

Examining the implementation of the Linda Mama free maternity program in Kenya

Policy Brief - November 2021

Introduction

Maternal mortality is still unacceptably high in Kenya where 362 mothers die out of 100,000 live births, partly because of inadequate access to skilled care during delivery. A key access barrier to skilled delivery care is out-of-pocket (OOP) payment paid by women to healthcare providers to access services. Kenya has introduced several health financing reforms aimed at reducing financing barriers of access to maternal services for women that need them. In 2013, a free maternity policy that removed user fees for maternity services in all public healthcare facilities was introduced. In October 2016, the free maternity policy was revised to include private providers, and its management was transferred from the Ministry of Health (MOH) to the National Hospital Insurance Fund (NHIF) and branded the "Linda Mama program".

In 2019, researchers from KEMRI-Wellcome Trust, in collaboration with ThinkWell and NHIF, carried out a process evaluation of the implementation of the Linda Mama program in five selected counties in Kenya. Of the five counties, one was one of the country's universal health coverage (UHC) pilot county and the other had a local county-run UHC program.

Findings

In some counties, newborns were excluded from benefiting from Linda Mama

The program was intended to cover all Kenyan pregnant women and their newborns for a period of one year. However, in some counties, newborns were not considered to be beneficiaries of the program, reflecting some misunderstanding about their inclusion and how to make a claim reimbursement for these services.

Key Messages

- In 2013, Kenya introduced a free maternal care program abolishing all user-fees for deliveries at public healthcare facilities and the Ministry of Health (MOH) started reimbursing health facilities for these costs. The program was transferred to the National Hospital Insurance Fund (NHIF) in 2016, thereafter renamed as the Linda Mama program
- The Linda Mama program offered an expanded benefit package compared to the original free maternity program. However, the package excluded some important services including ultrasounds, family planning, and immunization, and others services like care for the newborn and outpatient complications for the mother were covered on paper but not in practice.
- While the program intended to eliminate out-of-pocket (OOP) payments for maternal services, some healthcare facilities continued to charge fees which represent a financial barrier to access
- Public health facilities in some counties could not use Linda Mama funds because they had to send these funds to the county revenue account. This had a negative influence on service delivery
- The Linda Mama reimbursement to healthcare facilities by the NHIF was associated with delays. Additionally, facilities reported that the set payment rates for Linda Mama services were not enough to cover the costs incurred during service delivery
- Facilities faced challenges with submitting claims such as a lack of adequate training, lack of computers and photocopy machines, claim system hang-ups, lack of IDs, and the lack of focal persons to make Linda Mama claims.. These resulted in facilities losing out on some reimbursements
- There was poor communication to key stakeholders of the program. For instance, the UHC pilot county was not receiving reimbursements for the program however, there was no clear communication on whether the program should continue or not after UHC roll out. Furthermore, there was a lack of information among mothers in the counties about the program

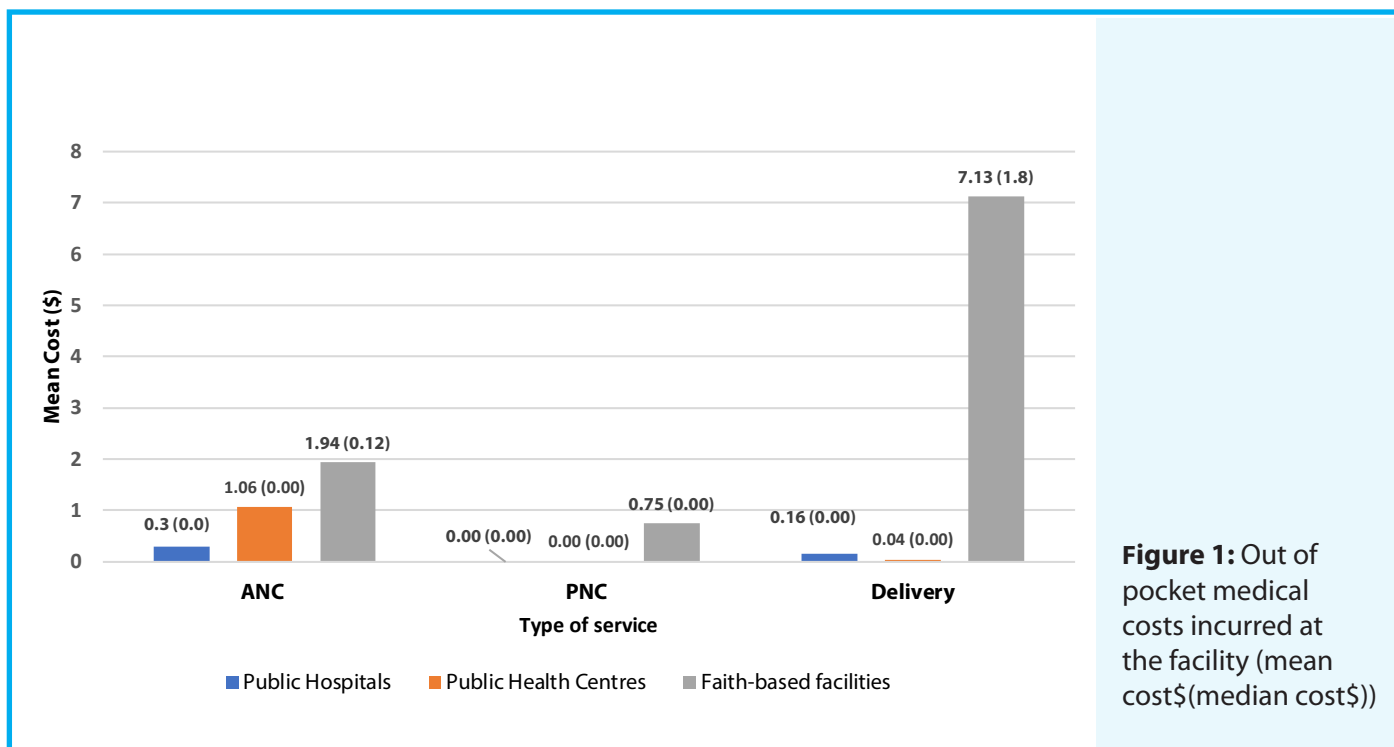
Linda Mama beneficiaries could not access some services that were part of the Linda Mama benefit package

The services that the mothers were entitled to according to the Linda Mama implementation manual were antenatal care, delivery services, postnatal care, emergency referrals, complications, and newborn care, see Table 1. In practice some services such as care for the newborn, outpatient complications, referral costs were not being covered. Additionally, some essential services such as ultrasounds, family planning, immunization, medical abortions, and Anti-D medications were not included in the services that mothers were entitled to.

Linda Mama beneficiaries incurred some OOP payments to access maternal services

The Linda Mama program intended to eliminate OOP payments for accessing maternal services. However, there were some patients who had to incur medical costs outside the facility due to the unavailability of drugs and other supplies.

The mean reported OOP costs during an ANC visit ranged from \$0.3 (median=\$0) in public hospitals to \$1.94 (median=\$0.12) in faith-based facilities; items paid for included ultrasounds, drugs, and photocopy costs. For PNC visits, no OOP costs were incurred at the public facilities, however, the mean OOP cost in faith-based facilities was \$0.75 (median=\$0) and was mainly drug costs. Lastly, mean OOP costs for deliveries ranged from \$0.04 (median=\$0) in public health centre to \$7.13 (median=\$1.8) in faith-based facilities. Items paid for during delivery visits included drugs for the newborn, basins, cotton wool, tissues, photocopy, chlorhexidine, cannula, NG-tube costs, registration costs, and for mama kits (care packages). Details of OOP medical costs incurred at the facilities are listed in figure 1.



Public healthcare facilities did not access Linda Mama reimbursements in some counties

In some of the counties, Linda mama reimbursements by the NHIF were deposited directly into the public facilities' bank accounts and they had access to the funds after workplans and budgets were drawn, and approvals sought. On the other hand, in some counties the public facilities were required to either redirect the Linda Mama funds from their account to the County Revenue Fund (CRF) account, or NHIF would directly deposit to the CRF account. These funds would not be remitted back to the health facilities and this would as a result influence service delivery. This is illustrated in Figure 2.

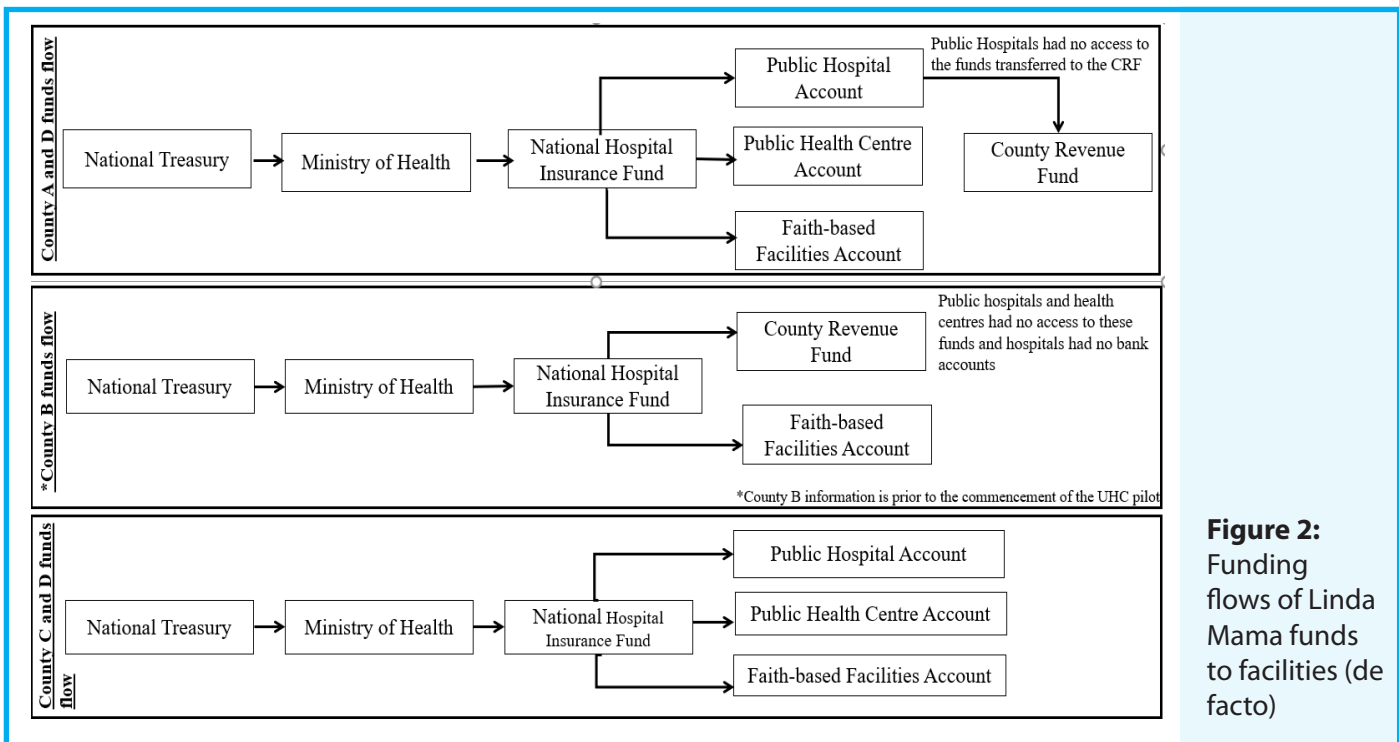


Figure 2: Funding flows of Linda Mama funds to facilities (de facto)

Funding disbursement by the NHIF to healthcare facilities was associated with delays

According to the Linda Mama implementation manual, NHIF was to ensure that there was a timely payment to the providers of within 30 days of receiving the invoices. The health facilities reported delays in receiving the payments and that the timing and amount that was to be reimbursed was unpredictable. This had resulted in pending claims to the facilities that ranged between 1% to 16% across all the facilities in the sampled counties for a period of 9 months. These pending claims are shown in Figure 3. On the other hand, the NHIF also reported delays in receiving funds from the Ministry of Health.

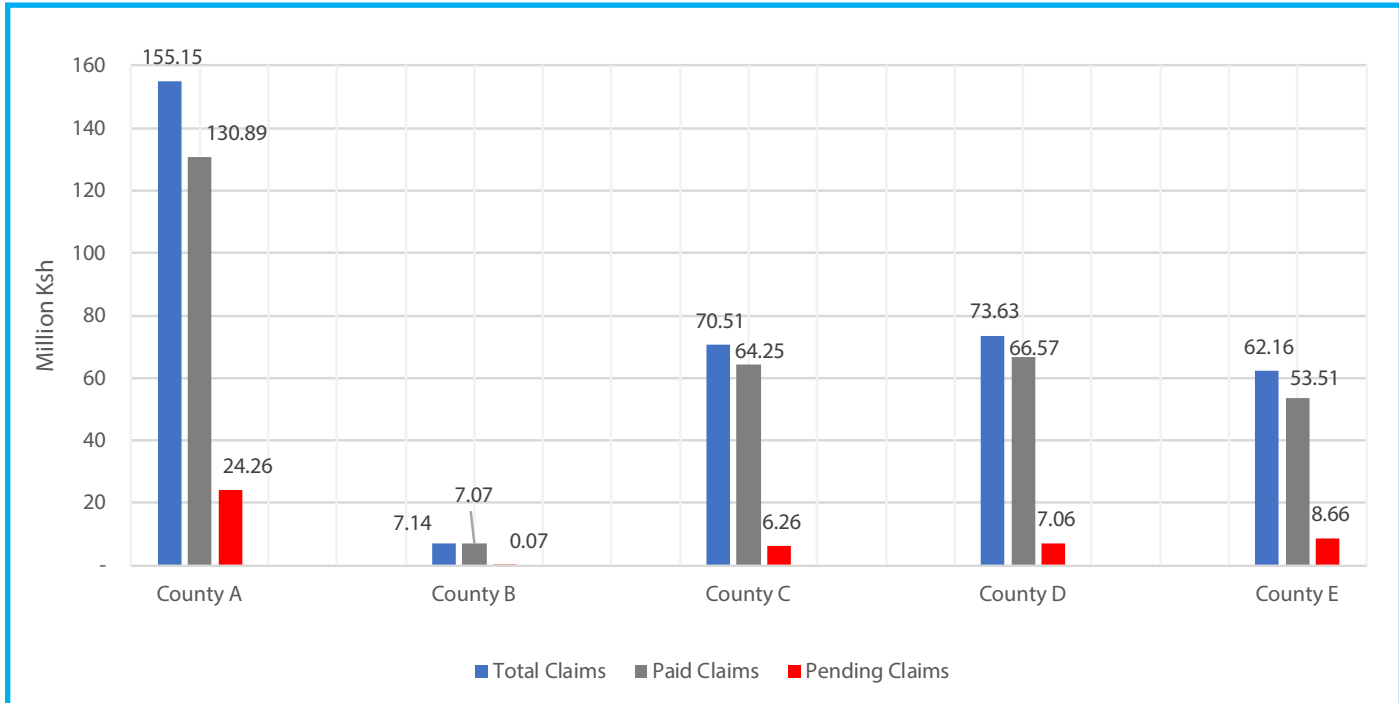


Figure 3: Claims summary per county. July 2018-March 2019

Linda Mama reimbursement rates were deemed insufficient to cover the incurred costs

Table 3 outlines the facility reimbursement rates under the Linda Mama program. Health facilities reported that the amounts reimbursed were not enough to cater for the costs incurred to offer the service. For instance, they pointed out that normal deliveries and caesarean sections were reimbursed at the same rate in public facilities. Further, the NHIF reimbursed facilities using higher rates under the national scheme. The facilities also reported that they were not to be reimbursed for referral services.

Table 1: Benefit package and reimbursement rates (de jure)

Services	Benefit package according to the <i>Linda Mama</i> implementation manual	Reimbursement rates according to the <i>Linda Mama</i> implementation manual					Notes
		Public primary care facilities (Tier 2)	Public primary and secondary referral facilities (Tier 3)	Public tertiary referral facilities (Tier 4)	Private/Faith based primary care facilities (Tier 2)	Private/Faith based primary and secondary referral facilities (Tier 3)	
Antenatal care	ANC profile, preventive services, prevention of mother to child transmission of HIV	KES 600 (USD 6)	KES 1000 (USD 10)	KES 1000 (USD 10)	KES 1000 (USD 10)	KES 1000 (USD 10)	Reimbursement for ANC-1 st visit
		KES 300 (USD 3)	KES 300 (USD 3)	KES 500 (USD 5)	KES 500 (USD 5)	KES 500 (USD 5)	Reimbursement for ANC-subsequent 3 visits
Delivery	Skilled delivery (including caesarean section), neonatal care including costs related to preterm births	KES 2,500 (USD 25)	KES 5,000 (USD 50)	KES 17,000 (USD 170)	KES 2,500 (USD 25)	KES 6,000 (USD 60)	Reimbursement for normal delivery
		—	KES 5,000 (USD 50)	KES 17,000 (USD 170)	—	KES 17,000 (USD 170)	Reimbursement for caesarean section delivery
Postnatal care	Vitamins, family planning services, screening, immunization, and early infant diagnosis of HIV	KES 250 (USD 2.5)	KES 250 (USD 2.5)	KES 250 (USD 2.5)	KES 250 (USD 2.5)	KES 250 (USD 2.5)	Reimbursement for PNC and new-born care (each of the 4 visits)
Emergency referrals	Ambulance services						
Conditions and complications during pregnancy	Outpatient and inpatient treatment						
†Care for the infant	Outpatient services including treatment and child welfare clinics, and inpatient services						

Note. Source: Linda Mama implementation manual and circulars sent to facilities from the NHIF

† Care of the infant is within the 1-year period that the mother is in the program

The claims process was faced with several challenges

Facilities reported that there was inadequate training on how to make claims, especially for the lower level facilities who had previously not interacted with the NHIF on lodging claims. The sub county teams were also not trained on lodging of claims and could not adequately support the facilities in this regard. This was further compounded by a high staff turnover rate and a shortage of a focal person to lodge claims.

Some facilities also lacked computers, modems, and photocopy machines to lodge claims and the online e-claim system had several hang ups. The lack of patient identification documents (ID) posed a challenge in processing claims.

In some of the health facilities it was identified that having a focal NHIF clerk for processing Linda Mama claims specifically and ensuring all health care workers had the knowledge of the claim process was instrumental in making the claims process easier.

There was varying availability of essential medical supplies in the sampled healthcare facilities

NHIF was expected to contract healthcare facilities with the structural capacity to provide the services in the Linda Mama benefit package. However, there was varying availability of essential medical supplies across the facilities. This is reported in table 2.

Table 2:Structural quality: availability of essential medicines and supplies

Essential medicines and supplies	Available today	Available in the last 90days
Penicillin	95% (n=19)	90% (n=18)
Metronidazole	95% (n=19)	90% (n=18)
Gentamicin	95% (n=19)	85% (n=17)
Oxytocin	95% (n=19)	95% (n=19)
Misoprostol	55% (n=11)	55% (n=11)
Functional blood pressure machine	100% (n=20)	
Functional bag and mask (two neonatal mask sizes)	100% (n=20)	
Uninterrupted oxygen supply in childbirth	65% (n=13)	
Uninterrupted oxygen supply in neonatal ward (10 facilities)	60% (n=6)	
Uninterrupted oxygen supply in paediatric ward (10 facilities)	60% (n=6)	
Soap and running water/alcohol rub in childbirth	95% (n=19)	
Soap and running water/alcohol rub in neonatal ward (10 facilities)	90% (n=9)	
Soap and running water/alcohol rub in paediatric ward (10 facilities)	100% (n=10)	

There were communication challenges in the program

NHIF branch offices communicated to facilities and counties through circulars and verbal communication. However, in 2 of the 5 counties, there was inadequate sensitization and a lack of proper cascade of information to county and sub-county health officials.

In the UHC pilot county, public healthcare facilities had not been receiving reimbursements for Linda Mama since UHC pilot rollout began. There was a lack of clarity at a county level, in the public and private facilities on whether the program should continue or not. MOH and NHIF reported that the program should be halted in public facilities during the UHC pilot however, these counties did not receive official communication.

There was a lack of information among the mothers on the availability of Linda mama, and unlike the previous free maternity policy, mothers had to register to access Linda Mama services.

Distance and associated transport costs were a barrier to access

Some of the counties were vast and the distance to facilities and transport costs was reported to be a barrier of access to care.

Conclusion

The process evaluation of the Linda Mama program reveals that there are barriers in access to maternal care, inefficiencies in the funding flow, claims process and reimbursement processes, and gaps in quality of care. Addressing these implementation challenges would contribute towards reducing the maternal mortality further and informative to the UHC reforms in Kenya.

Recommendations

Ministry of Health

- The Government of Kenya should consider making amendments to the public finance management act to ensure that health facilities have the autonomy to spend the Linda Mama funds according to their priorities.
- There needs to be better communication of the policy from the Ministry of Health. Specifically, more investments in improving community awareness of the program (possibly consider use of community health workers) and clear communication to the counties on the implications of the UHC scale up on the Linda Mama program in both the public and private sector.
- Costing of maternal and child health services should be done by the Ministry of Health to ensure that reimbursements are adequate to cater for the costs incurred.

NHIF

- NHIF should consider ensuring a stable and functioning e-platform system for lodging claims to allow for efficiency when registering and lodging claims. Training of subcounty teams by the NHIF should also be done to supplement the training that they offer to facilities, given the high staff turnovers in some of the public facilities.
- The NHIF should consider addressing bottle necks that cause delays in reimbursing the facilities and the Ministry of Health should also ensure timely transfers of funds to NHIF, without any variances. This would ensure that facilities are able to have essential drugs and supplies.
- The NHIF should consider addressing document challenges. Keeping in mind that the NHIF is trying to mitigate fraud, other exemptions should be explored in the absence of an ID/ANC book/next of kin document during delivery and in the absence of birth notifications in cases of abortions.
- The Ministry of Health and the NHIF should consider improving awareness on the service entitlements to health care providers and beneficiaries. Additionally, they should review and expand the service entitlements to include essential maternal health services that are currently excluded such as ultrasounds, family planning, immunization, and newborn care.
- The NHIF, as a strategic purchaser, should consider the active use of Linda Mama data as well as monitor quality of care under the program

Counties Department of Health

- Counties department of health should consider ensuring that the health facilities have the necessary hardware to facilitate claims. They should also ensure that there is an adequate capacity of human resources, regular support visits to ensure quality maternal and childcare.
- Providers should stop collection of OOP payments from women seeking maternal and childcare and invest in adolescent and youth friendly maternal services to minimize barriers to access of care and that the mothers are protected from financial hardships.
- Counties should strengthen engagement between county health managers and participating health facilities to help in identifying bottlenecks in the implementation of the program and liaise with NHIF branches to ensure better access to quality health services for beneficiaries,

About the Research

Stacey Orangi¹ | Angela Kairu¹ | Joanne Ondera² | Boniface Mbuthia³ | Augustina Koduah⁴ | Boniface Oyugi^{5,6} | Nirmala Ravishankar⁷ | Edwine Barasa^{1,8}

1. Health Economics Research Unit, KEMRI | Wellcome Trust Research Programme, Nairobi, Kenya
2. Independent Consultant, Nairobi, Kenya
3. ThinkWell, Nairobi, Kenya
4. Department of Pharmacy Practice and Clinical Pharmacy, School of Pharmacy, College of Health Sciences, University of Ghana, Ghana
5. Centre for Health Services Studies, University of Kent, Canterbury, CT27NX, United Kingdom
6. The University of Nairobi, P.O BOX 19676-00202, Kenyatta National Hospital, Nairobi, Kenya.
7. ThinkWell, Washington, DC, United States
8. Oxford Department of Medicine, University of Oxford, Oxford, UK.

We would also like to acknowledge the support of Fardosa Abdi from the National Hospital Insurance Fund; Felix Murira, Shano Guyo, Nick Mwendwa, and Daniel Koech from ThinkWell Kenya.

ThinkWell and KEMRI-Wellcome Trust produced this policy brief under the Strategic Purchasing for Primary Health Care (SP4PHC) grant from the Bill & Melinda Gates Foundation. ThinkWell is implementing the SP4PHC project in partnership with government agencies and local research institutions in five countries. For more information, please visit our website at <https://thinkwell.global/projects/sp4phc/>. For questions, please write to us at sp4phc@thinkwell.global

References

This Brief is based on a research paper published on 11th August 2021 as “Examining the implementation of the Linda Mama free maternity program in Kenya”. <https://doi.org/10.1002/hpm.3298>

