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Efficacy of Free Maternity Health Policy at Machakos Level 5 County Hospital (Kenya): An Exploratory Qualitative Study

Elvis Gichuhi[1] and Adelaide Lusambili[2*]

[1]Institute of Public Policy and Management, Strathmore University, Kenya

[2]Strathmore University Institute of Healthcare Management and Kemri-Wellcome Trust/Kenya

[*]**Corresponding author:** Adelaide Lusambili, Strathmore University Institute of Healthcare Management and Kemri-Wellcome Trust/Kenya, Tel: +447854505961; E-mail: Adelaide.Lusambili@aku.edu

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Abstract

Background: In 2013, the Government of Kenya introduced the country's Free Maternal Health Policy (FMHP). This policy funded free maternity services performed by trained health care professionals. In 2018, five years after the introduction of the FMHP, the country still reported 22.6 per 1000 neonatal deaths, and a UNICEF (2018) report ranked Kenyan maternal health care as one of the ten worst-performing in Sub-Saharan Africa. There is need to understand the efficacy of the FMHP to identify gaps in areas of improvement as well as to inform future policy on maternal health care practices.

Study aims: To understand the efficacy of Kenya's Free Maternal Health Policy using a cases study of Machakos Level Five Hospital (Kenya).

Methodology: In-depth and Focus Group Discussions (FGDs) with health care professionals implementing the FMHP.

Data analysis: Data were analysed using NVIVO 10 software.

Findings: The findings revealed that, although the FMHP led to an increase in hospital deliveries, overall the implementation and delivery of the policy was marred by organisational factors and poor planning.

Conclusions: There is an urgent need to re-evaluate the Free Maternal Health Policy in order to set up guidelines to improve its implementation. Goals for improving service delivery should include: (1) lowering staff: patient ratio; (2) reimbursing service providers in a timely fashion, to ensure smooth service delivery; (3) educating both communities and implementers about FMHP requirements and goals; (4) instituting a regular monitoring process to ensure FMHP goals are being met.

Keywords

Maternity health care; Health care financing; Free maternal health policy; Kenya healthcare

Abbreviations

FGD: Focus Group Discussions; FMHP: Free Maternity Health Policy; MoH: Ministry of Health; PI: Principal Investigator; SDGs: Sustainable Development Goals; UNICEF: United Nations Children International Emergency Children Fund

Introduction

Maternal and neonatal mortality in LMICs remains high (2.8 million per year) (UNICEF, 2018). Kenya has a high neonatal mortality, at 22.6 per 1000 neonatal deaths, and is among the 10 worst-performing countries in sub-Saharan Africa (UNICEF (2018). In 2013, the Government of Kenya initiated the Free Maternal Health Care Policy (FMHP) with the aim of ensuring that women give birth in government hospitals, under the care of trained health care professionals, at no cost to themselves. The goal of this policy was to reduce the country's high rate of maternal and neonatal deaths, which was in part attributed to lack of skilled birth attendants, and high costs that put maternity health care out of the reach of many poor women. By introducing FMHP, the Kenyan government sought to encourage women to abandon the services of traditional birth attendants in favour of birth attendants trained in modern medical techniques. After enacting the FMHP, the Kenyan Government devoted additional resources with the aim of achieving its Sustainable Development Goals (SDGs) 4 and 5 of a target maternal mortality rate of 70/100,000 live births (Ministry of Health & Government of Kenya, 2016).

Methodology

Location

The field research was conducted in Kenya's Eastern Province at the Machakos Level Five Hospital, a public hospital owned by the Kenyan Ministry of Health (MoH/Kenya). With a bed capacity of 375, Machakos accounts for 700-800 deliveries a month. In 2010 Machakos County government improved the hospital's infrastructure including additional new ambulatory care facility and new managers and health care staff. Compared to other County hospitals in Kenya, these improvements placed Machakos Hospital in an advantageous position in terms of implementing the FMHP.

Sample and recruitment

Participants in this pilot study included health care professionals directly involved in the provision of clinical and nursing services to pregnant women in both labour and new born wards. Because of their direct involvement with ante-natal, labour, post-natal, and new-born care, these health care professionals were assumed to have the most up-to-date and complete first-hand knowledge about patients' hospital experience.

In accordance with the Strathmore Ethics Committee Review's Standards for Ethical Approval, the researcher sent a request to participate in the current study to all relevant department heads at the Hospital, requesting approval to interview department members at times and venues convenient to them. Information was gathered during individual interviews with Key Informants (hospital administrators and clinical managers, N=10) deemed to have extensive knowledge about maternal health care policies and hospital policy development and decision-making. Key Informants included top Machakos Hospital managers: The Medical Superintendent (chief administrator, equivalent to a CEO), Health Administrative Officer, Health Records Officer, Obstetrics/Gynaecology Consultant, Accident and Emergency Manager, and Nurse Manager in Charge of Maternity Services. Additionally, the researcher conducted thirty-six individual interviews (N=36) with frontline staff (including medical officers, clinical officers, obstetrician and medical consultants, and nurses-in-charge). Finally, two Focus Group (FG=2) discussions involving a mix of nurses, doctors, and medical officers.

Data collection

After obtaining participants' written consent to participate in the study, the Principal Investigator (PI) began by pre-testing a customized Interview Guides. All Interviews began with an explanation of the study's objectives, the voluntary nature of study subjects' participation, and respect for issues of confidentiality. All interviews were tape-recorded and conducted on the Hospital premises. Interview templates were used as a guide to assess participants' acquaintance with FMHP aims, service requirements, and implementation process. Key focal points of the Interview Guides included: workers' understanding of which services under the FMHP are free, and which are not; the FMHP's effects on the number of deliveries taking place in the Hospital; financial and workforce resources made available to the Hospital to implement the FMHP; the FMHP's impact on health care workers, on the community, and on maternal and neonatal health outcomes. Interviews closed with questions about interviewees' view of FMHP successes and failures, and a request for recommendations to improve the policy's implementation in the field.

Interview Guides were designed to be flexible enough to allow interviewer to probe beyond initial answers to a formal question, in order to elicit fuller responses and to accommodate a variety of response styles. All the audio taped discussions were reviewed for clarity and, where discrepancies arose or poor clarity obscured the meaning, compared with the PI's hand-written notes taken during the interview. The clean audio files were then transcribed verbatim into Microsoft Word (2016) documents, which were then imported into NVivo 10 software, which was used to analyse and thematically code the collected data.

Findings

Beneficial changes observed after introduction of FMHP in terms of utilization of services

Findings from this study revealed that the introduction of FMHP was associated with increase in the use of services. Staff at the hospital observed this increase–which was visible with regard to ante-natal visits, deliveries, and post-natal visits. In addition, of women using the facility, a greater percentage was from poor areas. Many were giving birth in a hospital setting for the first time, and some had travelled many miles to reach Machakos Level Five Hospital.

"What I have seen is there is increased number of deliveries, initially we used to have 10, 15 but now we are even sometimes clocking 30 deliveries per week" [Key Informant-M7].

"Because some of the mothers who were being locked out from accessing the maternal health services, from the villages, from the poor backgrounds, at least now they could come to the hospital and get the services, knowing that they will not pay" [Individual Interview-M1].

The women accessing the services came from great distances to use these services and overall informants felt that maternal and neonatal outcomes improved.

"If you look at the Antenatal Care attendance since the free maternity, yeah and also the deliveries that we are getting, you get patients from Nairobi to Machakos [2 hours' drive] you get patients from Kitengela. I think it has impacted so much on umm, on the number now using the facility" [Key Informant-M9].

"I think maternal outcomes in general improved. Because more mothers are able to get uum, to get professional and various skilled birth delivery" [Key Informant-M8].

Inadequate infrastructural resources compromised the quality of maternal and neonatal care

Findings revealed that the increase in number of patients reduced staff: patient ratio ultimately leading to delayed timely delivery of services, poor quality of care and inadequate resources.

"More numbers meant more mothers getting skilled delivery but at the same time there were also issues of quality of care, given that the same number of staff was attending to more women, so there were delays in getting the appropriate treatment, there were more delays" [Individual Interview-M5].

"The thing is, like when the number which is seeking for the services are higher than the service provider, there is no way the quality will be better...you have to increase the service providers. So, you but are paying three consultants you want everybody in Ukambani to come to Machakos Level 5, it will never work" [FGD-1].

"If you compare the number of health workers and the number of patients, the ratio is very much varying, the patients and the health workers they can get the quality health services" [FGD 2].

In addition to high staff: patient ratio, participants felt that the FMHP was not accompanied by adequate resources to support its effective implementation. Thus the resources provided by the central government were not adequate to meet the increased demand that came with FMHP.

"I think there is need of improvement of the funding, number one, is need to look at the infrastructure, the expansion of the infrastructure is very key. The government needs to look at issues related to infrastructure and also issues related to personnel" [Key Informant-M10].

Staff raised issues around constrained space and bed capacity in the maternity and newborn area. Laboratory equipment's, drugs and supplies were deemed to be inefficient to merge the needs of the burgeoning pregnant women.

"We had 50 beds for example. Then here the number has gone up to 200. This used to be our newborn unit. Then they could not cope with the babies. So, the other one which was ward 10 was pushed there and then they did some renovation there. Up to now we are still moving, we are still" [Individual Interview-M3].

"We still have issues with our laboratory, we are not, most of the time we are not able to do the basic tests that we need, or our ultrasound also has issues, delays, that are not as reliable as we would like" [FG-1].

"There are no drugs, they get finished very quickly, okay what we used to use before and now, you find that they are not enough. You tell them maybe to go buy cotton wool or something of the sort. They think that the whatever, the items are supposed to be within the hospital. So, they imagine like we are stealing from them" [FGD-2].

Lack of clear FMHP policy guidelines and procedures

Data from this pilot study shows that few maternity health care workers have a clear understanding of what the FMHP guarantees and requires, making it unsurprising that it is not being fully and properly implemented. Health care workers generally feel overloaded and are not invested in implementing the policy. Many complained about the policy being vague and lacking properly laid out procedures. Nor is there a clear path for health care workers to submit suggestions on how the policy might be improved.

"Yeah, we were not involved, umm, it was brought to the hospitals without umm, without umm any education to the implementers. So, most of us actually don't know what it entails" [Individual Interview-M1].

"I think the way the policy was implemented; the policy did not come up with clear guidelines. They didn't define which services were to be offered, it was not backed up by structural or systemic upgrade for it to operationalize" [Individual Interview-M5].

Similarly, a lack of cohesion between policymakers and policy implementers was observed.

Many of those interviewed were unaware of the various services supposedly guaranteed by FMHP. They reported that patients were sometimes asked to pay out-of-pocket for some services, which they thought were to be offered free. Interviewees were also concerned about efforts to introduce other free service programs-such as the "Lind Mama," program which seemed to exclude mothers without health insurance whose post-delivery hospital stay exceeded 24 hours. Respondents noted that the Hospital's reimbursement procedures were especially unclear. Reimbursements to the hospitals were often delayed and sometimes did not match the actual number of deliveries conducted.

"Ideally in their system, when the hospital is full we [the maternity floor staff] should be five whereas the bed capacity is 570. Though sometimes you find the workload is too much. So, you find there is a bit of backlog. You find discharging has not been done as expected. So, you find that even admission now becomes a problem. At times we lose money in the process" [Key Informant-M10].

"We got back the money for free maternity, as a maternity we did not get increased allocation and then there are things that we could have wished to have, e.g. a second theatre which we didn't get, yeah. So currently still the same, we are still having the same turnover in the maternity unit, and most staff who work there fairly worn out because of the workload" [Individual Interview-M5].

Discussion and Conclusions

Using a case study of Machakos level 5 hospital, this pilot study aimed to find out the effectiveness of FMHP. The findings revealed that although utilization of services by pregnant women significantly increased, however, the quality of healthcare was compromised in part due to poor planning and inadequate infrastructural resources.

The findings of this study are consistent with those of other studies, which show that institutional maternal admissions increased once fees were removed, but that the staff-to-patient ratio increased, quality of care deteriorated, and the added numbers of patients put a severe strain on staff, facility infrastructure, and medical care resources [1-3].

Other studies confirm the same barriers to FMHP success identified in our study: insufficient infrastructure, inadequate staffing and equipment, poor attitudes from health care [2,4-6]. Virtually all researchers report high staff patient ratio, patient influx, a lack of guidance regarding implementation of the FMHP [5,7-9].

Our findings highlight key gaps between policy formulation and implementation in all areas of maternity health care education, training, awareness, monitoring, and evaluation. These gaps, and the resulting confusion in maternity health care facilities and among the public, suggest that the National Government and major stakeholders in health need to collaborate on the formulation of guidelines for the proper implementation of the Free Maternal Health Policy. Needless to say, the formulation of a policy includes processes that should be evidence based to have attainable objectives. Successful implementation will also require the establishment of stringent new strategies to monitor and evaluate FMHP practices, in order to make sure FMHP resources are allocated, as designed, on the basis of need.

In sum, this study confirms that the national Government's Free Maternal Health Policy is in very large part a resounding success. More women are taking advantage of the free services, and maternal and neonatal morbidity and mortality is going down. With success, however, comes greater demand, and the policy is long overdue for an overhaul to deal with the major disconnect between national policy, service providers and practices, and beneficiaries [10]. The country, and its mothers-to-be, would clearly benefit from an overhaul of the policy to involve all stakeholders and address the issues and obstacles to success identified above.

Research

To bring Kenya's maternal health care services up to international standards, the country will need to re-evaluate the efficacy of its practices and policies on a regular basis. Further research on the Free Maternal Policy's effect on care and maternal and neonatal outcomes in Kenya's maternity hospitals is an essential part of the information-gathering required to improve health care practices and policies.

Ethics

This research was approved by Strathmore Institutional Review Board.

Authors Contribution

EG collected data, analysed and compiled the final draft. AL advised on methodological design and a review of the final draft.

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