Contribution of a Science-Policy Café to a Shift in Kenya's Free Maternity Services Policy

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Why free maternity services policy in Kenya

Kenya continues to record high levels of maternal deaths and poor maternal health outcomes. According to the Kenya Demographic and Health Survey (KDHS) 2014, the national maternal mortality ratio is currently at 362 deaths per 100,000 live births, a decrease from 488 per 100,000 in 2008. This is well above the MDG target of 147 per 100,000 by 2015. It is estimated that for every woman who dies in childbirth in Kenya, more than 20-30 women suffer serious injury or disability due to complications during pregnancy or delivery (Kenya National Bureau of Statistics, 2014). The persistence of these undesirable outcomes despite improvements in other health indicators in the last decades is puzzling (Ministry of Medical Services and Ministry of Public Health & Sanitation, 2012).

Table1: Progress in Key RMNCAH Indicators

Key Indicators	KDHS 2008/09	KDHS 2014	SSA region
Neonatal mortality rate (per 1,000 Live births)	31	22	31.1*
Infant mortality rate (per 1,000 Live births)	52	39	61.1*
Under-five mortality rate (per 1,000 Live births)	74	52	92.4*
Maternal mortality ratio (per 100,000 live births)	488	360	510*
Total fertility rate (per women)	4.6	3.9	5.0*
Teen pregnancy (%)	18	18	-
Children under-five stunted (%)	35	26	-
Deliveries attended by a skilled provider (%)	43	62	48.6**
Pregnant women received any antenatal care (%)	92	96	77**
Children received all basic vaccines (%)	65	71	-
Children under 6 months exclusively breastfed (%)	32	61	37.7**
Contraceptive prevalence rate (any method) among currently married women (%)	46	58	23.6**
Unmet need for family planning (%)	25	18	24.4**

* Source- World Bank 2013, **2011, NA – Not available,
KDHS – Kenya Demographic and Health Survey, SSA – Sub Sahara Africa

Source: MoH 2016

Lack of access to quality maternal health services, including antenatal, delivery, and post-natal services, has been identified as one of the causes of the high maternal mortality and morbidity rates in the country. Many women reside far from health facilities and others prefer to deliver at home for cultural reasons or because maternity fees are beyond their reach. This is risky and contributes to high maternal deaths. Overall, only 60% of births in Kenya are delivered under the supervision of a skilled birth attendant (Kenya National Bureau of Statistics, 2014). Ensuring all women deliver with the help of a skilled birth attendant and can access emergency obstetric care is generally accepted as being the most efficacious strategy in the reduction of maternal mortality (Campbell O. & Graham W., 2006). The Head of Policy, Planning and Healthcare Financing at the Ministry of Health, Dr. Peter Kimuu, in trying to contextualize and show justification for the need for free maternity services explained that "*Before the initiation of the programme, in the second half of 2013, many mothers would be detained at health facilities because they were unable to raise the maternity fees being charged at public institutions*" (Ministry of Health, 2016).

How the Free Maternity Services Policy was Conceived

In 2012, the then Ministry of Medical Services developed a concept note on the provision of free maternity services, which the new Jubilee Government relied upon in 2013 to declare free maternity services across the country. In 2013, the Government of Kenya took a deliberate action to address the high maternal morbidity and mortality problem by introducing a free maternity services policy in all public facilities (Office of the President: Kenya, 2013). This declaration lifted financial barriers associated with using maternal health services and was designed to ensure all Kenyan mothers have access to maternity services in public facilities. This was expected to improve skilled health delivery from a paltry 44% recorded by the Ministry of Health (MoH) in 2008 and also improve the quality and attendance at post-natal care.

Implementation of the Policy Directive experienced a lot of Challenges

As with many other policies, the implementation of the presidential directive on free maternity services in Kenya faced a number of challenges, key among them are discussed below.

Public facilities became overwhelmed, occasioning poor quality services

The period following this policy declaration saw public health facilities overwhelmed with high numbers of women seeking maternal care services. According to the MoH programming data, within the first year of its launch, deliveries in public health facilities increased from 418,325 to 627,487, which translated to 61% of total deliveries in Kenya administered in public facilities. While this increased was good, it occasioned deterioration in the quality of services provided to women by the overwhelmed health workers.

Lack of guidelines for policy implementation

Except for a circular sent to public health facilities on the free maternity services policy, there were no guidelines defined to guide the implementation of this policy directive, more than two years after it was issued as at February 2015. As such, facilities were implementing the directive variedly based on their own interpretations and judgement.

Delayed reimbursements to facilities to cover free maternity services offered

More critically, there were many complaints by public facilities and county governments of the lengthy delays in the disbursement of refunds once the services were offered. This greatly hampered service provision since facilities had lost income due to this policy, and delayed refunds meant that they had little if no money at all to cover their service provision.

How the Science-Policy Café on Implementation of the Free Maternity Services Policy contributed to a Policy Shift

As all the challenges above were being experienced and highlighted in the media, the MoH was collaborating with the African Institute for Development Policy (AFIDEP) and other partners to implement the Strengthening Capacity to Use Research Evidence in Health Policy (SECURE Health) programme. One of the interventions of the SECURE Health programme was co-hosting with MoH regular science-policy cafés to deliberate evidence on urgent policy issues that the MoH was experiencing. It was therefore no surprise that the MoH proposed a science-policy café to discuss evidence that could inform policy solutions to the challenges that it was facing in the implementation of the free maternity services policy directive.

It should be noted that even as the MoH requested for this café, it was already in consultation with some development partners exploring ways of tackling the challenges facing the implementation of this policy. This science policy café was held in March 2015. Café panelists comprised a senior policymaker form the MoH, a health researcher from the Kenya Medical Research Institute (KEMRI), Nairobi county government official from the health department, and a practitioner from the national referral (Kenyatta National Hospital). The café was moderated by a highly respected Kenyan who is veteran reproductive and maternal health expert and lead World Bank advisor. Café attendance attracted policymakers from MoH and a few county governments, implementers, and researchers.

The café deliberated in-depth the challenges highlighted above and the evidence on how these challenges can be addressed, and eventually outlined recommendations for tackling the challenges.

Regarding the challenge of lacking policy guidelines for the implementation of the policy directive, the café recommended that MoH develops policy guidelines for the implementation of the free maternity services policy. MoH officials at the café indicated that there were some initial discussions on this with development partners who can support the process and committed to fast-tracking these efforts to ensure the guidelines are developed and issued in the next few months.

Regarding the issue of delayed reimbursements to facilities, experts at the café argued that the government should consider a different funding mechanism such as the demand-side mechanism, where vouchers are given to women and they decide which facility they want to deliver in. This would improve quality of services since facilities will have to improve their services to enable them to compete as well as to attract women. It was also indicated that there were cases of double-billing (also referred to as double-dipping), where a medical facility got reimbursed for delivery services, and if the same mother was covered by the National Health Insurance Fund (NHIF), the same delivery was again paid for to the facility by NHIF, resulting in double payment. A mechanism was proposed where NHIF handles the FMS re-imbursement instead of MoH to solve this problem, and save funds to cover other deserving medical cases.

At the café, facility managers further argued that they not only experienced delayed reimbursements, but the reimbursements only covered deliveries, leaving out other services such as the costs of complications experienced during deliveries. Antenatal care (ANC) and postnatal care (PNC) services were also not covered by the reimbursements. Such a scenario meant that facilities did not fully recover costs incurred in the provision of such services with the referral facilities such as the Kenyatta National Hospital having to bear high costs of providing treatment for complications referred from lower level facilities.

Relating to the issue of poor quality of care in public health facilities, experts argued that if the funding mechanism was changed to demand-side, women would choose where to deliver, and this would trigger competition among facilities in order to attract deliveries. To survive this competition, facilities would have no option but to improve the quality of care.

Progress made in incorporating the café recommendations into policy reforms

The café discussions and the recommendations gave MoH the impetus to fast-track efforts to address the challenges facing the implementation of the free maternity policy. As part of these efforts, the MoH's top leadership requested for a summary of the issues and recommendations that emerged from the café, which we provided.

To date, the MoH has developed two policy documents aimed at tackling the major challenges curtaining the implementation of the free maternity services policy in Kenya. The first one is on free maternity service provision in Kenya and the second one is on funding free maternity services in Kenya. According to the Dr. Kigen Bartilol, the head of the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) division/unit, both guidance documents have tried to address the issues of high cost, delayed disbursements of funds to facilities, high quality of free maternity services provided, and proper coordination of services at national and county levels (interview conducted on August 8, 2016).

Specifically, the MoH has redesigned the free maternity services directive from direct re-imbursement mechanism that pays for the number of deliveries reported, to a health insurance plan to be administered by NHIF. While the café proposed the NHIF as one of the effective mechanism for channeling facility reimbursements, the MoH went ahead to work with the World Bank to pilot some services and conduct analyses, which

indicated that Health Insurance Subsidy Programme (HISP) could improve lives in households. As such, the decision to shift to this funding mechanism was greatly informed by the results of these analyses by the World Bank.

This shift will not only ensure that quality of services provided by at the public health facilities is of the highest possible standard, but also seal loopholes for double payments by the government and at the same time ensure wider coverage by incorporating non-public health facilities such as the faith-based and private health facilities in the programme.

Explaining this, Dr. Kigen said "*this system will improve efficiency, accountability and minimize complaints associated with delays in disbursement of free maternity money while at the same time promoting the highest quality through the facility accreditation by NHIF*" (interview on August 8, 2016). He further noted that through the NHIF, women will not have to incur huge transport and other costs before getting to health facilities as services will be offered at NHIF-accredited facilities nearest to where women live.

Conclusion

It is widely acknowledged that public policy change is complex and often happens as a result of many factors. As such, the shift in Kenya's policy relating to the implementation of free maternity services is a result of an interaction of many factors, one of which is the science-policy café hosted by the SECURE Health programme. It is important to acknowledge that maternal health is a priority of the current government, and therefore the MoH was under pressure to tackle the challenges curtailing the implementation of this policy. Also, given this political priority, many development partners have been keen to support the MoH in realizing the reduced maternal deaths and poor maternal health outcomes that the current government hopes to realize by prioritizing maternal health. Within this context, the contribution of the science-policy café to the recent shifts in this policy can be seen as two-pronged.

One is that the café legitimated on-going government efforts to tackle the challenges facing the implementation of the policy. This is because the MoH has noted that at the time it proposed the café, it was already involved in discussions with a number of development partners to find ways and resources for tackling these challenges. The participation in the café by a wide range of health sector actors was therefore seen by MoH as legitimizing the recommendations that emerged from the café. And this is likely to be the reason by the MoH requested for a summary of the issues discussed and recommendations proposed by the café.

Two is that the café gave MoH the impetus to fast-track its efforts in tackling the challenges facing the implementation of the free maternity services policy. While there had been some level of media coverage on the challenges facing the policy, there had not 'public-kind-of' stakeholder forums on these issues. Thus, by convening key stakeholders in the health sector, who emphasized the urgency with which the MoH needed to address the challenges in order to reap the benefits of the free maternity services policy directive, the café gave MoH the impetus to fast-track its efforts in tackling the challenges facing the implementation of the policy.

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