Original article
Anti-Politics and Free Maternal Health Services in Kilifi County, Kenya

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Abstract

Maternal healthcare is a global agenda. Kenya introduced free maternity services (FMS) in 2013 to allow women to give birth for free in all government public health facilities. The introduction of FMS was timely due to the high maternal mortality rate in Kenya. FMS was also introduced to fulfil the Jubilee Party government's elections campaign promises. It is, however, not known how primary beneficiaries and health providers perceived the FMS roll-out following the presidential directive in 2013. This article aims to explore the roles of political contestations in FMS as a social protection scheme in Kenya. In this qualitative ethnographic study in Kilifi County, we interviewed the mothers who utilised FMS and the health workers who implemented the policy. The data gathered was analysed contextually and thematically. The prevailing narrative from the health services professionals and the mothers who participated in our study is that FMS is 'the president's thing' and has a clear political orientation; it is seen as deceiving the public in two ways: first by shrouding political interests, and second by adding to the burden of women, as delivery was not free – all the other services and medication before and after birth came at a cost. Health workers feel helpless and frustrated and, in most cases, they have to cope with meagre resources to ensure safe births. In some cases, quality of care is compromised due to supply-side constraints. This article shows how social protection has been used to gain political mileage and has not considered the local needs of the maternal healthcare system.

Keywords: anthropology, anti-politics machine; ethnography; free maternity services

Introduction

> *Free maternity – it is Uhuru's* [President Uhuru Kenyatta] *thing. He* […] *mentioned it at a political rally* […] *that all expectant mothers are delivering for free. I think he doesn't know that we are paying for the services in some health facilities. When we say* […] *we are using free maternity, doctors tell us we have to pay.* [The promise of free maternity services] *is just usual politics for getting votes from us.* (In-depth interview, new mom, 35 years old)

During the nine months of ethnographic fieldwork among mothers utilising free maternity services (FMS) and the healthcare workers delivering these services, it emerged that the introduction of FMS has a strong link to politics in Kenya. The epigraph is derived from an interview with a mother in the maternity ward of a public health facility in Kilifi County on the Kenyan coast. As a recurring theme in other interviews during fieldwork, it draws attention to how politics paved the way for the launch of FMS and how the political contestations and negotiations between different actors affected the implementation of FMS in Kenya. The quote also shows the local interpretation of political statements linked to the provision of services.

Notably, anthropologist James Ferguson (1996) argues that some neoliberal policies in developing countries – such as FMS in Kenya – have been used to fake government involvement in development and decentralisation to gain the elite political expectations and in meeting global health development expectations and goals. Ferguson argues that such services perform susceptible political operations that also involve the expansion of institutional state powers that are invisible and hidden under cover of invisible and under cover of a neutral, technical mission that nobody can notice or object. Ferguson (1996) calls this the anti-politics machine. Power is relative and relational and is exhibited at different levels ranging from policy decision-making to the local implementation of interventions (Lee 2015). In the recent past, researchers have increasingly drawn attention to the influence of power implicated throughout the global health field, noting that biomedical approaches in public health, which emphasise scientific evidence to guide decision-making, tend to ignore the distribution and exercise of power in health policy and systems (Lee 2015; Shiffman 2014). Failing to explicitly recognise the normative premises that undergird global health efforts (Ooms 2015), studies overlook why and how actors holding power may steer health efforts, in particular for either their own benefit or for that of the recipients. Significantly, politics play an important role either in making healthcare reform possible or preventing it from happening (Yilmaz 2017). In cases where reform is possible, politics influence the chances of reform being implemented and helps shape its content.

The exercise of power occurs among actors across the health system that may be dominant in particular local contexts (Mackenbach 2013). Administrators, bureaucratic agents and frontline health workers may exercise power during everyday health service delivery, with negative or positive consequences for the people they serve (Erasmus & Gilson 2008; Gilson, Schneider & Orgill 2014). When the practice of power is overlooked, it is difficult to understand why policy decisions and implementation obtain particular outcomes (Østebø, Cogburn & Mandani 2018). During elections, politicians may knowingly announce ambitious health policies that are not financially or administratively feasible (in the short or medium term) (Campos & Reich 2019). Some policies may be adopted for aspirational purposes and to drive budgetary or organisational changes necessary for implementation. But some challenges cannot be solved at implementation; some challenges may require re-designing the policy. Though the health system may be organised to direct the largest share of resources towards illnesses affecting the greatest number of people (Janes, Chuluundorj, Hilliard, Rak & Janchiv 2006), 'access to services beyond the primary care system is compromised by financial, opportunity, and informational cost barriers', which creates a fundamentally inequitable health system. This is the central argument in the politics of distribution (Ferguson 2015).

The distributive decisions governments make have important welfare implications for their citizens (Knoesen 2009; McCollum, Taegtmeyer, Otiso et al. 2019). These effects are particularly pronounced in African countries where small changes in resource allocation can lead to large changes in a local government's ability to provide public services, which in turn can positively or negatively affect the future welfare of citizens (Barasa, Cleary, English & Molyneux 2016). Globally, an equitable distribution of healthcare, according to needs instead of the ability to pay, is an important goal featuring on many health policy agendas(Barasa et al. 2016; Bonfrer et al. 2014; Yilmaz 2017). However, several studies have shown that inequitable distribution of health resources is a major problem that hinders access to healthcare services (Anyangwe & Mtonga 2007; Chelogoi, Jonyo & Amadi 2020; Kickbusch 2015; Sochas 2020). A good public health financing system fairly distributes resources among different socio-economic groups. It is a system that protects the poor and vulnerable from impoverishment due to healthcare expenditures (Shamu, January & Rusakaniko 2017).

Nevertheless, equity in healthcare has been a key concern in critical reflections (Roberts & Reich 2002). Most health reforms are grounded in utilitarian and liberal ethical frameworks.

The former stress cost-effectiveness and ultimate value, or deploying health resources to achieve the greatest good for the greatest number of people (that is, financing a primary healthcare approach), while liberal ethical frameworks emphasise guaranteeing equal rights and opportunities to achieve optimum health (Foley 2009; Roberts, Hsiao, Berman & Reich 2004). Neoliberalism views healthcare resources as part of a transformation of public resources and spaces into private ones for the efficient distribution of goods and services and, by extension, capital accumulation. The key to neoliberal approaches is the belief that the 'free market' is the most effective mechanism for the distribution of almost all goods and services, including healthcare, and that potential markets can be perfected (Wilkin & Conteh, 2018).

This article explores how mothers and healthcare providers perceive reforms in maternal health services in Kenya. It specifically looks at free maternity care and the 'state–citizen relationship' in the provision of health services in Kenya. The anti-politics machine asserts that health reforms based on utilitarian and liberal agendas intensify existing social inequalities and reinforce health inequities in Kenya. Studies in Madagascar, South Africa, Rwanda and Uganda have shown that free services are often used during election campaigns to attract votes (Fafchamps & Minten 2007; Frederick & Habiyonizeye 2018; Kajula, Kintu, Barugahare & Neema 2004; Walker & Gilson 2004).

One of the main targets of Sustainable Development Goals is maternal and child healthcare. This goal mainly encompasses reducing the maternal mortality rate to fewer than 70 per 100,000 live births by 2030 (World Health Organization 2015). Kenya introduced FMS in all public hospitals in 2013. The Jubilee Party government (2013–2021) pledged FMS to ensure access to professional maternal healthcare services for all – including the poor and vulnerable. Since the introduction of FMS, Kenya has reduced maternal mortality and improved coverage of health maternal health services (Kenya National Bureau of Statistics (KNBS), 2015). Yet, despite these successes, considerable inequities in health outcomes and uptake of health services persist, continuing to disadvantage the most vulnerable (KNBS et al. 2015; Ombere 2021; Ombere et al. 2023). Facility-based deliveries in Kenya increased from 44 percent in 2008 to 61 percent in 2015 (KNBS 2015). An increase in skilled care deliveries has been partly attributed to the FMS policy (KNBS et al. 2015; Ombere et al. 2023; Pyone, Smith & Van Den Broek 2017). However, most research on healthcare politics in Kenya (Barasa et al. 2016; Waithaka, Kagwanja & Tsofa 2020) does not give a primary

account of power relations among diverse actors and their interpretations of FMS, a gap that this article aims to address.

Methods

Study setting and design

Part of a larger interdisciplinary research project on inclusive growth through social protection in maternal health programmes in Kenya (using the acronym SPIKE), this qualitative study was aimed to obtain emic perspectives of FMS. It was conducted in Kilifi County in Coastal Kenya. Kilifi is classified as arid and semi-arid. More than 65 percent of Kilifi residents face seasonal water shortages, with droughts and floods compromising productivity and food security. Kilifi's dependency ratio stands at 101.45 percent. It is poor, with poverty estimated at 66.7 percent and food insecurity affecting approximately 67 percent of its households. The majority of the population lives outside of the metropoles (KNBS & ICF International 2015). The predominant community is the Giriama sub-tribe of the Mijikenda. The primary source of livelihood for the Giriama is subsistence agriculture (cashew nuts, palm wine and animal husbandry) supplemented by wage labour in the salt mines and as small traders. Kilifi is among the top fifteen counties contributing to the country's maternal and perinatal death burden (Mbugua & Kerry 2018; Ombere et al., 2022). Kenya's maternal mortality rate is still high at 342 per 100,000 births, while Kilifi has a maternal mortality rate of 289 per 100,000 births (KNBS & ICF International 2015).

This nine-month ethnographic study was conducted among the Giriama people in Kilifi (specifically in the following sub-counties: Kilifi North, Kilifi South, Ganze, Malindi and Magarini). Health facilities were purposively selected based on a 2015 exploratory study, during health facilities offering FMS were identified.

Sample selection

The study was conducted between March and July 2016 and February and July 2017 to enable long-term exploration and interaction with indigent mothers in health facilities and household settings. Purposive sampling was used to recruit the study participants. We sourced participants at healthcare facilities and looked for pregnant women or women who had babies no longer than six months before the study was conducted. The women were between 18 and 45 years old when we conducted the study. We conducted a total of 40 in-depth interviews with individual mothers and six focus group discussions with six to nine mothers. In addition, we conducted ten key informant interviews with health workers heading

maternity and child health departments – they had to have been in a management position for at least a year. Our conversations aimed to explore local perceptions of FMS as a social protection scheme. The role of politics in healthcare emerged as an overarching theme from the interviews and discussions. Moreover, a part of our research entailed participant observation at health facilities and in households, which included additional informal conversations with community members. In this article, 'poor mothers' refer to those who could not afford two meals a day, had poor access to clean water, good healthcare, poor housing, had more than seven children, and the children had poor nutrition status.

Data analysis and presentation

We analysed the ethnographic data we gathered hermeneutically and ran a content analysis of interview and focus group data (Braun & Clarke 2013). Interviews were transcribed using software, and coding was done manually to identify and list inductive codes. The themes were identified in line with the overall study objective, summarised in English and discussed by all authors. Informal conversations recorded by hand in notebooks were also coded and included in the analysis. The findings are described textually and illustrated using verbatim quotations. The authors obtained validation for the results of this study from various stakeholders.

Ethical considerations

The authors had permission to proceed with the study. An introduction letter was obtained from the county health office and ethical approval from Maseno University's ethics committee. Furthermore, participants were informed of the nature of the study and that participation was entirely voluntary. They could withdraw anytime they wished. Informed consent was obtained from all participants, and the respondents were assured of confidentiality. Human privacy and dignity was respected throughout the data collection and analysis.

Findings

'Free' is political and expensive

During the time we conducted our fieldwork, Kenya was preparing for the 2017 general elections, and all parties – including Uhuru Kenyatta's ruling Jubilee Party – were making pledges to the Kenyan people as part of their election campaigns. Healthcare – and especially FMS – was one of the key political pledges made by the Jubilee Party. In the rural villages, our participants observed that the Jubilee Party's FMS promise was specifically to win votes in coastal regions, where the main opposition party held sway. Both mothers and health workers felt FMS was a good social protection scheme, and health facilities' indicators on maternal health had improved. However, poor mothers felt the Jubilee Party was taking advantage of their poor conditions to win votes and questioned how FMS would be delivered without adequate personnel and infrastructure (beds and other equipment such as modern ultrasound machine, pulse oximeters, scanners and essential medication for maternal healthcare). One mother recalled how her pregnancy was a tough journey amid poverty. Most participants referred to FMS as *Ile ya Uhuru,* Swahili for '*Uhuru's thing*'. Some also referred to FMS as being '*for Jubilee'*. Moreover, it was felt that FMS was a political promise and in fact *not* free – mothers were paying. For instance:

> *Free maternity – it is Uhuru's thing. He* […] *mentioned it at a political rally* […] *that all expectant mothers are delivering for free. I think he doesn't know that we are paying for the services in some health facilities. When we say* […] *we are using free maternity, doctors tell us we have to pay.* [The promise of free maternity services] *is just usual politics for getting votes from us.* (in-depth interview, new mom, 35 years old)

And from one of the focus group discussions:

> [The President] *said we deliver for free, which is an excellent thing for the poor, but if you calculate the amount of money I have used from antenatal clinic to the time of delivery, I tell you, it is not free. Maybe it is called free because you don't pay for delivery.* (focus group discussion, August 2017)
>
> *But free maternity is for political campaigns. Nobody cares whether we are charged in the hospital or not*. (focus group discussion, May 2017)

Healthcare workers could see the benefits of FMS but were critical of the practicalities, as can be seen from this citation:

> [FMS] *has been good for the poor mother* […] *More mothers come to deliver* [now that they do not have to pay] *and we do not have enough space, no beds to accommodate all. Equipment supplies are low and, lastly* […] *no more hiring of nurses. FMS was the baby for the campaign by our President, and it worked. Many women voted for him*

> *because of these promises* […] *In the long run, what is the end product of these free things as in the quality of service? Are there enough human resources to manage the free programmes?* (in-depth interview, senior healthcare worker, public health facility, June 2017)

The health worker cited here felt the President pledged and introduced FMS not to improve care but primarily to buy votes, without paying attention to the sustainability of these programmes and how they would be financed. Therefore, the discourse prevails that despite FMS being a good social protection scheme, it led to healthcare facilities being overwhelmed. The views of the cited healthcare worker was a theme cutting across interviews with all other healthcare professionals at all the health facilities. These carers felt that while FMS had increased access to health care and benefited the poor, it was not oriented to the long term.

Frustrations and powerlessness

Frustration and powerlessness of health workers emerged in different contexts. When we returned in 2016 to a public healthcare facility to ask a maternal and child health unit matron whether anything had changed in terms of FMS since our previous conversation in 2015, during the exploratory phase of this study, her irritation was clear:

> *I can't keep on repeating the same thing, and there are no changes! Please come with another thing* […] *I told you; we don't have FMS here. Right now the clients pay, then we offer services*. (in-depth interview, matron in the maternal and child health unit, public healthcare facility)

She went on to reveal that she and her colleagues felt helpless and frustrated by the system and by how the word 'free' had been used to 'deceive' pregnant women. For her, if the policy does not cover antenatal and post-natal services, then there is no free maternity care. Maternity and child clinics charged a minimum of 200 Kenyan shillings for prenatal profiling and additionally for laboratory fees, medicine and subsequent visits, she said, estimating that mothers spent at least 20 shillings. She emphasised that their frustration emanated from the particular dilemma FMS brought about for healthcare workers: strain due to higher demand for free care that is, in fact, not costless:

> *Free maternity covers delivery only. Here in* [maternal and child health], *we charge mothers, but I wonder… Why only free delivery and not free antenatal and postnatal*

care? (in-depth interview, matron in the maternal and child health unit, public healthcare facility).

Health workers' helplessness and frustration also emanated from top management, which links to political leadership. Healthcare workers must offer their services as directed by the county and national government, regardless of whether there is adequate infrastructure, equipment or human resources or not. Healthcare workers noted that the devolution of essential services, such as healthcare, was timely and good but highly politicised. When essential requirements are not in place, the quality of healthcare, including of mothers and babies, is likely to be compromised. A matron in a health facility likened their situation to a parent-child relationship:

> *Devolution of healthcare is a good thing but has a lot of challenges. If your 'father' has said, you offer services on his behalf, then you must offer services. You cannot refuse. Because he is the father, who are you to say no? You as a son, you have to give the services, whether poor or good.* (in-depth interview, matron, public healthcare facility)

Another matron, who was the head of the maternity ward, said:

> *Some of us fear to talk about free maternity. You know, it was the President's initiative. We cannot manufacture drugs or human resources if the county doesn't purchase them or employ. Even the quality of maternity care is compromised because we have to improvise* […] *when our supplies* […] *are finished. We feel so bad that this good policy has not considered necessities that can make it successful for health workers and clients.* (in-depth interview, matron and head of maternity ward, public healthcare facility)

Discussion

The notion of anti-politics emerged as an overarching theme in this study, which set out to examine local perceptions of FMS as a social protection scheme. In this section, the key themes are discussed.

This study shows that, on the one hand, FMS in Kenya was perceived as a good social protection scheme. On the other hand, FMS was seen as expensive, as women had to incur costs, burdening already poor households. Furthermore, mothers perceived free maternity as a political tool that was used to secure votes. The narrative that FMS is 'the president's thing' prevailed, with a clear political orientation, and this distrust in traditional politics can be labelled as anti-politics (Ferguson 1996). Development projects are always assumed to serve a good purpose (Ferguson 1996) yet often produce (sometimes perhaps unintended) negative effects, including the expansion of state power and the translation of political realities such as poverty and powerlessness into 'technical' problems to be solved by 'development' agencies, the government and experts (Ferguson 1996). This study provides evidence that the political class and, more particularly, the ruling Jubilee Party in Kenya used FMS as a political tool to win votes in the opposition-dominated parts of the country. Poor households in these areas became convinced that FMS was a favour government was extending to its poor citizens and that they needed to support the ruling party to continue benefiting from this scheme.

In this instance, FMS hid political interests. Secondly, it burdened poor women because it was in fact not costless – all the other services before and after birth carried a cost. Therefore, for women, the narratives that became evident in our study were that free does not mean free and that FMS was a political project that burdened rather than helped.

The emic (or local) perception of FMS was that free ended up being just a label used for political gain (to win votes during the elections) and it is a system behind which women did not find modern development but exclusion based on financial status. After experiencing the system first hand and coming to understand that free was not really without cost but was in fact quite the opposite – it carried a charge – poor women lost their trust in FMS. The 2017 election campaign was not the first time the ruling party in Kenya pledged to remove fees if they were voted in again; it also happened in the 2013 national elections (Barasa et al. 2016). The study findings also emulate the experience in other countries, such as the United Kingdom (Dixon 2019), Mexico (Mills 2006), South Africa (Walker & Gilson 2004),

Rwanda (Frederick & Habiyonizeye 2018) and Uganda (Kajula et al. 2004). All these studies show pledges made by political parties during election campaigns that were difficult to keep.

FMS has been shown to have increased hospital births and improved maternal mortality rates in Kenya (Gitobu, Gichangi & Mwanda 2018; Lang'at & Mwanri 2015; Mwabu, Mwanzia & Liambila 1995; Ombere 2021). However, as our study shows, the provision of FMS did not significantly reduce household spend among the indigent communities. Our study corroborates Lang'at & Mwanri's (2015) findings that despite the positive outcomes of FMS, there were challenges that hindered its successful implementation. These included inadequate human resources and shortages of essential commodities such as medication and medical supplies; these negatively affected the quality of care.

We found that such challenges frustrated health workers and added to their feelings of powerlessness. As it ignored the concerns of these frontline health workers, the implementation of FMS was very difficult. Since these frontline workers ultimately translate policies into practice and influence the lived experience of patients, they aggravate negative perceptions (Gilson 2016).

Our study revealed that as the political pressure mounted to roll out FMS, so did challenges the healthcare workers faced (not enough supplies or resources), and these challenges were inadequately addressed. More babies were being professionally delivered, yet the quality of care was compromised by supply-side constraints.

Our study shows that FMS in all health facilities might be a comprehensive social protection programme, yet many poor mothers were still excluded from it. Equitable distribution of healthcare according to need rather than ability to pay is an important health goal (Bonfrer et al. 2014). We found that poor women were easily excluded from accessing FMS by more affluent women who know what Douglas North (2005) refers to as 'the rules of the game'. What we saw confirms what studies have shown – that FMS actually excludes the poor from maternal health services (Chuma & Okungu 2011; Gitobu et al. 2018; Lee, Madhavan & Bauhoff 2016; McKinnon, Harper, Kaufman & Bergevin 2015; Okungu, Chuma & Mcintyre 2017; Pyone et al. 2017; Sharma, Leslie, Kundu & Kruk 2017). Our study shows that in Kenya, FMS was an institutional product of powerful actors, who profited from this institutional change in their specific way and also let other elites further profit from the services, while poor and marginalised mothers were increasingly excluded, having to pay for what was labelled 'free'. Ferguson (2015) uses the phrase the 'politics of distribution' where only the few and only the majority benefit, and there is exclusion (usually of the poor).

Our study shows FMS operates at different levels in Kenya: at the development level, to achieve the Sustainable Development Goals, and to implement pro-poor policies. Nevertheless, anti-politics emerge as political and power issues become evident to healthcare service providers and poor mothers. Our evidence shows how mothers and healthcare workers saw right through the political interests of FMS. Secondly, FMS that is in fact not without cost actually achieves the opposite of what the policymakers want it to do – it burdens its prospective beneficiaries. In our study, these beneficiaries are mothers from disadvantaged economic backgrounds who should be able to but can in fact not deliver their babies for free as they are obliged to paying for all the other services and medication needed before and after birth (Ferguson 1996; Ombere 2018).

Conclusion

Our study has shown that the shift towards making delivery care free to all is a bold and timely one. However, the experiences of mothers and healthcare workers show the introduction of FMS has not solved the challenges poor mothers face in accessing and utilising maternal health services. The introduction of FMS is linked to gaining political mileage, yet our findings show anti-politics in terms of the distrust mothers and healthcare workers display. The participants accused the state of using FMS not for improvement of care but to buy votes. Moreover, it also did not alleviate financial burdens, as poor mothers still incurred expenses when utilising FMS in public health facilities.

In addition, our findings show that FMS frustrated healthcare workers who felt powerless in their attempts to offer services labelled ‘free’ that were in fact not. Our study also shows that notwithstanding their frustrations and feelings of powerlessness, healthcare workers tried to make do with a lack of resources (brought about by higher demand due to FMS) to ensure safe deliveries. It was clear that there was concern among these workers that care could be compromised under these circumstances.

From this study, it has emerged that political promises alone do not buy better health. Good policies that are commensurate with local needs can promote equity of care and stand a better chance of improving services provided to the people. Therefore, sincere political will and actions are fundamental to promote a quality healthcare system.

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Disclosure statement

The authors declared no conflict of interest.

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