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Maternal Health Financing and Postpartum Detentions: Political Will as an Underlying Determinant For Respectful Maternity Care in Kenya

Kerigo Odada

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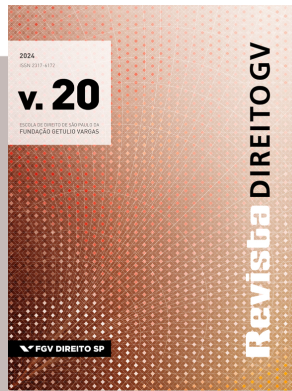

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Kerigo Odada
PhD Candidate at University of Pretoria, Centre for Human Rights
(kerigo.odada@gmail.com)
https://orcid.org/0000-0001-6426-2817

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[MANUSCRITO ACEITO PARA PUBLICAÇÃO]

ABSTRACT

Maternal health financing is one of the critical aspects of health financing that the Kenyan government has focused on from as early as 1965. Over the years, through several policy initiatives, the government has demonstrated its commitment to providing free access to maternal healthcare services, especially for the poor, although with limited success. Like many other government projects, the implementation of free maternity care initiatives has been full of political, technical and financial challenges, which, as of 2024, have taken a turn for the worst with the government's 2024/25 national budget slashing the budgetary allocation for free maternal health care by half. Presently, the maternal healthcare financing model either prevents women from accessing maternity care services due to the high cost of care or places them at risk of postpartum detention and abuse in hospitals. This article, through a qualitative methodological approach involving the analysis of secondary data collected from various sources available via desktop research, therefore demonstrates that legal recognition of rights without equitable health financing plans and political will does not address the challenges associated with inequitable access to respectful maternity care.

KEYWORDS

Obstetric violence; maternal; health; financing; postpartum-detention; politics.

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RESUMO

O financiamento da saúde materna é um dos aspectos críticos do financiamento da saúde em que o governo queniano se tem concentrado desde 1965. Ao longo dos anos, através de várias iniciativas políticas, o governo demonstrou o seu compromisso em proporcionar acesso gratuito aos serviços de saúde materna, especialmente para os pobres, embora com sucesso limitado. Tal como muitos outros projetos governamentais, a implementação de iniciativas de cuidados de maternidade gratuitos tem estado repleta de desafios políticos, técnicos e financeiros, cenário que, a partir de 2024, piorou com o orçamento nacional do governo para 2024/25 que reduziu a dotação orçamental para cuidados de saúde materna gratuitos pela metade. O atual modelo de financiamento dos cuidados de saúde materna impede o acesso das mulheres aos serviços de cuidados de maternidade devido ao elevado custo dos cuidados ou as coloca em risco de detenção pós-parto e de abusos nos hospitais. Este artigo, através de uma abordagem metodológica qualitativa que envolve a análise de dados secundários recolhidos de diversas fontes disponíveis através de investigação documental, demonstrará, portanto, que o reconhecimento legal de direitos sem planos equitativos de financiamento da saúde e vontade política não endereça os desafios associados ao desigual acesso aos cuidados respeitosos de saúde materna.

PALAVRAS-CHAVE

Violência obstétrica; maternidade; saúde; financiamento; detenção pós-parto; política

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RESUMEN

La financiación de la salud materna es uno de los aspectos críticos de la financiación de la salud en los que el gobierno de Kenia se ha centrado desde 1965. A lo largo de los años, a través de varias iniciativas políticas, el gobierno ha demostrado su compromiso de brindar acceso gratuito a los servicios de atención de salud materna, especialmente para los pobres, aunque con un éxito limitado. Como muchos otros proyectos gubernamentales, la implementación de iniciativas de atención de maternidad gratuita ha estado llena de desafíos políticos, técnicos y financieros que, a partir de 2024, han empeorado con el presupuesto nacional del gobierno para 2024/25 recortando la asignación presupuestaria para la atención de salud materna gratuita a la mitad. El actual modelo de financiación de la atención de salud materna impide que las mujeres accedan a los servicios de atención de maternidad debido al alto costo de la atención o las pone

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en riesgo de detención posparto y abuso en los hospitales. Por lo tanto, este artículo, a través de un enfoque metodológico cualitativo que involucra el análisis de datos secundarios recopilados de diversas fuentes disponibles a través de investigación documental, demostrará que el reconocimiento legal de derechos sin planes de financiamiento de salud equitativos y voluntad política no aborda los desafíos asociados con Acceso desigual a una atención maternal respetuosa.

PALABRAS CLAVE

Violencia obstétrica; salud materna; financiamento; detención posparto; política.

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INTRODUCTION

Kenya has designed and implemented several maternal health financing programmes throughout history. These initiatives have focused on increasing access to facility-based childbirth to lower Maternal Mortality Ratios (MMR) and make progress towards achieving Universal Health Coverage (UHC) (Onambele et al., 2023; WHO, 2005). Unfortunately, however, despite these efforts, the cost of care still remains one of the major barriers limiting access to facility-based care, particularly for pregnant persons. Like many parts of Africa, the financial inaccessibility of maternal healthcare services in Kenya continues to limit the uptake of facility-based care with a disproportionate impact on poor women (Eric et al. 2018; Gitobu 2018, 77; Wamalwa 2015, 375). To date, prohibitive rates of Out-Of-pocket (OOP) expenses incurred during facility-based childbirth continue to force many people to choose between health and other competing priorities, pushing many households into poverty while others avoid seeking facility-based care altogether (Victora et al. 2012).

Furthermore, beyond posing financial risks to healthcare users, evidence also shows that OOP expenses predispose service users to the loss of liberty through detention in health facilities for inability to pay user fees, and this includes postpartum detention. Postpartum detention is a practice typically enforced within medical facilities where victims who cannot pay user fees are confined within certain sections of the hospitals and prevented from leaving until the hospital expenses are cleared (Cowgill & Ntambue 2019, 3). It is a practice that, despite not being legally provided for within the law or policy, has been documented in several major

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hospitals, including Kenyatta National Hospital, Pumwani Maternity Hospital, and Mama Lucy Kibaki Hospitals, which are publicly funded by the government.

Hospital detention, which postpartum detention is part of, is illegal because it involves the arbitrary deprivation of liberty and security without following the appropriate procedure enshrined in Article 29 of the Kenya constitution (The Constitution of Kenya 2010). A right that was affirmed in the case of *Gideon Kilundo & Daniel Kilundo Mwenga v Nairobi Women's Hospital* where the court held that although hospitals also have a right to demand payments for services, detaining a patient was not an appropriate avenue for effecting the recovery of debt because it is a violation of fundamental human rights and freedoms (*Gideon Kilundo & Daniel Kilundo Mwenga v Nairobi Women's Hospital 2018).*

While it is recognised that there have been several developments in the management of maternal health services in Kenya, presently, access is still riddled with inequalities due to several factors, such as poor health governance architecture, inadequate financing, and lack of political will. With approximately 7.8 million people in Kenya living in extreme poverty, many households are one hospital visit away from detention in hospitals, including postpartum detention. Poverty rates in Kenya as of 2024 are alarmingly high, with roughly 10.6 million Kenyans in rural areas living on less than USD 2.15 US a day and around 1.7 million in urban areas residing in extreme poverty; below the USD 2.15 marker (Cowling 2024).

Overall, hospital detentions violate human rights and are illegal as per Kenyan law. However, this research limits itself to the postpartum detention of pregnant persons and their newborns. Through analysis of postpartum detention in Kenya, this article endeavours to demonstrate that arbitrary deprivation of liberty after delivery is a consequence of the state's failure to implement a comprehensive and equitable health financing plan that would ensure health care is accessible, available, acceptable and of quality (Center for Reproductive Rights & the Federation of Women Lawyers 2007).

This article shall unveil the fact that postpartum detention is a structural creation emanating from the politics of law and policy implementation and is designed to produce systematic differences in health status between different socio-economic groups. These differences are produced because social drivers of inequality, such as gender, parity, level of education, socioeconomic status, and disability, intersect with overarching systems of power and oppression to determine one's health outcome (Velasquez et al., 2022). Following this approach, this article will also highlight how laws and policies, as part of a society's social and

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political structure, play a fundamental role in determining the extent to which one can realise one's highest attainable standard of health, including Respectful Maternity Care (RMC). Intergroup differences in maternal health outcomes and health, in general, are a creation of laws and policies designed or implemented to produce structural disparities in health, which are unfair and avoidable (Braveman 2006; WHO 2011).

Maternal health outcomes result from multiple social factors intersecting with law and policy which are intrinsically political in nature. To substantiate this, the article shall first provide a background on postpartum detention in Kenya, which will then be followed by a discussion on the legal and policy frameworks on the rights to health and liberty. The article will then delve into the issue of maternal health financing to establish the nexus between postpartum detention, political will and financial inequalities. Drawing this connection should demonstrate that political will, supported by an enabling policy environment and adequate resource allocation, ultimately determines how much a country can comprehensively realise respectful maternity care and eliminate postpartum detention. Finally, the last section of the article will wrap up the discourse and provide recommendations on how the government should address maternal health inequalities in society, which are a consequence of systemic differences in the opportunity groups have to achieve optimal health (Whitehead 1992).

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1. METHOD

A scoping review guided by the principles of Arksey & O'Malley's framework was used to answer the main research question of this study: does political will play a role in addressing challenges associated with maternal health financing, postpartum detention, and maternal health disparities in Kenya (Arksey and O'Malley 2005). Using this framework, the researcher examines the extent to which postpartum detention occurs in Kenya, why it occurs and its intersection with the various manifestations of political power, particularly law, policy and government.

Through this review, the researcher endeavours to establish the value of undertaking a full systematic review to address challenges associated with maternal health financing and postpartum detention. The study uses electronic and non-electronic data sources to examine the gap between the legal and policy framework and lived experiences regarding access to respectful maternity care and postpartum detention in Kenya. To guide the data collection, a

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scoping review of literature focused on postpartum detention, maternal health financing, social inequalities in health, and political determinants of health was done.

Several primary documents and reports were drawn upon, including reports by the World Health Organisation (WHO) reports, Lancet Reports, and the Kenya government. For peer-reviewed publications, searches were conducted on academic journals, including PubMed, The BMJ, and BMC and internet sources such as Google Scholar and general Google search. The following keywords used were, amongst others, resource allocation in healthcare, out-of-pocket expenditure in health, healthcare financing, health policy, maternal health financing, universal health coverage, social-economic determinants of health, health governance, obstetric violence, respectful maternity care, detention in hospital, and Kenya. Relevant literature selected was subsequently included if it helped meet the following objectives:

1. To identify and map the existing research on maternal health financing in Kenya.
2. To understand the challenges and barriers to the implementation of free maternity services.
3. To explore the phenomenon of postpartum detention and its implications for women's health rights.
4. To highlight the importance of political will, policy environment, and resource allocation in realising the right to health.

Through this, the researcher could systematically identify and chart relevant literature that meets predetermined inclusion criteria, meets the specified objectives, and answers the research questions.

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2. POSTPARTUM DETENTION IN KENYA

Detention in healthcare facilities for non-payment of user fees is one of seven categories of disrespect and abuse women encounter during facility-based childbirth (Bowser 2010). It is a human rights violation directly linked to the financial accessibility of maternal healthcare services and is a powerful disincentive for women contemplating facility-based childbirth (Mwabu 1995). Though not provided for in an official policy, this practice has been documented in several hospitals in Kenya and other countries like Congo, Burundi, Tanzania, and Nigeria, amongst others (Bowser 2010; Okofor et al. 2015, 110-3).

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Postpartum detention in health facilities in Kenya was documented in 2007 by the Centre for Reproductive Rights (C.R.R.) and the Federation of Women Lawyers (FIDA) (C.R.R. and FIDA 2007). The report, which documented various forms of obstetric violence, revealed how women, especially poor women, suffered at the hands of medical practitioners when they were most vulnerable (C.R.R. and FIDA 2007). For example, a patient reported that she had witnessed women being forcibly detained in the wards and later taken to the nurses' hostel and kept there until their hospital bills were settled (C.R.R. and FIDA 2007). In the same report, doctors were also interviewed, and one of them, Doctor Shadrack Ojwang, an obstetrician gynaecologist, confirmed that detention was an existing phenomenon in Kenyan hospitals and not only Pumwani, which was notorious for the practice (Abuya et al. 2015).

In June of the same year, the Standard Newspaper documented cases of postpartum detention in Kenya for non-payment of user fees (C.R.R. and FIDA 2007). According to the report, approximately 50 women in Kenya at any given movement, due to their inability to pay their hospital bills, fall victim to postpartum detention (C.R.R. and FIDA 2007). These women are usually removed from sight and hidden at the far ends of the wards, where they are under strict surveillance (C.R.R. and FIDA 2007). According to one of the interviewees who narrated their experience of postpartum detention at Kenyatta National Hospital (K.N.H.), being arbitrarily detained at the hospital was, in her opinion, worse than being in an actual prison (C.R.R. and FIDA 2007).

Detention at the K.N.H. meant that “one was left to simmer in their misery idle, depressed and constantly being reminded of the fact that their only crime was poverty” (C.R.R. and FIDA 2007). Another interviewee also narrated how the hospital staff mistreated her and was not even given a bed while in detention for a whole week at the said hospital, while others provided horrific accounts of being forced to sleep on the floor next to a flooding toilet with one bedsheet and a thin blanket, denial of vital services, forceful separation from families and sexual abuse. (C.R.R. and FIDA 2007).

Later, in 2012, the Centre for Reproductive Rights (C.R.R.) and the Federation of Women Lawyers (FIDA), on behalf of Millicent Awuor and Margaret Oliele, filed a case before the High Court of Kenya, challenging the legality of the postpartum detention of the two women at Pumwani Maternity Hospital in Nairobi (*Omuya and Oliele v Attorney General* 2012). In the petition, the court determined in their favour and declared their detention arbitrary and unlawful. Additionally, the court stated that the staff at Pumwani Maternity Hospital had unlawfully and unreasonably infringed upon the petitioners' fundamental rights and freedoms,

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including the right not to be subjected to cruel, inhuman, and degrading treatment as set out in the Kenyan Constitution *(Omuya and Oliele v Attorney General 2012)*.

The court also went further and affirmed that it was incumbent upon the government to ensure women's rights were upheld and that they were also protected from cruel and inhuman treatment, especially in obstetric care. Consequently, the government of Kenya was instructed to take necessary steps to protect patients from arbitrary detention in healthcare facilities, including the enactment of laws and policies (*Omuya and Oliele v Attorney General* 2012). Sadly, no major administrative changes followed these decisions, and in 2015, another report was published by Chatham House documenting incidences of detention in hospitals for non-payment of user fees (Yates et al. 2015).

Following numerous cases of postpartum detention globally, the World Health Organisation (WHO) issued a statement condemning the postpartum detention of women and their newborns in facilities (WHO 2015). According to the organisation, such treatment violates women's rights to respectful care and threatens their rights to life, health, bodily integrity, and freedom from discrimination (WHO 2015). Kenya was highlighted as one of the countries notorious for this practice.

Although not publicly acknowledged by the government, hospital detention in Kenya has been featured in the Kenyan media several times. In 2013, the media reported that the then-governor of Nairobi, Mike Mbuvi Sonko, rescued women from postpartum detention at Pumwani Maternity Hospital and at Mama Lucy Hospital for accumulated hospital bills running into more than USD 10,000 (Motaroki 2019). In 2017, four mothers and their newborns were detained in Embu County, where they were locked in the basement of a private hospital for being unable to pay their hospital bills, which were over 3,704 USD (Wanyoro 2017).

In Mombasa County, a mother was detained together with her triplets over a medical bill of 18,518 USD. Nancy Masara said the cost of the medical bill went up because her babies were born prematurely and kept in the incubator for a month (Mwawasi 2017). Lastly, in 2018, a police officer, Judith Amoit, was reported to have been detained with the bodies of her twins for being unable to pay her hospital fees of almost 27,777 USD (Kiage 2017). The hospital management refused to set her free until her medical bill was cleared by the Kenya Police Service (Odenyo 2018).

Postpartum detention of women and their children for the non-payment of user fees is a form of obstetric violence that limits the right to liberty and security of the person through arbitrary detention. Therefore, in the next section, the researcher shall elaborate on the

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interaction between law, policies, and government in providing maternal health services. Following Dawes' Dawes (2020) conceptualisation of politics as a determinant of health, which has three main pillars: Voting, government, and policy, this section shall establish the connection between laws, policies, politics, and postpartum detention and their overall effects on access to maternal health care. Relevant laws and policies on RMC in Kenya and the challenges of implementing them shall be discussed to draw attention to how politics influences postpartum detention due to the inevitable relationship between government and policy and their attendant implementation (Dawes 2020).

This section shall also discuss the various legislative provisions pertaining to the right to liberty, as it is the direct right affected in the event of postpartum detention. Establishing this connection is important because it unveils how voting impacts health. Through voting, people are elected to government and influence the realisation of rights. These elected representatives shape the legal, economic, and social conditions to realise rights (Dawes 2020*)*.

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3. THE LEGISLATIVE FRAMEWORK GOVERNING THE RIGHT TO HEALTH AND LIBERTY

3.1 HEALTH

The Constitution of Kenya is the supreme law of the Republic. It is binding on all persons and institutions at national and county government levels (The Constitution of Kenya 2010). Moreover, under Article 2(5), the Constitution of Kenya provides that general rules of international law that Kenya is party to form part of the laws of Kenya, and the government is bound by those commitments (The Constitution of Kenya 2010). As the supreme law of the land, the constitution guarantees all Kenyans fundamental rights and freedoms. It also imposes a duty on all state organs and state officers to abide by the national values and principles of governance under Article 10; the values and principles of public service set out in Article 232; and the principles and standard of human rights provided for under Chapter Four.

The Bill of Rights, specifically Article 20 (2), guarantees all persons the “right to enjoy their rights and freedoms to the greatest extent consistent with the nature of the right or fundamental freedom” (The Constitution of Kenya 2010). These rights and fundamental freedoms are not subject to any limitation except as provided by the law and only when the

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limitation is reasonable and justifiable in an open and democratic society (The Constitution of Kenya 2010).

The right to health in Kenya is enshrined in Article 43, which guarantees Kenyans access to the highest attainable standard of health, including sexual and reproductive health and rights (SRHR), access to emergency medical treatment, and appropriate social security for persons who are unable to support themselves and their dependents (The Constitution of Kenya 2010). Therefore, in executing its mandate, the state must take all appropriate measures to realise the rights guaranteed in Article 43 (The Constitution of Kenya 2010).

These measures should factor in the needs of vulnerable groups in society and must involve the domestication of any relevant provisions contained in international treaties and conventions that Kenya has ratified (The Constitution of Kenya 2010). The right to health is also enshrined in Article 46 and Article 53. Sadly, as much as the government has a duty to respect, protect, and fulfil these rights, the realisation of the rights set out in Article 43 is subject to the availability of resources as provided in Article 20(5).

In addition to a comprehensive Bill of Rights, the Constitution also provides for a devolved system of governance that created forty-seven (47) county governments meant to operate semi-autonomously under the national government (The Constitution of Kenya 2010, Article 6). These two governing entities are “distinct but interdependent” and execute their mandate pursuant to the fourth schedule and section 5(2)(c) of the County Government Act (The Constitution of Kenya 2012, Article 17). These provisions anchor the spirit of devolution and decentralised various services, such as health care, which is now the prerogative of county governments (The Constitution of Kenya 2010).

It must be highlighted that, in as much as health service delivery has been devolved to the counties, the national government still retains leadership of healthcare services delivery as it is in charge of: “policy development; management of national referral health facilities; capacity building and technical assistance to counties; and consumer protection, including the development of norms, standard and guidelines” (The Constitution of Kenya 2010).

Still within the devolved system of government and of significance to the realisation of the right to health is chapter 12 of the Constitution, which provides for public finance (The Constitution of Kenya 2010). Under this chapter, the Constitution provides that the county governments will receive a minimum of 15% of all national government revenue to deliver on

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their mandates (The Constitution of Kenya 2010). Furthermore, an Equalisation Fund is also established for marginalised countries to cater to specific social services at a minimum of 0.5% of national government revenue. (The Constitution of Kenya 2010). The Equalisation Fund seeks to address inequities that may exist between counties because of historical injustices (The Constitution of Kenya 2010).

Beyond the Constitution, the right to health is also governed by other policy and legislative instruments, such as the Health Act, enacted in 2017 to fast-track the realisation of this right (Health Act 21 of 2017). Section 5 of the Act guarantees free maternal health care, which has been designated as a function of the county governments (Health Act 21 of 2017, Section 5). Further, Section 6 of the Act provides for the realisation of SRHR, including the right to access appropriate healthcare services related to obstetric care and the postpartum period (Health Act 21 of 2017, Section 6).

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With regard to health financing, section 86(1) provides that the Ministry of Health shall ensure progressive financial access to universal health care (Health Act 21 of 2017, Section 86(1)). This shall be achieved by developing mechanisms for an integrated national health insurance system that provides for social health protection. Other statutes that are important in this discourse on the right to health include the Public Finance Management Act (Public Finance Management Act 2012) and the County Governments Act which provides for the development of plans that form the basis for all budgeting and spending in the country and the counties (Republic of Kenya 2012, Article 17). The Intergovernmental Relations Act is also relevant as it provides the framework for the relationship between the county and national governments (Republic of Kenya 2012, Article 12).

3.2 LIBERTY

The Kenyan Constitution guarantees all its citizens the right to liberty and security of the person. Under Article 29, everyone is protected from arbitrary deprivation of their liberty and security without just cause and without following the appropriate procedure (The Constitution of Kenya 2010, Article 29; *Emmah Muthoni Njeri v Nairobi Women's Hospital*, 2021; *Tryphosa Jebet Kosgey v Elgon View Hospital*, 2016). Moreover, by virtue of Article 2(6) and (5), amongst others, the International Covenant on Civil and Political Rights (ICCPR), which is the main international human rights instrument that protects individuals' right to liberty and security, underscores individuals’ right to be protected from arbitrary deprivation of their

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liberty (U.N. General Assembly 1999). Specifically, under Article 9, everyone is guaranteed the right not to be subject to arbitrary arrest or detention except on such grounds provided for in the domestic laws of a country and in a procedurally legal manner (U.N. General Assembly 1999, Article 9).

Under Article 11, the ICCPR safeguards debtors' rights against arbitrary arrest by providing that imprisonment merely for one's inability to pay a debt or discharge a contractual obligation is illegal (U.N. General Assembly 1999, Article 11). Regionally, Article 6 of the African Charter provides that every individual shall have the right to liberty and security of their person respected (Organisation of African Unity 1982, Article 6). No one may be deprived of their freedom without cause except as provided for by law.

In particular, no one may be arbitrarily arrested or detained (O.A.U. 1982). Additionally, the Maputo Protocol, under Article 4, guarantees every woman the right to integrity and security of their person and respect for their life (A.U. 2003, Article 4). State parties are also called upon to take all appropriate steps to ensure the elimination of all forms of exploitation, cruel, inhuman or degrading punishment and treatment (A.U. 2003, Article 4). The Protocol further calls upon member states to take both legislative and administrative measures to eliminate violence against women in all its forms, both in private and public (A.U. 2003).

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4. POLITICAL WILL AS A DETERMINANT OF MATERNAL HEALTH FINANCING IN KENYA

Health inequalities exist due to systematic differences rooted in social, economic and political injustices (Commission on Social Determinants of Health 2008). These inequalities have been referred to as a wicked problem because addressing them remains a mirage despite their known root causes. Solving them has been impossible due to shortcomings in policy implementation, which is a political process (Petticrew et al. 2009, 453-6). Access to quality maternal health care in Kenya, specifically financial access, is a wicked problem. Despite successive governments championing the development and implementation of robust legal and policy frameworks to ensure its availability and accessibility from independence, financial access still remains a challenge (Olungah & Ochako 2019). OOP expenditure on health significantly continues to limit many pregnant persons from accessing health care services

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because facility-based delivery remains one of the single most costly events during pregnancy (Jo Borghi et al. 2006, 1457–65).

Building upon the discourse around political determinants of maternal health, this section shall discuss maternal health financing initiatives by successive regimes to provide a na overview of the situation. Through this discussion, this section endeavours to provide evidence that RMC is a political choice, and like politics, its realisation is a continuous struggle for power among various competing priorities (Velasquez et al. 2022). Unpacking this discussion through a lens that captures politics as a determinant of health allows this study to critically uncover the extent to which different power constellations, institutions, processes, interests, and ideological positions affect the realisation of RMC.

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Since 1965, the Kenya government has implemented several policy initiatives meant to facilitate free access to maternal healthcare services, especially for poor women (Chuma and Maina 2012). Some of these initiatives include the Free Maternity Services Program of 1965, the Elimination of User Fee for Primary Care 2007, the Beyond Zero Campaign launched in 2014, and the *Linda* Mama Program that was launched in 2016. These initiatives, which have been launched pursuant to, amongst others, Kenya Vision 2030, the Constitution of Kenya, and the Health Sector Strategic and Investment Plan 2014–2018, all have one goal: providing free maternal healthcare services in all public healthcare facilities (Chuma and Maina 2012). Unfortunately, like many other government projects, these health financing initiatives have been full of governance, technical and financial challenges with the effect that women, especially poor/ impoverished women, continue to have limited access to free, adequate maternal services (Okech and Lelegwe 2016, 223).

Health financing, as one of the key features of UHC, requires governments to allocate at least 5% of their total annual budget to health if they are to achieve 90% coverage for maternal and child health services (WHO 2010). Health financing within the framework of UHC is the process through which funds are mobilised, accumulated and allocated to cater to people's health needs individually and collectively within a country's health system (WHO 2000). The idea is to make funding available and incentivise providers to guarantee all persons access to quality public health care when the need arises (WHO 2000). Over the years, Kenya's health financing system has been an amalgamation of several financing programmes that co-exist simultaneously (Waris and Latif, 2015 376–390). These financing programmes encompass revenue collected by the state, social insurance – which in this case is the National Hospital

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Insurance Fund (NHIF), private insurance, OOP payments and foreign aid (Waris and Latif, 2015 376–390).

Implementing health financing reforms for UHC is political (Sparkes et al. 2019, 183-194) hence, in June 2013, the national government issued a directive that removed user fees for maternal health services pursuant to the government's mission to reduce OOP expenditure and fast-track the realisation of UHC (Chuma and Maina 2013, 6). Reducing OOP expenditure was meant to ensure the poor and other vulnerable groups have increased access to quality health care (Chuma and Maina 2013). The government, through the Ministry of Health (MoH), committed about 35 million U.S. Dollars (USD) to fund the free maternal health policy and a further 6.5 million USD to facilitate free access to primary health care services at health centres and dispensaries (Wanjiru and Maina 2017). Additionally, a budget was set aside to reimburse public health facilities that were losing revenue because of this initiative (Wanjiru and Maina 2017).

In the 2013 policy pronouncement, the National Government was required to reimburse health facilities for the free maternity services that they handled (Ministry of Health 2015, 1). The rate was approximately 25 USD per birth at health centres and dispensaries and approximately 46 USD for every birth at level 4 and 5 hospitals, which was to be paid directly to the health facilities (Ministry of Health 2015). This budget covered normal deliveries, caesarean sections, and other pregnancy-related complications. Additionally, antenatal and postnatal care was free up to six weeks after delivery, which also applied to referrals made in case of pregnancy-related complications (Ministry of Health 2015).

Following this free maternity services program rollout, facility-based childbirth in Kenya increased from 44% in 2008 to 61% in 2014 (Njuguna 2017, 1-2). This conversely resulted in a decrease of 11.9% in 2013 and 5.4% in 2014 in low-cost private hospitals (Njuguna 2017, 1-2). Unfortunately, due to poor planning and minimal resource allocation by the national government, the free maternity services initiative was compromised over time (Tama et al. 2018, 603-613). The quality of care decreased, reducing confidence in the system and resulting in lower utilisation of the facilities in the long run (Gitobu et al. 2018, 77). Implementation challenges that affected the success of this program emerged, particularly the irregularity or lack of reimbursement of facilities that provided maternal health services for free (Wamalwa 2015, 375).

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While initially, facilities did indeed receive reimbursements for services delivered, the government progressively failed to honour their commitment (Tama et al. 2018, 603-613). The facilities provided the services as required but were not reimbursed partly because funding from MoH or national government was sometimes channelled through the county governments and not directly to the facilities (Barasa et al. 2017, 329-337). County governments allocated these resources based on the priorities of the county bureaucrats, and quality maternal health care was not included in this list of priorities (Barasa et al. 2017, 329-337).

Eventually, the lack of maternal health rebate compromised the quality of care, leaving those who sought maternal health care services wondering what aspect of the services were free. Many were forced to pay for some services or were asked to buy supplies from private clinics and pharmacies (Olungah and Ochako, 2019). According to some healthcare providers, the failures experienced in implementing the free maternity initiative are attributable to the fact that it was a policy solution that was not well thought through (Olungah and Ochako, 2019). The cover, as envisaged, did not take care of the entire pregnancy process. According to them, it should have been renamed “free pregnancy and delivery care” (Olungah and Ochako, 2019).

Another major problem was that key stakeholders within the health sector were not involved in the policy formulation process. From the outset, health workers did not support how the free maternity services were hurriedly executed within the devolution structure, which was generally unplanned and lacked the appropriate structures needed to realise this initiative. Thus, in as much as the policy pronouncement did indeed lead to an increase in the utilisation of maternal health care services at the health facility level, the implementation process was not well coordinated from the time of policy pronouncement to the commencement of the provision of free maternal health care services (Olungah and Ochako, 2019). There was a complete disconnect between what was expected to happen and what happened in reality. The policy pronouncement should have been adequately translated into a policy statement, and a clear process of resource allocation provided (Olungah and Ochako, 2019).

Before devolution, hospitals were mainly financed through revenue allocations from the national government and user fees (Barasa et al. 2017, 329–337). However, with the advent of devolution, there is a state of confusion due to the poor transition into the devolved system of governance (Barasa et al. 2017, 329–337). The changes in financing models, though well intended, have interfered with hospitals' autonomy over their financial management, jeopardising service delivery (Barasa et al. 2017, 329–337).

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4.1 UHC AND ITS EFFECT ON MATERNAL HEALTH FINANCING IN KENYA: THE POLITICS OF THE NATIONAL HEALTH INSURANCE FUND (NHIF) AND THE SOCIAL HEALTH INSURANCE FUND (SHIF)

From as early as 1996, the government has tried to provide a social health insurance scheme for Kenyans (Mwaura et al. 2015). Through NHIF, a social health insurance scheme that was initially limited to formally employed Kenyans, the government has provided financial protection to Kenyans when accessing healthcare services (Okech and Lelegwe 2015, 9–23). NHIF, as a policy initiative, was envisioned to cushion employed citizens from the heavy costs associated with health care (Chuma and Okungu 2011, 673-686). In fact, with time and increased demand for more coverage, in 1998, the Act establishing the NHIF was amended to facilitate the inclusion of Kenyans in the informal sector, and all formally employed adults who were citizens.

The amendment also corporatised the NHIF, making it a fully autonomous institution managed by a board of directors drawn from stakeholders within the health sector (Abuya et al., 2018). Throughout the years, NHIF has undertaken several initiatives to ensure the country achieves UHC, including the launch of health subsidies for the poor; revision of monthly premiums and increase in provider reimbursement rates through capitation (Barasa et al. 2017, 329–337).

With regard to free maternity care, former President Uhuru Kenyatta's government transferred the initiative to the NHIF in 2016 to promote sustainability (Ministry of Health 2016). This move was supposed to expand coverage to private for-profit facilities and faith-based providers to provide more options for maternity care to as many women as possible (Ministry of Health 2016). The move was also meant to help improve the logistical efficiency in reimbursing facilities that were initially absent (Abuya et al. 2018). Sadly, NHIF failed to comprehensively and efficiently provide free maternal health care services just like many other government initiatives. The provision of maternal health care services under NHIF was castigated for providing substandard health care services in accredited facilities, a cumbersome claiming process and poor accessibility in rural areas (Abuya et al. 2018)

It must be underscored that since its establishment, the NHIF has undergone various reforms to increase coverage among Kenyans with little success. As a result, in 2023, the government introduced a bill to replace NHIF with a newly proposed Social Health Insurance

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Fund (SHIF) (Aradi 2023). The Social Health Insurance Act (The Social Health Insurance Act 2023) was enacted together with the Primary Health Care Act (The Primary Health Care Act 2023), Digital Health Act (Digital Health Act 15 of 2023), and Facility Improvement Financing Act (The Facilities Improvement Financing Act 2023), all of which are part of the government's overall agenda to achieve UHC.

The SHIF Act, in particular, establishes the Social Health Authority as the oversight body to take over from the previous NHIF board (The Social Health Insurance Act 2023). Under SHIF, there shall be three funds: the Primary Health Care Fund, the Social Health Insurance Fund and the Emergency, Chronic, and Critical Illness Fund, and their management shall be the prerogative of the Social Health Authority. SHIF requires all employed persons to make mandatory contributions of 2.75% of their income to the fund, while self-employed or unemployed Kenyans will contribute USD 2.31 in a graduated arrangement based on their contribution ability (The Social Health Insurance Act 2023). SHIF is to replace NHIF and has, in the 2024/2025 budgetary allocation, received an additional USD 181,720,000 added to the initial USD 144,760,000 allocated to it for UHC in 2023-24 (National Assembly 2024;6).

The increased budgetary allocation for SHIF, however, cannot be celebrated as it may not contribute to the realisation of UHC. The allocation comes against the backdrop of a decreased 2024-25 health financing budget to the health sector, as it has been reduced to approximately USD 980,694,000. USD 109,652,400 has been cut from the health budget, which was at USD 1,090,346,400 in the 2023-24 fiscal year. This cut follows a previous reduction of USD 43,243,200 that reduced health funding to USD 1,090,346,400 from USD 1,133,589,600 for the 2022-23 financial year (Saya 2023).

SHIF remains highly unpopular amongst many Kenyans as questions around corruption, transparency, and lack of public participation remain unsettled. The discontent is reflected in a decision by the High Court directing parliament to amend sections 26 (5) and 27 (4) of the Social Health Insurance Act, which were found unconstitutional for violating the right not to be denied emergency medical treatment and section 38, which is unconstitutional for violating provisions on openness, accountability and public participation in financial matters (*Aura v Cabinet Secretary, Ministry of Health & 11 others 2024*). The High Court in determining this case, directed parliament to undertake 'sensitisation, adequate, reasonable, sufficient and inclusive public participation in 120 days, during which all three Acts would remain suspended. Unfortunately, an appeal against this decision was filed, and the Court of

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Appeal stayed the High Court judgement pending the determination of the Appeal (*Cabinet Secretary Ministry of Health v Aura & 13 others 2024*). Consequently, the three Acts remain fully operational. SHIF is currently being rolled out amidst controversy as service providers are unwilling to adopt the new system due to unpaid debts, amongst other transparency and financial accountability concerns. The ongoing crisis continues to negatively impact the availability of essential services, with kidney and cancer patients being the recent most affected group (Oketch, 2024).

Moreover, in addition to the absve budgetary cuts, the funding for the free maternal health program under the Linda Mama initiative has also been reduced by half, to approximately USD 15,441,756.00, despite experts warning of negative repercussions, including increased MMRs (Saya 2023). The *Linda Mama* initiative was launched as the main vehicle through which free maternity services were to be provided (Ministry of Health 2016). This initiative incorporated free maternity services in all public health facilities, an additional 2,000 facilities in the private sector, and 700 faith-based facilities, reaching an estimated 700,000 women every year (Ministry of Health 2016).

Linda Mama is a scheme publicly funded through the MoH that provides a free package of antenatal, delivery, and postnatal health care services. The scheme caters to women not covered under the NHIF or other forms of the insurance scheme, and with the proposed budgetary cuts, the already struggling maternal health financing will more than likely collapse. Slashing the maternal health budget will lead to a surge in deaths as pregnant women, especially those in rural areas and informal settlements who cannot afford to pay for hospital deliveries, will opt for home deliveries, risking their lives if they develop complications. For those who opt to seek care, OOP will result in them being significantly at risk of postpartum detention in the event they cannot afford the cost of care.

CONCLUSION

Suffice it to say that resource allocation for healthcare affects the availability, accessibility and quality of services people receive in health facilities, including maternal health services (Kruk et al., 2018). Allocating resources for health, however, is not just a legal and technical decision. It is a political decision ultimately brought to life by policies developed and subsequently implemented to facilitate the distribution of money, power and resources (Bambra

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et al. 2005; Kickbush 2015, 1-2). Through postpartum detention, this article has demonstrated that to address challenges associated with maternal health financing in Kenya and postpartum detention, health and health disparities must be conceptualised as a political problem.

Implementing maternal health financing policies without creating an enabling environment for its realisation is an exercise in futility that will leave many women at risk of postpartum detention. Thus, although the current government has increased funding for UHC, its health financing approach remains counterproductive. With the overall budget for health reduced and the budget for free maternal health care slashed by half, it is difficult to believe there is a genuine effort to reduce the OOP expenditure on maternal health care. The move to reduced health financing will definitely compromise access to healthcare services because OOP expenditure on health will eventually overburden many Kenyans. The current health financing approach, including maternal health financing, which is based on affordability, inevitably perpetuates inequality because accessing health care services is determined by people's purchasing power.

To counter these challenges, a clear and comprehensive fiscal policy plan and guideline for all health facilities, including those providing free maternal health services, must be developed, implemented and strengthened through political goodwill. Furthermore, Kenya must develop and enforce public finance management laws to facilitate standardised budgeting and planning processes at the county and national levels. These processes should pave the way for direct facility financing and financial autonomy of county public hospitals. Without all the above, the mandate to provide health care services should be transferred back to the national government.

Lastly, there must be a strong political will to safeguard the realisation of the right to health. Political will, or lack thereof, determines the realisation of health rights, including maternal health care. Politics is a determinant of health and must be seen as a facilitator of systemic processes that structure relationships, distribute resources, and administer power. Therefore, there is a need for the political discourse in Kenya to shift from rhetoric and actually execute proper health governance frameworks that will establish a sustainable health financing plan that does not rely on user fees or donor funding.

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