Implementing Free Maternal Health Care in Kenya

Challenges, Strategies, and Recommendations

By Nicole Bourbonnais, 6 November 2013

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1.0 Introduction

Kenya has long suffered from high maternal morbidity and mortality rates. The most recent estimates set the maternal mortality rate at 488 deaths per 100,000 live births, well above the MDG target of 147 per 100,000 by 2015.[1] For every woman who dies in childbirth in Kenya, it is estimated that another 20-30 women suffer serious injury or disability due to complications during pregnancy or delivery.[2] These high rates have persisted despite improvements in other health indicators over the past decades.[3]

The problem is driven, at least in part, by lack of access to quality maternal health services, including ante-natal, delivery, and post-natal services. Although health sector infrastructure has grown over the past decade, [4] many women still live at a considerable distance from health facilities, cannot afford to pay fees for maternal services, and/or face other barriers to accessing quality care. Access to skilled delivery is a particular challenge. Overall, only 44% of births in Kenya are delivered under the supervision of a skilled birth attendant, well below the target of 90% of deliveries by 2015. Traditional birth attendants continue to assist with 28% of births, relatives and friends with 21%, and in 7% of births, mothers receive no assistance at all.[5]

On June 1, 2013, the Government of Kenya took action to address this problem by initiating a policy of free maternity services in all public facilities, effective immediately.[6] Health facilities soon began to feel the effect of this policy. On the day of the announcement, Pumwani Maternity Hospital delivered an unprecedented 100 births.[7] By July, the Director of Public Health and Sanitation estimated a 10% increase in deliveries across the country, with increases of 50% in certain counties.[8] In some facilities, these numbers have been even higher. According to representatives of Kenyatta National Hospital (KNH), within a month the number of pregnant women seeking maternal care had increased by 100 per cent.[9]

In July 2013, the government committed Sh3.8 billion to fund the free maternal health care program, with an additional Sh700 million for free access to health centers and dispensaries, Sh3.1 billion for recruitment of 30 community nurses per constituency, Sh522 million for recruitment of 10 community health workers per constituency, and Sh 1.2 billion for provision of housing units to health care workers, within its overall allotment of Sh10.6 billion for health care in the 2013/14 national budget. Sh60 billion has also been allotted to county governments to be

[1] "Kenya's Other Great Catastrophe: Women and Infants Dying in Childbirth," *The Guardian*, September 28, 2013, http://www.theguardian.com/commentisfree/2013/sep/28/kenya-westgate-maternal-infant-mortality.
[2] *Realising Sexual and Reproductive Health Rights in Kenya: A Myth or Reality?* (Kenya National Commission on Human Rights, 2012)., p40-41.
[3] *Kenya Health Sector Strategic & Investment Plan, July 2012-June 2018* (Nairobi: Ministry of Medical Services and Ministry of Public Health & Sanitation, 2012)., p20.
[4] Ibid., p20.
[5] Kenya National Bureau of Statistics (KNBS) and ICF Macro, *Kenya Demographic and Health Survey, 2008-2009* (Calverton, Maryland: KNBS and ICF Macro, 2010). 122.
[6] "Speech by H.E. Hon. Uhuru Kenyatta, C.G.H., President and Commander-in-Chief of the Defence Forces of the Republic of Kenya During the Madaraka Day Celebrations" (Nyayo National Stadium, June 1, 2013), http://www.statehousekenya.go.ke/.
[7] "Despite Newly Free Deliveries in Kenya, Some Mothers Opt for Traditional Birth Attendants," *Women Deliver*, July 24, 2013, http://www.womendeliver.org/updates/entry/despite-newly-free-deliveries-in-kenya-some-mothers-opt-for-traditional-bir.
[8] "Free Maternal Health Care Holds Promise in Kenya," *PSI Impact Blog*, July 16, 2013, http://blog.psiimpact.com/2013/07/the-daily-impact-free-maternal-health-care-holds-promise-in-kenya/.
[9] Henry Owino, "Despite Setbacks, Free Maternal Health Care Will Work Out," *Reject* no. 087 (July 16, 2013): 6.

used on health, leading to a total of Sh95 billion for health overall.[10] And yet, several observers from within the health system have expressed concern that these commitments will not be nearly enough to meet the additional demand placed on facilities and staff due to the free maternity health policy. Others have questioned the feasibility and the appropriateness of the policy altogether which, they warn, might lead to a decline in quality of services, could further increase reproductive inequalities across the country, and will do little to address – and could even worsen – human rights violations in health facilities. All parties agree: it will not be an easy road forward.

What are the key challenges facing free maternal health care in Kenya? What strategies can the government undertake to ensure the program is a success and achieves the goal of enhancing the state of maternal health in Kenya? This paper uses evidence from Kenya, as well as other countries that have implemented free maternal health care policies, in order to assess the situation and advise the government on best practices moving forward. It begins by outlining the national and international framework guiding the right to reproductive health. It then documents some of the key challenges facing the free maternal health care program and outlines several strategies for ensuring free services are implemented fully, effectively, and without compromise to other key arenas of intervention. Finally, it closes with a summary of recommendations to the Government of Kenya and other stakeholders.

2.0 Rights Framework for Maternal Health

The framework for free maternal health services is provided for under several local, regional, and international mandates. Article 43(1)(a) of the Constitution of Kenya 2010 states that:

> Every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.

Reproductive health is widely recognized to include family planning, antenatal, delivery, and postnatal health services. The Constitution of 2010 further provides that a person has the right to emergency treatment (Article 43(2)), the right to inherent dignity and the right to have that dignity respected and protected (Article 28), and the right to access information (Article 35). The Kenya National Patients' Rights Charter (2013) outlines the right to access health care, the right to receive emergency treatment in any health facility irrespective of ability to pay, the right to the highest attainable quality of health care products and services, the right to be treated with respect and dignity, the right to information, and the right to complain, among others.[11]

Several international frameworks exist to guide the implementation of the right to health generally and the right to reproductive health in particular. General Comment No. 14 of the Committee on Economic, Social and Cultural Rights states that health services must be available with sufficient health facilities and trained health professionals.[12] The Committee on

[10] "Press Statement by Communication Secretary and State House Spokesperson on Cabinet Meeting Held 25 July 2013," July 24, 2013, http://www.statehousekenya.go.ke/.
[11] *The Kenya National Patients' Rights Charter, 2013* (Ministry of Health, October 2013).
[12] See General Comment No. 14 para 12 available at http://www.unhchr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En and accessed on 10th August 2011.

Elimination of Discrimination Against Women (CEDAW) requires states to ensure women have appropriate services in connection with pregnancy, childbirth, and post-natal care, including family planning and emergency obstetric care.[13] Kenya has also committed to fulfilling the Millennium Development Goals to reduce the maternal mortality ratio by three quarters and achieve universal access to reproductive health.[14]

The United Nations Population Fund (UNFPA) has outlined the principles of the Human Rights Based Approach (HRBA) to sexual and reproductive health rights. The HRBA states that governments, as duty bearers, have three levels of obligation to right-holders (all persons): (1) to *respect* sexual and reproductive health rights (SRHR) by refraining from interfering with the enjoyment of these rights, (2) to *protect* SRHR by enacting laws that create mechanisms to prevent violations of these rights by state authorities or by non-state actors and (3) to *fulfill* SRHR by taking active steps to put in place institutions and procedures, including the allocation of resources, to enable people to enjoy these rights.[15]

In addition, Kenya has signed on to several regional mandates regarding health/reproductive health. Kenya participated in and committed to the 2001 Abuja Declaration, pledging to commit at least 15% of the national budget to health care.[16] Kenya signed (but did not ratify) the Maputo Protocol on the Rights of Women of 2003, which recognizes reproductive rights and commits state parties to establishing and strengthening existing pre-natal, delivery, and post-natal health and nutritional services for women.[17] As a member of the African Union, Kenya launched the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in November 2010, reiterating the Campaign's slogan that "no women should die while giving life."[18]

In recent years, several African countries (including Burundi, Zambia, Burkina Faso, Liberia, Niger, and Sudan) have enacted policies to make deliveries and/or health care for mothers and children free or nearly free in order to fulfill these mandates.[19] Kenya's new free maternal health services policy is a potentially positive step in this direction. However, in order to comply with Kenya's international, regional, and local obligations, implementation of this policy must not override or diminish other rights provided by these frameworks.

3.0 Challenges

3.1 Resources

The Government of Kenya's current allotment of Sh95 billion for health represents only 5.7% of the total budget, well below the 15% required by Kenya's commitment to the Abuja Declaration. This contradicts the Jubilee Coalition's manifesto, which promised to increase the health budget

[13] CEDAW General Recommendation 24 available at http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24.
[14] http://www.undp.org/content/kenya/en/home/mdgoverview/overview/mdg5/.
[15] http://www.unfpa.org/rights/approaches.htm
[16] http://www.un.org/ga/aids/pdf/abuja_declaration.pdf
[17] http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf , p15-16.
[18] UNFPA African Regional Office on Status of the CARMMA Launch Report March 2011 available at http://www.unfpa.org accessed on 13th November 2011.
[19] Sophie Witter et al, *Providing Free Maternal Health Care: Ten Lessons from an Evaluation of the National Delivery Exemption Policy in Ghana* (Global Health Action, 2009)., p1.

line progressively to reach 15%; in fact, the current budget is a decrease from rates of 7.2% in 2010, 6.1% in 2011, and 5.9% for 2012. It also falls far short of the Ministry of Health's 2012 task force report, which called for a minimum of Sh217 billion for a three-year health stimulus package.[20] Doctors and other stakeholders have expressed further concern that the Sh60 billion allotted to county governments will not be used entirely on health, given other priorities like infrastructure, salaries, and local development funds.[21] This lack of sufficient funds could seriously jeopardize the success of the maternal health program.

Insufficient or slow distribution of the funds that *are* available for the program could also create problems. Although some facilities have reportedly been given extra money to cover the influx of deliveries,[22] others have remained in limbo, uncertain of how to balance the new policy for free care with their need to cover costs. A matron at Pumwani Maternity Hospital, for example, noted that while the hospital used to charge Sh5,000 for normal deliveries and Sh10,000 for a caesarian, the government was reimbursing them at a flat rate of Sh5,000 per delivery, creating a critical financial gap. [23] Another hospital stated that they were waiting to put the directive into practice until provided with official written communication on procedures and protocols to deal with the institution's financial needs.[24] As documented in other countries that have implemented free delivery services, such as Ghana, these funding and implementation gaps can create serious friction between communities and health staff and between facility managers and higher levels of the health system.[25]

3.2 Infrastructure, Equipment and Staffing

Kenyan public health facilities have long suffered from insufficient infrastructure, equipment and staffing. Recent survey data found that only 36% of public health facilities offering delivery services had all the basic delivery room infrastructure and equipment needed, with rural areas and lower level facilities particularly unequipped.[26] The Kenya Health Sector Strategic & Investment Plan (2012-2018) also estimates that current staff levels meet only 17% of minimum requirements needed for effective operation of the health system.[27] Kenya has only 7 nurses per 4,000 residents, half the number (14 per 4,000) recommended by the World Bank.[28] These health workers are also unevenly distributed across the country, with particular gaps in the North Eastern and Northern Rift provinces.[29]

These problems have been only further enhanced by the initiation of free maternal health services. Hospitals have reported increased overcrowding in maternity wards, with some

[20] *Strengthening Health Service Delivery: Report of the Taskforce* (Ministry of Medical Services and Ministry of Public Health and Sanitation, January 2012),
[21] "Kenya's 2013/14 Health Budget Cuts Threaten to Cripple Sector," accessed October 25, 2013, http://www.standardmedia.co.ke/?articleID=2000086000&story_title=kenya-s-2013-14-health-budget-cuts-threaten-to-cripple-sector&pageNo=2.
[22] "Free Maternal Health Care Holds Promise in Kenya."
[23] "We Need Accountability, Not Money, To Fix The Health Sector."
[24] Bosire Bonfiace, "Kenyan Hospitals Slow to Comply with Waived Maternity Fee Directive," *Sabahi*, June 5, 2013, http://sabahionline.com/en_GB/articles/hoa/articles/features/2013/06/05/feature-02.
[25] Sophie Witter et al, *Providing Free Maternal Health Care*. P3.
[26] *Realising Sexual and Reproductive Health Rights in Kenya*., p48-49.
[27] *Kenya Health Sector Strategic & Investment Plan, July 2012-June 2018*., 49.
[28] "We Need Accountability, Not Money, To Fix The Health Sector," *The Star*, July 13, 2013, http://www.the-star.co.ke/news/article-130247/we-need-accountability-not-money-fix-health-sector."Free Maternity Services in Kenya Could Endanger Mothers' Lives, Experts Warn," July 18, 2013, http://www.standardmedia.co.ke/
[29] *Kenya Health Sector Strategic & Investment Plan, July 2012-June 2018*., p45-49.

mothers forced to leave the hospital early to make room for others or even deliver on the floor due to lack of beds. Nurses have also reported being overburdened due to the new policy, with nearly all working overtime and as few as three nurses aiding 20 mothers at a time.[30] Although the Government of Kenya has committed funds to increase staffing, according to Dr. John On'gech (Head of Reproductive Health at Kenyatta National Hospital) the promised 30 new nurses per constituency is but "a drop in the ocean,"[31] as there is a deficit of some 90 nurses at his hospital alone.[32]

3.3 Access to Facilities

One of the most critical barriers to maternal health care in Kenya on a national scale is the lack of physical access to facilities, due to the insufficient number of facilities, distance to facilities, and inadequate transportation infrastructure. In fact, in replies to Kenya's 2008-2009 Demographic and Health Survey, the largest percentage (42%) of women who delivered outside a health facility did so because the facility was too far away or there was no transport to the facility, compared to only 17% who cited the cost of delivery as the key barrier. Cost of health facilities ranked as a factor above 30% only for women in Nairobi, with rural women far more likely to report that they did not deliver in a hospital because it was too far or they lacked transport. In North Eastern, where only one maternity wing is currently operational, 68.8% of women were deterred because of distance, lack of transport, or because the facility was not open, versus only 4.9% who cited cost as the key barrier to skilled delivery.[33]

The free maternity program is thus most likely to have the deepest effect in Nairobi, a region which already has the highest rate of births delivered under medical professionals at 89%, compared to 32% in North Eastern and 26% in Western.[34] If not accompanied by wider investments to increase the number of health facilities in rural areas and provide transportation infrastructure to link women to these facilities, the program may have the result of only further enhancing reproductive inequalities between Kenya's regions and counties.

3.4 Quality of Service

Kenya's public health facilities have long been plagued by reports of abuse, mistreatment, and negligence of patients at the hands of staff, a problem enhanced by poor supervision and understaffing. Patients also report that the public health system is not culturally sensitive, failing to adapt to local circumstances such as cultures which require women to be attended by female practitioners.[35] Health workers are also frequently insufficiently trained. The World Bank's recent report on Kenyan health facilities, for example, found that only 58% of public

[30] "Free Maternity Services in Kenya Could Endanger Mothers' Lives, Experts Warn."
[31] "How Free Is Free Maternal Delivery Program in Kenya?," *Lyneoyugi*, July 10, 2013, http://lyneoyugi.wordpress.com/2013/07/10/how-free-is-free-maternal-delivery-program-in-kenya/.
[32] Owino, "Despite Setbacks, Free Maternal Health Care Will Work Out."
[33] Kenya National Bureau of Statistics (KNBS) and ICF Macro, *Kenya Demographic and Health Survey, 2008-2009*. p121.
[34] Ibid., p120-123.
[35] *Realising Sexual and Reproductive Health Rights in Kenya*, p50-60, *Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities* (Center for Reproductive Rights and Federation of Women Lawyers – Kenya, 2007)

health providers could correctly diagnose at least 4 of the 5 most common conditions patients present with, and only 44.6% properly managed maternal/neonatal complications.[36]

Increasing the burden on health professionals without adequate increases in compensation and/or staffing threatens to enhance this systemic problem further. As nurses argue, not only is it impossible to effectively supervise over 20 mothers in a ward at once (as some have been doing since the start of the program), it is taxing to work overtime every night and enhances already existing morale problems.[37] Indeed, less than a month after implementation of free maternal health care, more than 2,000 nurses at the Kenyatta National Hospital went on strike, demanding fulfillment of a promised 46 per cent increment in their basic pay awarded by the High Court in September 2012.[38] Although the government agreed to implement the pay raise, it remains to be seen whether this will provide sufficient incentive to cope with the demands of free maternal health care.

The poor quality of service in facilities is also well-known among potential patients and acts as a significant deterrent to engaging with the public health system. Indeed, women in North Eastern cited the poor quality of service (17.3%) and lack of female providers (9.0%) as some of the key barriers preventing them from delivering in health facilities, more so than cost of delivery (4.9%).[39] Already, some Kenyan women interviewed by the press have stated their fear that free maternity care will lead to an even further decline in quality and enhance disrespect for their rights. As a result, they have reaffirmed their commitment to use more sensitive (if less skilled) traditional birth attendants and avoid public facilities – free or not.[40]

3.5 Broader Causes of Maternal Mortality

While lack of access to affordable, quality delivery services is a major cause of maternal mortality, it is not the only one. In fact, according to experts, some of the top causes of maternal mortality are easy to prevent and treat illnesses such as malaria, infection from germs, and diarrhea early in pregnancy.[41] A lack of sufficient primary health care and antenatal care prevents these and other potential complications from being detected and treated accordingly. Several provinces in Kenya, such as Western and Nyanza, report low use of doctors, and over one quarter of women in North Eastern do not get any antenatal care at all.[42] It is not clear whether the Government of Kenya plans to include antenatal care within "free maternity health care," but thus far the policy appears to be limited to delivery services.

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[36] Gayle H. Martin and Obert Imphidzai, *Education and Health Services in Kenya: Data for Results and Accountability*, Service Delivery Indicators: Education/Health (Washington, DC: International Bank for Reconstruction and Development/The World Bank, July 2013)., p2-4.
[37] "Free Maternity Services in Kenya Could Endanger Mothers' Lives, Experts Warn."
[38] "Patients' Agony as Nurses Strike," June 19, 2013, http://www.nation.co.ke/news/Patients-agony-as-nurses-strike/-/1056/1888814/-/y1ajyx/-/index.html.
[39] Kenya National Bureau of Statistics (KNBS) and ICF Macro, *Kenya Demographic and Health Survey, 2008-2009*. p121.
[40] Miriam Gathigah, "Kenya's Mothers Shun Free Maternity Health Care," *Inter Press Service*, July 9, 2013, http://www.ipsnews.net/2013/07/kenyas-mothers-shun-free-maternity-health-care/. "Despite Newly Free Deliveries in Kenya, Some Mothers Opt for Traditional Birth Attendants."Jane Otai, "What Is Free Maternity Care in Kenya Worth?," *Impatient Optimists*, August 28, 2013, http://www.impatientoptimists.org/Posts/2013/08/What-Is-Free-Maternity-Care-in-Kenya-Worth.
[41] Shitemi Khamadi, "ROAD MAP: Delivering Free Maternal Health," *Diplomat East Africa*, September 19, 2013, http://www.diplomateastafrica.com/component/content/article/36-latest/1328-road-map-delivering-free-maternal-health-.
[42] Kenya National Bureau of Statistics (KNBS) and ICF Macro, *Kenya Demographic and Health Survey, 2008-2009*. P115.

Unsafe abortions are also a major and entirely preventable cause of maternal morbidity and mortality in Kenya. Although the Constitution of 2010 permits abortions to protect the life or health of a mother, women in Kenya continue to turn to unsafe procedures by unskilled practitioners en masse, due to lack of awareness of the law, stigmas against abortion, resistance from health workers, and fear of prosecution by the police.[43] Although in ideal conditions abortions are a safe procedure with negligible rates of complications, unsafe abortions can lead to serious complications including high fever, sepsis, shock, or organ failure. According to a recent report by the Ministry of Health and APHRC, some 119,912 women received care in public facilities for complications from unsafe abortions in 2012, with a high case-fatality rate of 266 deaths per 100,000 unsafe abortions.[44] Indeed, complications from unsafe abortions are estimated to account for some one third of maternal deaths in Kenya.[45]

All of these problems are underlay by wider education, socio-economic status, and gender inequalities. Maternal mortality, child mortality, and abortion rates tend to be highest in regions with poor health indicators overall and higher poverty levels.[46] Critical delays are also caused when communities are not aware of the signs of life threatening complications and/or when women are delayed in making the decision to seek services, suggesting the importance of providing information and sensitizing communities to improve health seeking behavior.[47] Maternal health in Kenya is further restrained by women's lack of decision-making power and resources for seeking health care, weak negotiating power in sexual and reproductive health matters, heavy physical workloads even during pregnancy, and exposure to sexual violence.[48]

4.0 Strategies

The UNFPA's Human Rights Based Approach to sexual and reproductive health calls on duty-bearers to:

- Create an enabling policy environment that promotes reproductive health and rights, including building capacity to strengthen health systems, partnering with civil society and community-based organizations, and monitoring budgetary appropriations to ensure that reproductive health care is covered.
- Widen access to comprehensive reproductive health services, with an emphasis on disadvantaged groups.
- Build awareness of the reproductive rights of women, men and adolescents so that they can claim their rights to reproductive health.
- Encourage, involve, and build the capacity of individuals and communities to participate in the design, implementation, monitoring and evaluation of reproductive health programmes and services that affect their lives.[49]

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[43] *Realising Sexual and Reproductive Health Rights in Kenya,* p46-48.
[44] *Incidence and Complications of Unsafe Abortion in Kenya: Key Findings of a National Study* (African Population and Health Research Center, Ministry of Health, Kenya, Ipas, and Guttmacher Institute, August 2013)., p4.
[45] *Realising Sexual and Reproductive Health Rights in Kenya.*
[46] *Incidence and Complications of Unsafe Abortion in Kenya.*, p25. *Realising Sexual and Reproductive Health Rights in Kenya.*, 42-45.
[47] *Realising Sexual and Reproductive Health Rights in Kenya.*p68.
[48] Wendy J Graham and Sudan F Murray, "A Question of Survival: I. A Review of Safe Motherhood in Kenya," in *Safe Motherhood Initiatives: Critical Issues*, ed. Marge Berer and TK Sundari Ravindran (Reproductive Health Matters, 2000)., p106.
[49] http://www.unfpa.org/rights/approaches.htm

The following sections provide four strategies that respond to this call, followed by a summary of recommendations.

4.1 Ensure Sufficient and Efficient Resource Allocation

Increasing the budget line on health is absolutely essential in order to strengthen health systems and ensure there is sufficient infrastructure, equipment, and staff to implement universal maternal health care effectively. Kenya should follow the lead of other African countries, such as Ghana and Rwanda, and create a clear and progressive plan to meet the Abuja Declaration's goals, starting with an increased commitment to health care in the next budget.[50] The government ministries and other stakeholders also need to take action to ensure resources are distributed efficiently. This can be done, in part, by establishing a specific task force or unit within the Ministry of Health to develop and manage the policy of free maternal health care, in order to create clear lines of responsibility and enhance ownership of the process. This unit should also set up a strong monitoring and evaluation component to track progress and ensure proper use of funds.[51]

Increases in staffing should rank highly in resource allocation. The government's commitment to hiring 30 nurses per constituency (8700 total) and 10 community health workers per constituency (2900 total) should be fast-tracked and matched with further commitments for next year's budget. The Kenya Health Sector Strategic and Investment Plan (KHSSP) outlines total requirements and existing numbers of health staff, calling for an increase of 19,515 nurses in addition to 231,982 trained community health workers.[52] These estimates were drafted before the implementation of the free maternal health system and should thus be taken as minimums. Indeed, the National Nurses Association of Kenya Chairperson Jeremiah Maina has estimated that some 60,000 nurses are required to implement the program successfully.[53] Experience in other countries has also highlighted the value of increasing health worker salaries to compensate staff for longer hours created by the increased demand on services, and ensure sufficient motivation.[54]

In addition to staffing, health facilities also need the equipment and infrastructure to provide quality care. The KHSSP identified a shortage of some 3,091 equipped maternity facilities. The Plan also calls for 5,033 more utility vehicles and 3684 wheel ambulances to enhance transport infrastructure.[55]

4.2 Adopt a Holistic Approach

As discussed above, skilled delivery is only one of many factors influencing maternal morbidity and mortality. Boosting primary healthcare could thus save thousands of lives,[56] as could ante-natal care, which would allow health workers to identify problems early on and make timely

[50] Khamadi, "ROAD MAP: Delivering Free Maternal Health."
[51] Sophie Witter et al, *Providing Free Maternal Health Care*. P4.
[52] *Kenya Health Sector Strategic & Investment Plan, July 2012-June 2018*. 4.2.3
[53] "Free Maternity Services in Kenya Could Endanger Mothers' Lives, Experts Warn."
[54] Sophie Witter et al, *Providing Free Maternal Health Care*., p4.
[55] *Kenya Health Sector Strategic & Investment Plan, July 2012-June 2018*., 4.3.3
[56] Khamadi, "ROAD MAP: Delivering Free Maternal Health."

referrals.[57] The Government of Kenya should clearly define what is currently included in free maternal health care services and should expand these to include comprehensive reproductive health care, including antenatal and pr0-natal care.

Investing in family planning should also not be seen as a trade-off, but rather, a compliment to free delivery services. Family planning allows mothers to space their children and thus regain health in between pregnancies, prevents unwanted pregnancies and induced abortions, and limits HIV transmission from mother to child, thus reducing maternal morbidity and mortality; in short, family planning "is to maternal health what immunization is to child health."[58] Although the current government has increased the budget for family planning to Sh790 million, this falls short of the Sh1.74 billion called for by the KHSSP in order to move towards meeting the total need for services,[59] and should be increased further.

Safe abortion services can also go a long way in both reducing maternal morbidity/mortality and the burden on the health system created by unsafe abortions. In South Africa, for example, there was a 90% reduction in abortion-related deaths from 1999 to 2001 as safe abortion services were expanded in compliance with the Choice of Termination of Pregnancy Act.[60] In Mexico City, provision of safe abortions services was estimated to reduce government health costs by 62%, while 99.6% of legal procedures were complication free.[61] The Ministry of Health in Kenya has recognized this need, calling on the government to educate healthcare providers and women on the grounds when abortion is legal, and ensure all 47 counties implement the Ministry of Health's abortion-care related Standards and Guidelines.[62]

Broader health education with a focus on maternal health issues, gender equality, and reproductive rights is also essential. Women need to be taught to recognize the signs of complications early and empowered to make decisions about their health. Men, too, should be enlisted in the battle to safeguard maternal health.[63] A project in northwestern Nigeria, for example, engaged elders, men, and women in an effort to detect the main causes of maternal deaths in the area and create a community agenda. The project led to increased awareness of maternal health issues among all parties and the creation of new community-supported facilities and transport services, leading to a significant reduction in delays of treatment due to male resistance, lack of transportation, or unawareness of the severity of complications.[64] The government of Kenya and other stakeholders can look to this and other projects as a model of the role to be played by health education campaigns in reducing delays in treatment and enhancing maternal health.

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[57] Kenya National Bureau of Statistics (KNBS) and ICF Macro, *Kenya Demographic and Health Survey, 2008-2009*., 116
[58] *National Family Planning Costed Implementation Plan, 2012-2016* (Ministry of Health, October 2012)., p4.
[59] *Kenya Health Sector Strategic & Investment Plan, July 2012-June 2018*.4.3.1, p60.
[60] *Report on Initiatives That Exemplify Good or Effective Practices in Adopting a Human Rights Based Approach to Eliminating Preventable Maternal Mortality and Morbidity* (South African Human Rights Commission, National Human Rights Institution, April 2011).
[61] S´anchez Fuentes, M.L., J. Paine and B. Elliott-Buettner (2008) 'The Decriminalisation of Abortion in Mexico City: How did Abortion Rights become a Political Priority?', *Gender & Development* 16(2), 356-358.
[62] *Incidence and Complications of Unsafe Abortion in Kenya*., p27.
[63] *Realising Sexual and Reproductive Health Rights in Kenya*. p68.
[64] Dora J Shehu, "Community Participation and Mobilisation in the Prevention of Maternal Mortality in Kebbi, Northwestern Nigeria," in *Safe Motherhood Initiatives: Critical Issues*, ed. Marge Berer and TK Sundari Ravindran (Reproductive Health Matters, 2000).

4.3 Focus on Marginalized Areas

In order to have a significant impact on overall maternal health indicators in Kenya, these efforts must specifically target previously marginalized areas, especially North Eastern, where 68% of women deliver without the assistance of a skilled medical professional and 25% receive no antenatal care at all. Indeed, a focused project aimed at reducing the shockingly high maternal mortality rate of 1000-1200 per 100,000 births in North Eastern would undoubtedly go a long way towards improving indicators in the country as a whole. [65] Projects should also target informal settlements such as Korogocho in Nairobi, where maternal mortality ratios are as high as 706 deaths per 100,000 live births – almost double the national average.[66]

These areas need, first of all, more health facilities per capita, and more health workers. Construction of new facilities should prioritize disadvantaged areas and incentives should be provided to encourage health workers to make the move, at least temporarily. Local health centers also need improved infrastructure to provide delivery services, effective referral systems from TBAs to local health facilities and from local to provincial hospitals, and local transportation, ambulance and emergency services need to be created or enhanced. These efforts should be envisioned as part of a broader strategic development plan for these marginalized areas.

4.4 Ensure Comprehensive, Human Rights Based Training of All Health Workers

Studies by the World Bank and World Health Organization have shown that proper training and motivation of frontline service providers can be just as important, if not more important, than increased financing in attaining human development goals. When staff are properly training and accountability relationships between policymakers, frontline service providers, and users of services are strong, better results are seen.[67] This training should include not only delivery skills, but also infection control, interpersonal skills, and supervisory structures, with audit processes set up to regularly review quality of care. Officials should also train TBAs in detecting signs of complications early to ensure more adequate referrals.[68]

As part of this effort, the Ministry of Health and other stakeholders should undertake a comprehensive study of health worker attitudes, beliefs, and concerns. In other areas, such as South Africa, such studies have identified key misconceptions and genuine structural problems that shape providers' job satisfaction and treatment of patients.[69] The Ministry of Health should then develop a strategy to address these concerns, enhance job satisfaction and performance, and incorporate human rights principles into training workshops and curricula. The MoH and Kenya Medical Practitioners and Dentists Board must also work to demonstrate that they are

[65] Bosire Boniface, "Kenya's North Eastern Province Battles High Maternal Mortality Rate," *Sabahi*, March 12, 2012, http://sabahionline.com/en_GB/articles/hoa/articles/features/2012/03/12/feature-02.
[66] "Kenya's Other Great Catastrophe."
[67] Gayle H. Martin and Obert Imphidzai, *Education and Health Services in Kenya: Data for Results and Accountability*. p1
[68] Graham and Murray, "A Question of Survival: I. A Review of Safe Motherhood in Kenya." P110
[69] Helen Schneider and Lucy Gilson, "The Impact of Free Maternal Health Care in South Africa," in *Safe Motherhood Initiatives: Critical Issues*, ed. Marge Berer and TK Sundari Ravindran (Reproductive Health Matters, 2000).

serious about reforming the system by displaying the National Patients Rights Charter in all health facilities, informing patients of its contents, and taking complaints seriously.

In these ways, the government can begin the long task of rebuilding community trust and faith in public services, as part of a broader effort to strengthen the maternal health program and health systems more generally. Indeed, studies have shown that both community awareness and accountability to the community are critical to ensuring proper implementation of health programs.[70] As one public health worker put it: "if the Kenyan government wants to prevent maternal and infant mortality, they must make delivery services not only available to anybody, but desirable to everybody."[71]

5.0 Summary of Recommendations

Ensure Sufficient and Efficient Resource Allocation

- Outline a plan to increase health resources to meet 15% of the total national budget, in order to fulfill Kenya's commitment to the Abuja Declaration and the Jubilee Coalition's own election manifesto promises, beginning with an increase in the 2014/15 budget
- Establish a tracking system to ensure county governments commit the allotted Sh60 billion to health as advised
- Create a special task force within the Ministry of Health to develop and manage the free maternal health care program
- Establish clear monitoring and evaluation procedures to track results of the program
- Clearly outline the amount, nature, and delivery system of government reimbursements to hospitals for free maternity services, and specify what is included
- Ensure all public health facilities have all the basic delivery room infrastructure and equipment needed, including sufficient number of beds
- Significantly enhance human resources by:
    - a) increasing staffing levels based on targets set by the KHSSP, including 19,515 nurses and 231,982 community health workers
    - b) increasing the salaries of health professionals
- Create and equip new maternity facilities towards the target of 3,091 additional equipped facilities called for by the KHSSP
- Invest in ambulance and utility vehicles to enhance equipment distribution and access to facilities

Adopt a Holistic Approach

- Incorporate ante-natal and post-natal care into free maternal health care services, if not already included (clarify policy)
- Invest more resources in family planning to promote child spacing and prevent unwanted pregnancy

[70] TK Sundari Ravindran and Marge Berer, eds., "Introduction: Preventing Maternal Mortality: Evidence, Resources, Leaderhip, Action," in *Safe Motherhood Initiatives: Critical Issues* (Reproductive Health Matters, 2000), 1–7.
[71] Otai, "What Is Free Maternity Care in Kenya Worth?".

- Provide sufficient equipment for safe abortions services, educate healthcare providers and communities on Article 26 (4) of the Constitution 2010, and ensure all 47 counties implement the MoH's abortion-related standards and guidelines
- Undertake a comprehensive maternal health education campaign which focuses on key causes of delay of treatment and seeks to promote gender equality in health decision-making

Focus on Marginalized Areas

- Develop a strategic plan to identify and address the main causes of the especially high maternal mortality rates in North Eastern and informal settlements in Nairobi
- Provide financial and other incentives to encourage health workers to serve in North Eastern, informal settlements, and other neglected areas
- Prioritize North Eastern and other marginalized areas in the construction of new health facilities and in health education projects
- Enhance transportation infrastructure by building new roads, supporting community transport unions, and increasing the number of ambulances and cars for referrals
- Provide funding and technical support for the creation of local community transportation organizations to assist women in emergencies

Ensure Comprehensive, Human Rights Based Training of All Health Workers

- Ensure all health workers are trained to properly manage maternal and neonatal complications
- Enhance accountability and supervisory structures between policymakers, frontline service providers, and users of services
- Undertake a study of health workers to identify key needs, concerns, and complaints, then design a policy to address concerns, enhance job satisfaction, and improve quality of service
- Hold workshops for health workers on the human rights based approach and incorporate into all training curricula
- Display the National Patients Rights Charter in all facilities, inform patients of its contents, and effectively handle complaints
- Adopt an affirmative action approach to hiring of culturally appropriate, female practitioners