Additional Interventions Needed to Achieve the Aim of Free Maternity Services in Kenya

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PARLIAMENT OF KENYA

Policy Brief

Introduction

Structure

This Policy Brief begins by outlining the national framework guiding the right to reproductive health. It then highlights some barriers to free maternity service program and finally outlines several policy interventions to address the barriers to ensure that all women in need of maternal and child health services are able to access them when in need.

Status of maternal and child health services in Kenya

In Kenya there has been a persistent problem of lack of access to quality maternal health services, including ante-natal, delivery, and post-natal services due to high fees for maternal services among other factors. Prior to the abolition of user fees for maternal health services, expectant women in Kenya had to not only contend with hospital charges, but also with other barriers to access which included, lack of transport, fears about negative attitudes of health workers, long distances to health facilities and cultural preferences . As a result of these barriers, only 44 percent of births in Kenya were delivered under the supervision of a skilled birth attendant, well below the GOK target of 90 percent deliveries by 2015 (KDHS 2008/9). Traditional birth attendants continued to assist 28 percent of births, relatives and friends assisted 21 percent while seven percent of mothers received no assistance at all while giving birth (KDHS 2008/9).

Beginning 2013, Kenya started offering free maternal and child health services in public hospitals. The overall goal was to reduce the maternal mortality rate which in 2009 stood at 488 deaths per 100,000 live births, well above the MDG target of 147 per 100,000 by 2015 . 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 . These high rates have persisted despite improvements in other health indicators over the past decade. This Policy Brief argues that although the abolition of user fees is a welcome intervention, the goal of ensuring that all births take place in the presence of a skilled health care professional (in this case at a health facility) will not be achieved unless attention is paid to the other barriers that affect access to health facilities. It is therefore important to institute other interventions that will ensure access to the free maternal and child health services provided at government health facilities.

Key Messages

- The abolition of user fees in public health facilities for maternal and child health services is an important step in reducing maternal mortality rates.
- However, user fees are not the only access problem faced by women and children in need of these services: transport costs, inadequate staff numbers and mistreatment of expectant mothers by health facilities' staff constitute additional barriers to access.
- Failure to introduce interventions that target these other barriers will undermine the noble objective of ensuring access to maternal and child health services for all women in need.
- It is recommended that the government trains and redistributes adequate numbers of health care staff while providing means of transport and subsidies as appropriate to each geographical region of the country.

Methodology

The development of this policy brief was based on a review of secondary sources of information and research evidence. These included Internet searches of evidence through such engines such as Google, Google Scholar and Pubmed as well as Kenya government policy documents

Situational analysis of maternal and child health services in Kenya

The Government of Kenya abolished maternity charges in public health facilities through a presidential decree on 1st June, 2013 to encourage women to give birth at health facilities under the care of skilled personnel. This was in line with the resolutions of the African Union favoring point-of-service user fees exemptions for pregnant women and children under the age of five years and also in line with the Jubilee Government's pre-election promise. The policy aims at reducing maternal complications as well as maternal mortalities in Kenya. In this regard, the government allocated KShs. 4 billion (USD 44.4 million) in the 2013/2014 budget for implementation of the programme .

Under this programme, health centers and dispensaries should be reimbursed Kshs. 2,500 (equivalent of USD 27.7) for every delivery, through the Hospital Sector Services Fund. Hospitals should be reimbursed KShs. 5,000 (equivalent of USD 55.6) for every delivery conducted in the facility, through the Hospital Management Service Fund. In addition, the government set aside KShs. 3.6 billion (USD 40 million) to hire 7,500 additional health workers to cope with the expected increase in workload.

In order to meet the main objective of the policy, which is to ensure that every birth occurs in the presence of a skilled medical attendant, it is important to equally address other factors that prevent access to medical care in health facilities. A user fee at the point of access has been identified as one of the barriers to access of maternal health services in Kenya. However this is not the only barrier to access. Other documented barriers include transportation, social barriers, mistreatment from nursing staff, implementation barriers, inadequate supplies, myths and misconceptions and social dynamics . Access to free maternity services will not be achieved by abolition of user fees alone, unless these other barriers are addressed. Consequently, reduction in maternal deaths due to pregnancy complications will equally not be achieved as envisaged. In Kenya at the moment, there lacks a documented policy direction on how to address these other barriers. This Policy Brief suggests strategies for addressing these other identified barriers to accessing maternal health services in order to ensure that free maternal and child health services can be accessed by all women who need them.

Free maternal health services and the Kenya Health Policy Framework

The abolition of maternity charges in Kenyan public health facilities is in line with the Kenya Health Policy Framework, which, as guided by the Constitution of Kenya (2010), has adopted a rights-based approach to health services. In this approach, every citizen has a right to the highest attainable standard of health; including reproductive health and the State shall provide appropriate social security to persons who are unable to support themselves and their dependants (Article 43. Economic and Social Rights).

The Kenya Health Policy, 2014–2030 gives directions to ensure significant improvement in the overall health status of citizens in line with the country's long-term development agenda as set out in Vision 2030, the Constitution and with its health related global commitments. It demonstrates the health sector's commitment, under the government's stewardship, to ensuring that the country provides the highest possible standards of health, in a manner responsive to the needs of the population. In line with this Health Policy Framework, Kenya's president, through a presidential decree issued on 1st June 2013, announced that the government had abolished maternity charges in public health facilities in order to help expectant mothers' access maternal care and reduce maternal mortality. Following this pronouncement, user fees have been abolished in all public health facilities. And while this programmatic change does eliminate one of the barriers to accessing maternal health services, there is need to find ways to address the other barriers to access to services in order to ensure that all women in need have access to specialised treatment in public health facilities.

Access problems besides cost at point-of-service

There are three major delays that have been identified as barriers contributing to the high incidence of maternal mortality. These include a delay in reaching a health facility for treatment, delay in receiving treatment and delay in deciding to seek care . Among these three, a lack of transport and emergency ambulance services can further exacerbate any emergency, especially in cases of complicated pregnancies (UNFPA 2011) .

Transport services affect access to both preventative and emergency childbirth care, playing a key role in the survival of women and their newborns, as complications in birth may rapidly become life-threatening. In low income countries, particularly rural areas, considerable time is spent by women and their families waiting for transportation, and travelling to health facilities (Babinard and Roberts 2006). Adding to this is poor roads, too few vehicles and high transportation costs, all of which are major causes of delay in decisions to seek and reach emergency obstetric and postnatal care (Babinard and Roberts 2006).

Treatment from nursing staff

Fear of harsh treatment from nursing staff has often led to women opting not to deliver their babies in health facilities. Pregnant women often complain of being neglected, insulted and occasionally being physically assaulted by nurses in government health facilities. As a result of this mistreatment, many of them shun government facilities during childbirth. In a systematic review of factors affecting use of antenatal care in developing countries, rude and unfriendly attitudes of nurses were identified as major barriers deterring mothers in Zimbabwe from delivering in hospital. Rural women in Tanzania also expressed fears of discrimination from health facility staff as a reason for avoiding hospital deliveries . Specific to rural western Kenya, van Eijk and colleagues found that only a small subset of the population identified anticipation of unpleasant treatment as a reason women chose not to access hospitals for delivery.

Image: H6 Partners/Flickr

Inadequate staff numbers

The Kenya Health Sector Strategic and Investment Plan (2012-2018) estimates that current staff levels meet only 17 percent of minimum requirements needed for effective operation of the health system. Kenya has only 7 nurses per 4,000 residents, half the number (14 per 4,000) recommended by the World Health Organization (WHO) (Bourbonnais 2013). According to Burns (2000) employing qualified personnel to monitor labor in the health facility has a great impact on reducing maternal mortality. The problem in Kenya is exacerbated by the fact that health workers are unevenly distributed across the country with particular gaps in the North Eastern and North Rift counties. The table below demonstrates these deficiencies in selected counties in the North and North Eastern regions of the country.

Table 1. Nurses deficiencies in selected counties in the North, Coast and North Eastern Kenya

Counties	% Nurses compared to WHO requirements
Garisa	17%
Isiolo	11%
Lamu	6%
Mandera	5%
Marsabit	11%
Samuburu	11%
Tana River	7%
Turkana	10%
Wajir	8%
West Pokot.	14%

Source: MOPHS/MOMS HRIS 2012

There is a growing concern that patients are being harmed by inadequate staffing related to increasing severity of illness and complexity of care. The safety and quality of patient care is directly related to the size of the staff and training and experience of the nursing workforce. The appropriate size of the workforce needed for effective operation of the health system has to be met for better service delivery. The government allocation of funds to train extra numbers of nurses for health facilities is a laudable move. However, these allocations need to be rationalised both in numbers and in distribution. Regions with severe nurse shortages ought to be given priority in the new allocations while a staff redistribution strategy ought to be embarked on in the short term to deal with severe staff shortages. Inadequate staff numbers will undermine the success of the free maternal and child health services in the long run unless the problem is tackled.

Discussion of Policy Options

Addressing Transport Barriers

There are three main approaches identified to address the transport barriers to enable women and children to access clinics and hospitals for maternal and child care. These include: (i) public/private partnerships and transportation programmes (as was done in Ghana and Nigeria); (ii) specialised health transport including donkey cart ambulances (as used in Somalia), bicycle ambulances (used in Zambia), motorcycle ambulances (in Malawi), and car ambulances (done in South Africa); and (iii) transport funds or transport vouchers, where women are given financial support (cash or voucher) to assist them with transport to receive maternal healthcare services (as done in Bangladesh, India, Nepal, Sierra Leone and Uganda) .

i.Public/private partnerships and transportation programmes

These programmes focus on training and encouraging local taxi drivers to transport women to health centres, so that they can access the required healthcare services. Examples where such a programme has worked successfully have been identified in Ghana (i.e. collaboration with Ghana private roads and transport unions project) and in Nigeria (i.e. Emergency Transport Scheme). These programmes have proven to be highly effective in low resource and developing countries with low uptake of healthcare services (Theophilus 2013).

This program will create opportunities for collaboration for instance contracts with commercial vehicles and taxi unions can be executed and shared with the members of the public to facilitate easy transportation to the health facility in a need arises.

ii. Specialised health transport

This has been used in remote rural areas in Malawi as a means to improve access to obstetric health care facilities for women in labor or needing prenatal care. Lightweight off-road motorcycles, equipped with a side car holding a stretcher for the patient, have been found to be efficient . Motorcycle ambulances reduce the delay in referring women with obstetric complications from remote rural health centres to the district hospital, particularly under circumstances where health centers have no access to other transport or means of communication to call for an ambulance . They are also a relatively cheap and effective option for referral of patients in developing countries, particularly in rural areas with little or no public transport. An equivalent of 19 motorcycle ambulances can be bought for the price of one Toyota land cruiser car ambulance. Operating costs compare in a similar way .

iii. A Transport fund or transport voucher

This is a scheme where women are given financial support (cash or a voucher) to assist them with transport to the nearest health facility in order to receive maternal healthcare services. In many instances this allows them to use local transport to and from the health facility for antenatal, delivery and postnatal care. Several initiatives have been implemented in South Asia (in Bangladesh, India and Nepal) and in Africa (in Sierra Leone and Uganda). In this program, taxi drivers, the motor riders, communities and the riders' representative association, will agree to prices for transporting pregnant women at a rate as close as possible to the market rate. A day rate and a night rate will be agreed in order to curtail any exploitative pricing for transporting pregnant women. Also phone numbers of taxi drivers and riders will be shared with communities, and will be available at dispensaries and health facilities.

Recommendations

In view of the varied landscape, transport requirements and specific local contexts, the government must evaluate the three transport options discussed above and institute them appropriately for each region in the country. For example, where no proper roads exist, the possibility for motorcycles or donkey cart transport should be explored. Where transportation programmes that use voucher systems and schemes are appropriate such as in many urban and peri-urban areas, these should be introduced and be protected, monitored and reinforced. There is need to invest in ambulance and utility vehicles to enhance equipment distribution and access to facilities.

The government must embark on a realistic program to train and re-distribute adequate numbers of health care providers (not merely nurses) for each facility. Such a move would ensure that the ratio of nurses to maternal and child health care clients attains the WHO recommendations. While the move to train 7,500 nurses per year is laudable, a realistic programme that sets timelines for the achievement of the WHO requirement is needed.

The MOH should propose a refresher course or an on-the-job training for employed nurses, supervision and monitoring exercises to ensure that nurses treat maternal and child health patients with respect.

There is a need to engage in community empowerment and education to address women's fears especially the young pregnant mothers regarding the nature of treatment at health facilities. Once the skilled personnel have been retrained, women taking antenatal services need to be informed of the changed attitudes and practices at government health facilities.

References

Bourbonnais, N (2013) Implementing Free Maternity Health Care in Kenya: Challenges, Strategies, and Recommendations. Retrieved from: http://www.knchr.org/Portals/0/EcosocReports/Implementing%20Free%20Maternal%20Health%20Care%20in%20Kenya.pdf

Kenya's Other Great Catastrophe: Women and Infants Dying in Childbirth, The Guardian, September 28, 2013, Retrieved from: http://www.theguardian.com/commentisfree/2013/sep/28/kenya-westgate-maternal-infant-mortality.

Kenya National Commission on Human Rights (2012). Realising Sexual and Reproductive Health Rights in Kenya: A Myth or Reality? A Report of the Public Inquiry into Violations of Sexual and Reproductive Health Rights in Kenya p40-41

Wamalwa, E.W. (2015). Implementation challenges of free maternity services policy in Kenya: the health workers' perspective. Pan Africa Medical Journal, 22:375. Retrieved from: http://www.panafrican-med-journal.com/content/article/22/375/full/ff.Vt%UDokUw doi:10.11604/pamj.2015.22.375.6708

Barriers to the use of basic health services among women in rural southern Egypt (upper Egypt). Nagoya J Med Sci. 2013 Aug; 75(3-4): 225–231.

Thaddeus, S., Maine, D. (1994). Too far to walk: maternal mortality in context. Soc Sci Med; 38: 1091-1110 Retrieved from: http://www.maternityworldwide.org/what-we-do/three-delays-model/

Pariyo, G., Mayora, C., Okui, O., Ssengooba, F., Peters, D. et al. (2011). Exploring new health markets: experiences from informal providers of transport for maternal health services in Eastern Uganda. BMC International Health and Human Rights 11(Suppl 1): S10.

Simkhada, B., van Teijlingen, E.R., Porter, M., Simkhada, P., (2008) Factors affecting the utilization of antenatal care in developing countries: systematic review of the literature. J Adv Nurs;61(3):244–60.

Kowalewski, M., Jahn, A., Kimatta, S. (2000). Why do at-risk mothers fail to reach referral level? Barriers beyond distance and cost. Afr J Reprod Health;4(1):100–9.

van Eijk, AM., Bles, HM., Odhiambo, F., Ayisi, J.G., Blokland, I.E., Rosen, D.H., et al. (2006). Use of antenatal services and delivery care among women in rural western Kenya: a community based survey. Reprod Health 2006;3(2):1–9

The Strengthening Primary Health Care in South Africa Programme (2014) Transport barriers: Approaches to accessing maternal and child health services by Josianne Roma-Reardon

Motorcycle ambulances in Malawi reduce maternal mortality (2007), Mobility and Health (International Forum for Rural Transport and Development (IFRTD)), retrieved 22/ 07/2016

Hofman, Jan J.; Dzimadzi, Chris; Lungu, Kingsley; Ratsma, Esther Y.; Hussein, Julia (2008), Motorcycle ambulances for referral of obstetric emergencies in rural Malawi: Do they reduce delay and what do they cost?

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