civil Society Organization, Faith Based Organization, Private actors and the communities including persons with disabilities, marginalized communities, youth and children in the designing and implementation of the free maternity program.

2. Policy and legal framework

The Ministry of Health should undertake a review of existing policies, in particular Kenya Health Policy 2012 – 2030, National Reproductive Health Policy and National Adolescent Sexual and Reproductive Health Policy with a view to mainstreaming the free maternity services into all

existing policies. Additionally county governments should also undertake a review of relevant policy documents at the county level and align them with the constitutional framework.

The National parliament should enact into law the Reproductive Health Care Bill 2014 and the Health Bill 2015 in order to provide a sound legal basis for implementing the free maternity services directive at the county level. Similarly, county assemblies should consider enacting laws that recognize the right to safe motherhood and entrench provision of free maternity services.

3. Integrating needs of special interest groups

The Ministry of Health should also undertake a comprehensive maternity care needs assessment for special interest groups including adolescents and youth, persons with disability and marginalised women and girls in order to design appropriate and targeted interventions for all categories of SIGs. In particular, the Ministry should expand disability friendly infrastructure and services in all public health facilities.

4. Addressing critical barriers to accessing FMS

In order to address socio-cultural barriers to accessing FMS, the Ministry of Health should enhance community outreach services at the grassroots level to empower citizens and users on the importance of accessing skilled delivery services at public health facilities. This may entail strengthening community referral services and working with community health workers as well as local chiefs, and village elders to identify expectant mothers and sensitizing on the need to seek timely health care services. The Ministry should also prioritize expanding access to maternity services through use of mobile clinics and community health extension workers in marginalized areas.

The Ministry of Health and County departments responsible for health should also undertake a staff and infrastructure audit in all public health facilities to determine the staffing and infrastructure needs for each facility with a view to deploying or recruiting additional staff and enhancing supplies, equipment and other commodities in facilities that have witnessed dramatic increase in demand for services. Special attention should be paid to areas with poor maternal health indicators such as Kilifi County where the uptake of FMS services has risen significantly without commensurate upgrade of infrastructure or increase in staff levels.

5. Referral mechanisms

It is important that Counties establish an effective referral and evacuation programs well linked to all public health facilities especially in less developed and challenges areas including infrastructure. Referral mechanisms must lie at the lowest levels of health structure such as

dispensaries where most mothers and couples encounter their first point of contact on issues of delivery. Due to shortage of human resources and inadequate physical infrastructure, most dispensaries are not able to manage complicated pregnancies which have to be referred to other health providers hence the need for a well-planned referral system supported by a standby ambulance.

6. Awareness creation

The Ministry of Health and County departments responsible for health should conduct a communication needs assessment of the program and undertake a widespread public sensitization campaign, using appropriate communication channels, to enable users understand the scope of FMS. This campaign should also be made widely accessible to all groups including special interest groups such as adolescent and youths and persons with disabilities taking into account the low education levels of many of the beneficiaries of the program.

7. Partnership with private sector

To the greatest extent possible the Ministry of Health should forge partnership with private facilities to expand the program to private health facilities under a government waivered or subsidized program.

8. Funding FMS program

The FMS being a national strategic health intervention being implemented at county level where health service is devolved, it is important for the national and county government to draw an implementation and funding framework for the FMS program. They should ensure adequate resource allocation and timely disbursements of funds to all public health facilities. Funds earmarked for reimbursement to county public health facilities should be disbursed through mechanisms that respect the different roles of the two levels of government but without unnecessarily resulting to delays that compromise service provision.

The implementation and funding framework should also prioritize additional funding to counties in marginalized areas with poor maternal health indicators such as Kilifi and Mandera counties that may have additional funding needs in order to cope with upsurge in demand.

9. Monitoring and evaluation

The Ministry of Health should undertake a comprehensive evaluation of the FMS programs to determine its direct contribution to maternal mortality, infant and neonatal mortality and

morbidity. It is also important for county governments to use the robust monitoring data on FMS gathered at public health facilities through local health information systems in order to expand coverage or predict and plan for referral programs.

To Oversight Bodies

The relevant constitutional commission and independent offices should extend their oversight role within their respective mandate to address challenges emerging from implementation of FMS program.

1. The Controller of Budget

The Controller of budget should issue clear guidelines and regulations on funding disbursement and execution of the FMS including guidelines on segregation of county resources for county government support to FMS.

2. The Commission on Administrative Justice

The commission on administrative justice should monitor any mal administrative practices at public health facilities and in county health department to ensure smooth delivery of quality FMS to Kenyans from public facilities.

3. The National Gender and Equality Commission

NGEC should continue to monitor and audit the implementation of the FMS with focus to establishing the extent of applications of principles of equality and inclusion and advise the health sector on appropriate measures to address health inequalities in maternal and child health. The monitoring should include citizen hearing as a sure way of including the right to participation by the citizens.

NGEC and working with other stakeholders should finalise and launch and disseminate the standards on the right to health for its immediate application in audits, assessments and increase with input to health at county and national level and in the private sector.

5. Annexes

Annex 1: Ranking of select Counties by Number of Maternal Deaths and Maternal Mortality Ratio

Rank	Region	maternal	Rank	Region	Maternal mortality ratio (deaths per 100,000 live birth
	KENYA	6,623		KENYA	495
1	MANDERA	2,136	1	MANDERA	3795
2	WAJIR	581	2	WAJIR	1683
3	NAIROBI	533	3	TURKANA	1594
4	NAKURU	444	4	MARSABIT	1127
5	KAKAMEGA	364	5	ISIOLO	790
6	KILIFI	289	6	SIAYA	691
7	NANDI	266	7	LAMU	676
8	BUNGOMA	266	8	MIGORI	673
9	HOMABAY	262	9	GARISSA	646
10	MIGORI	257	10	TAITATAVETA	603
11	KISUMU	249	11	KISUMU	597
12	SIAYA	246	12	HOMABAY	583
13	TRANSNZOIA	234	13	VIHIGA	531
14	GARISSA	208	14	SAMBURU	472
15	KWALE	203	15	WESTPOKOT	434
	Other counties	85			
	Total	6,538			
Percent of the total number of deaths		98.7			

Annex 2: Ranking of Select Counties by Burden of Maternal Mortality

County	Maternal deaths	MMR	Percent of deaths during		
			Pregnancy	Delivery	2 months after delivery
Mandera	2,136	3795	28	56	16
Turkana	175	1594	24	54	22
Wajir	581	1683	28	60	12
Migori	257	673	24	45	30
Nakuru	444	374	28	40	31
Siaya	246	691	22	28	50
Kisumu	249	597	18	33	48
Nairobi	533	212	25	38	38
Homa Bay	262	583	22	34	43
Kakamega	364	316	20	44	36
Garissa	208	646	25	61	13
Marsabit	97	1127	30	47	23
TaitaTaveta	129	603	16	36	48
Isiolo	32	790	25	56	19
Lamu	52	676	10	65	25
Kenya	6,623	495	26	48	26

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