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

FINANCIAMIENTO DE LA SALUD MATERNA Y DETENCIONES POSPARTO: LA VOLUNTAD POLÍTICA COMO DETERMINANTE SUBYACENTE PARA LA ATENCIÓN RESPETUOSA DE LA MATERNIDAD EN KENIA

FINANCIAMENTO DA SAÚDE MATERNA E DETENÇÕES PÓS-PARTO: VONTADE POLÍTICA COMO DETERMINANTE SUBJACENTE PARA CUIDADOS DE MATERNIDADE RESPEITOSOS NO QUÊNIA

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Abstract
Maternal health financing is a critical aspect 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 worse, with the government's 2024/2025 national budget slashing the budgetary allocation for free maternal healthcare by half. The current 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, shall demonstrate that legal recognition of rights associated with maternal health 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.

Resumen
La financiación de la salud materna es un aspecto crítico 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 2024/2025 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 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 los derechos asociados con la salud materna 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 maternal; financiamiento; detención posparto; política.

Resumo
O financiamento da saúde materna é um aspecto crítico do financiamento da saúde em que o governo queniano se tem concentrado desde 1965. Ao longo dos anos, por meio 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 2024/2025, que reduziu pela metade a dotação orçamentária para cuidados de saúde materna gratuitos. 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 coloca-as em risco de detenção pós-parto e de abusos nos hospitais. Este artigo, por meio 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 dos direitos associados à saúde materna 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; saúde materna; financiamento; detenção pós-parto; política.

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Introduction[1]

Kenya has designed and implemented several maternal health financing programmes throughout its 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, despite these efforts, the cost of care remains one of the major barriers limiting access to facility-based care, particularly for pregnant persons. As in 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 (Tama *et al.*, 2018; Gitobu; Gichangi; Mwanda, 2018, p. 77; Wamalwa, 2015, p. 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, which occurs because of their inability to pay user fees, and this includes postpartum detention. Postpartum detention is a practice typically enforced within medical facilities. In it, victims who cannot pay user fees are confined within certain sections of hospitals and prevented from leaving until the hospital expenses are cleared (Cowgill; Ntambue, 2019, p. 3). It is a practice that, despite not being legally provided for within the law or policy, has been documented to have occurred in several major hospitals, including Kenyatta National Hospital, Pumwani Maternity Hospital, and Mama Lucy Kibaki Hospitals, which are publicly funded.

Hospital detention, which includes postpartum detention, is illegal because it involves the arbitrary deprivation of liberty and security without following the appropriate procedure enshrined in Article 29 of the Kenyan constitution (Kenya, 2010). This is 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 have a right to demand payments for services, detaining a patient is 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

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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 2.15 USD 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, which would ensure healthcare is accessible, available, acceptable, and of quality (CRR; FIDA, 2007).

This article will expose postpartum detention as a structural creation emanating from the politics of law and policy implementation, 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 status, intersect with overarching systems of power and oppression to determine one's health outcome (Velasquez; Figueroa; Dawes, 2022). Following this approach, this article will also highlight how laws and policies, as part of a society's social and 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 preventable (Braveman, 2006).

Maternal health outcomes result from multiple social factors intersecting with law and policy, which are intrinsically political in nature. To demonstrate this, the article will 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 summarise 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).

1. Method

A scoping review guided by the principles of Arksey and O'Malley's (2005) 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? Using this framework, this study 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, this paper endeavours to establish the value of undertaking a full systematic review to address challenges associated with maternal health financing and postpartum detention. This 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 collection of data, a scoping review of literature focused on following postpartum detentions, maternal health financing, social inequalities in health, and political determinants of health was carried out.

Several primary documents and reports were drawn upon, including reports by the World Health Organisation (WHO), the Lancet, and the Kenyan government. For peer-reviewed publications, searches were conducted within academic journals, including PubMed, the BMJ, and BMC, and internet sources, such as Google Scholar and general Google search. The following keywords, among others, were used: 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 lens, it was possible to systematically identify and chart relevant literature that meets predetermined inclusion criteria, attends to the specified objectives, and answers the research questions.

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 it is a powerful disincentive for women contemplating facility-based childbirth (Mwabu, 1995). Though absent from any official policy, this practice has been documented in several hospitals in Kenya and other countries, such as Congo, Burundi, Tanzania, and Nigeria, among others (Bowser, 2010; Okafor; Ugwu; Obi, 2015, p. 110-113).

Postpartum detention in health facilities in Kenya was documented in 2007 by the Centre for Reproductive Rights (CRR) and the Federation of Women Lawyers (FIDA) (CRR; 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 (CRR; FIDA, 2007). For example, one 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 (CRR; FIDA, 2007). In the same report, doctors were also interviewed. One interviewee, Doctor Shadrack Ojwang, an obstetrician gynaecologist, confirmed that detention was an existing phenomenon in Kenyan hospitals and not only in Pumwani, the hospital notorious for the practice (Abuya *et al.*, 2018).

In June of the same year, the Standard Newspaper documented cases of postpartum detention in Kenya for non-payment of user fees (CRR; 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 (CRR; FIDA, 2007). These women are usually removed from sight and hidden at the far ends of the wards, where they are under strict surveillance (CRR; 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 (CRR; 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" (CRR; FIDA, 2007). Another interviewee narrated how the hospital staff mistreated her and did not even give her a bed while she was in detention for a whole week at the aforementioned hospital. Others provided horrific accounts of being forced to sleep on the floor in the vicinity of a flooding toilet with a single bedsheet and a thin blanket, while yet others reported denial of vital services, forceful separation from families, and sexual abuse (CRR; FIDA, 2007).

Later, in 2012, the CRR and the 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 the plaintiffs' 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, including the right to freedom from cruel, inhumane, 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 inhumane 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 to that end (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; Brookes; Whitaker, 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 country notorious for this practice.

Although not publicly acknowledged by the government, hospital detention in Kenya has been featured in the Kenyan media on several occasions. For instance, Nation Media House, one of Kenya's biggest media entities, has, in the past, reported that "an alarming number of newborns in the country are detained in hospitals because their mothers cannot afford the cost of delivery" (Muchiri *et al.*, 2010 [2020]). This media report, which was first published in 2010 and updated in 2020, reveals how dozens of mothers had been detained in hospitals in Kenya for months in poor conditions with their babies. The news report further highlighted that, in all the major hospitals they visited, detained mothers were confined to the farthest corner and could not leave the wards even to bask in the sun (Muchiri *et al.*, 2010 [2020]).

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 totalled 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. The mother, Nancy Masara, reported that 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 (Green, 2018; Sellah, 2017).

Postpartum detention of women and their children for non-payment of user fees is a form of obstetric violence, infringing on the right to liberty and security through arbitrary confinement. Therefore, the next section shall explore the interaction between law, policies, and government in providing maternal health services. The paper shall follow Dawes' (2020) conceptualisation of politics as a determinant of health, which has three main pillars: voting, government, and policy. This section will illustrate the connection between laws, policies, politics, and postpartum detention, highlighting their overall effects on access to maternal healthcare. Relevant laws and policies on RMC in Kenya will be examined, along with the challenges of their implementation, to draw attention to how politics influences postpartum detention due to the inevitable relationship between government and policy (Dawes, 2020).

This section will 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 required to realise rights (Dawes, 2020).

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 (Kenya, 2010). Moreover, under Article 2(5), the Constitution of Kenya provides that general rules of international law that Kenya is a party must be part of the laws of Kenya, and the government is bound by those commitments (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.

Article 20(1) of the Bill of Rights specifically 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" (Kenya, 2010). These rights and fundamental freedoms are not subject to any limitation, except as provided by the law and only when the limitation is reasonable and justifiable in an open and democratic society (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 (Kenya, 2010). Therefore, in executing its mandate, the state must take all appropriate measures to realise the rights guaranteed in Article 43 (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 (Kenya, 2010). The right to health is also enshrined in Articles 46 and 53. Sadly, as much as the government has a duty to respect, protect, promote, 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 (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 Governments Act (Kenya, 2012a, Article 17). These provisions anchor the spirit of devolution and decentralise various services, such as healthcare, which is now the prerogative of county governments (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" (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 (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 their mandates (Kenya, 2010). Furthermore, an Equalisation Fund was also established for marginalised counties to cater to specific social services at a minimum of 0.5% of national government revenue (Kenya, 2010). The Equalisation Fund seeks to address inequities that may exist among counties because of historical injustices (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 (Kenya, 2017). Section 5 of the Act guarantees free maternal healthcare, which has been designated as a function of the county governments (Kenya, 2017, Section 5). Further, Section 6 of the Act holistically provides for the realisation of SRHR, including the right to access appropriate healthcare services related to obstetric care and the postpartum period (Kenya, 2017, Section 6).

Regarding health financing, section 86(1) of the Act provides that the Ministry of Health shall ensure progressive financial access to universal healthcare (Kenya, 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 important in this discourse on the right to health include the Public Finance Management Act and the County Governments Act, which provide for the development of plans that form the basis for all budgeting and spending in the country and the counties (Kenya, 2012b, Article 17). The Intergovernmental Relations Act is also relevant as it provides the framework for the relationship between the county and national governments (Kenya, 2012c, 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 (Kenya, 2010, Article 29; Emmah Muthoni Njeri v. Nairobi Women's Hospital, 2021; Tryphosa Jebet Kosgey v. Elgon View Hospital, 2016). Moreover, this protection is reinforced by virtue of Article 2(6) and (5), amongst others, in 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 (United Nation General Assembly, 1966). Under Article 9, everyone is guaranteed the right to freedom from arbitrary arrest or detention, except on such grounds as provided for in the domestic laws of a country and in a procedurally legal manner (United Nation General Assembly, 1966, Article 9).

Under Article 11, the ICCPR further safeguards debtors' right against arbitrary arrest by providing that imprisonment is illegal when carried out merely for an individual's inability to pay a debt or discharge a contractual obligation (United Nation General Assembly, 1966, 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, 1981, 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 (Organisation of African Unity, 1981). Additionally, the Maputo Protocol, under Article 4, guarantees every woman the right to integrity and security of their person and respect for their life (African Union, 2003, Article 4). State parties are also called upon to take all appropriate steps to ensure the elimination of all forms of exploitation, and cruel, inhumane, or degrading punishment and treatment (African Union, 2003, Article 4). The Protocol further calls upon member states to take both legislative and administrative measures to eliminate violence against women (VAW) in all its forms, both in private and in public (African Union, 2003).

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, and solving them has been impossible due to shortcomings in policy implementation, which is a political process (Petticrew *et al.*, 2009, p. 453-456). Access to quality maternal healthcare 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 the availability and accessibility from independence, financial access remains a persistent challenge (Masaba; Mmusi-Phetoe, 2020). OOP expenditure on health continues to significantly limit many pregnant persons from accessing healthcare services, as facility-based delivery remains one of the single most costly events during pregnancy (Borghi *et al.*, 2006, p. 1457-1465).

Building upon the discourse around political determinants of maternal health, this section will discuss maternal health financing initiatives by successive regimes to provide a reflection 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; Figueroa; Dawes, 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.

Since 1965, the Kenyan government has implemented several policy initiatives meant to facilitate free access to maternal healthcare services, especially for poor women (Chuma; Maina, 2012). Some of these initiatives include the Free Maternity Services Program of 1965, the Elimination of User Fee for Primary Care, the Beyond Zero Campaign launched in 2014, and the *Linda Mama* Program started 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; Maina, 2012). Unfortunately, like many other government projects, these health financing initiatives have encountered 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; Lelegwe, 2015, p. 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 person's access to quality public healthcare 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; Latif, 2015, p. 376-390). Thus far these programmes encompass

revenue collected by the state, social insurance – which in this case is composed of the National Hospital Insurance Fund (NHIF), private insurance, OOP payments, and foreign aid (Waris; Latif, 2015, p. 376-390).

Implementing health financing reforms for UHC is political (Sparkes *et al.*, 2019, p. 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; Maina, 2013, p. 6). Reducing OOP expenditure was meant to ensure that poor and other vulnerable groups have increased access to quality healthcare (Chuma; Maina, 2013). The government, through the Ministry of Health (MoH), committed about 35 million USD to fund the free maternal health policy and allocated a further 6.5 million USD to facilitate free access to primary healthcare services at health centres and dispensaries (Wanjiru; Maina, 2017). Additionally, a budget was set to reimburse public health facilities that were losing revenue because of this initiative (Wanjiru; Maina, 2017).

In the 2013 policy pronouncement, the national government was required to reimburse health facilities for the free maternity services that they handled (Kenya Ministry of Health, 2015, p. 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 (Kenya 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 (Kenya 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; Kamau; Muruka, 2017, p. 1-2). This conversely resulted in decreases of 11.9% in 2013 and 5.4% in 2014 in low-cost private hospital births (Njuguna; Kamau; Muruka, 2017, p. 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, p. 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; Gichangi; Mwanda, 2018, p. 77). Implementation challenges that affected the success of this program emerged, particularly the irregularity or lack of reimbursement of facilities that had provided maternal health services for free (Wamalwa, 2015, p. 375).

While, initially, facilities did indeed receive reimbursements for services delivered, the government progressively failed to honour their commitment (Tama *et al.*, 2018, p. 603-613). The facilities provided the services as required, but were not reimbursed, partly because funding from the MoH or national government was sometimes channelled through the county governments rather than directly to the facilities (Barasa *et al.*, 2017, p. 329-337). County

governments allocated these resources based on the priorities of the county bureaucrats, and quality maternal healthcare was not included on this list (Barasa *et al.*, 2017, p. 329-337).

Eventually, lack of maternal rebate compromised the quality of care, leaving those who sought maternal healthcare services uncertain about what aspects of the services were covered. Many were now forced to pay out-of-pocket for some services or were required to buy supplies from private clinics and pharmacies (Masaba; Mmusi-Phetoe, 2020). 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 (Masaba; Mmusi-Phetoe, 2020). The coverage, as initially envisioned, did not account for the entire pregnancy process. 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 the hurried implementation of free maternity services within the devolution structure, which was generally unplanned and lacked the appropriate structures needed to support the initiative. Although the policy did lead to an increase in the utilisation of maternal healthcare services at the health facility level, the implementation was poorly coordinated from the time of policy pronouncement to the commencement of the provision of free maternal healthcare services (Masaba; Mmusi-Phetoe, 2020). There was a complete disconnection 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 should have been provided (Masaba; Mmusi-Phetoe, 2020).

Before devolution, hospitals were mainly financed through revenue allocations from the national government and user fees (Barasa *et al.*, 2017, p. 329-337). However, with the advent of devolution, hospitals no longer received allocations from the national government (Barasa *et al.*, 2017, p. 329-337). These changes in financing systems interfered with hospitals' autonomy over their financial management, jeopardising service delivery (Barasa *et al.*, 2017, p. 329-337).

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 1966, the government has tried to provide a social health insurance scheme for Kenyans (Mwaura *et al.*, 2015). Through the 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; Lelegwe, 2015, p. 9-23). The NHIF, as a policy initiative, was envisioned to cushion employed citizens from the heavy costs associated with healthcare (Chuma; Okungu, 2011, p. 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 working in the informal sector, as well as all formally employed adult 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, the 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, p. 329-337).

With regard to free maternity care, the previous government transferred the initiative to the NHIF in 2016 to ensure sustainability (Kenya Ministry of Health, 2016). This move was supposed to expand coverage to private for-profit facilities and faith-based providers, with the intention to provide more options for maternity care to as many women as possible (Kenya Ministry of Health, 2016). The move was also meant to help improve the logistical efficiency in reimbursing facilities that were initially absent from the roll (Abuya *et al.*, 2018). Unfortunately, like other government initiatives, the NHIF failed to comprehensively and efficiently provide free maternal healthcare services. The provision of maternal healthcare services under the NHIF was rebuked for delivering substandard healthcare services in accredited facilities, introducing a cumbersome claim process, and providing 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, but it has done so with little success. As a result, in 2023, the government introduced a bill to replace the NHIF with a newly proposed Social Health Insurance Fund (SHIF) (Aradi, 2023). The Social Health Insurance Act (Kenya, 2023a) was enacted together with the Primary Health Care Act (Kenya, 2023b), the Digital Health Act 15 of 2023 (Kenya, 2023c), and the Facilities Improvement Financing Act (Kenya, 2023d), 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 (Kenya, 2023a). Under the SHIF, three funds are created: the Primary Health Care Fund, the Social Health Insurance Fund, and the Emergency, Chronic, and Critical Illness Fund, all of which are managed by the Social Health Authority. The SHIF requires all employed individuals to make mandatory contributions of 2.75% of their income to the fund, while self-employed or unemployed Kenyans will contribute 2.31 USD in a graduated arrangement based on their contribution ability (Kenya, 2023a). The SHIF is to replace the NHIF and has, in the 2024-2025 budgetary allocation, received 181,720,000 USD in addition to the initial USD 144,760,000 allocated for UHC in 2023-2024 (Republic of Kenya National Assembly, 2024).

The increased budgetary allocation fot the SHIF, albeit welcome, cannot be celebrated and is not expected to contribute much to the realisation of UHC. The allocation comes against the backdrop of a decreased 2024-2025 health financing budget, which was reduced from 1,090,346,400 USD in the 2023-2024 fiscal year to 980,694,000 USD, a cut of 109,652,400 USD. This reduction comes against the backdrop of a previous cut of 43,243,200 USD, which

reduced health funding from 1,133,589,600 USD in 2022-2023 to 1,090,346,400 USD in 2023-2024 (Saya, 2023). The SHIF was set to take effect from the first of July 2024 but has since been postponed, following the Senate's decision that the Social Health Insurance General Regulations, 2024, and the Social Health Insurance Tribunal Procedure Regulations, 2024, be annulled for lack of public participation (Mwere, 2024).

Moreover, the funding for the free maternal health program under the *Linda Mama* initiative has also been reduced by half, from 4 billion to 2 billion Kenyan shillings, 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 (Kenya 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 (Kenya Ministry of Health, 2016).

Linda Mama is a scheme publicly funded through the MoH that provides a free package of antenatal, delivery, and postnatal healthcare 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 expenses will result in them being at risk for 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, and this includes 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; Fox; Scott-Samuel, 2005; Kickbusch, 2015, p. 1-2). 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, which 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 healthcare slashed by half, it is difficult to believe there is a genuine effort to reduce the OOP expenditure on maternal healthcare. 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 the ability to access healthcare services is determined by people's purchasing power.

To counter these challenges, a clear and comprehensive fiscal policy plan and guidelines 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 of the above, the mandate to provide healthcare 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 healthcare. 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 to execution of proper health governance frameworks that will establish a sustainable health financing plan that does not rely on user fees or donor funding.

REFERENCES

ABUYA, Timothy *et al.* Measuring Mistreatment of Women throughout the Birthing Process: Implications for Quality of Care Assessments. *Reproductive Health Matters*, [*s.l.*], v. 26, n. 53, p. 48-61, Sept. 2018. DOI: 10.1080/09688080.2018.1502018

AFRICAN UNION. *Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa*. 2003. Available at: https://au.int/sites/default/files/treaties/37077-sl-PROTOCOL_TO_THE_AFRICAN_CHARTER_ON_HUMAN_AND_PEOPLES_RIGHTS_ON_THE_RIGHTS_OF_WOMEN_IN_AFRICA.pdf. Accessed on: Nov. 7th, 2024.

ARADI, Gloria. Kenya Healthcare: President William Ruto Signs Controversial UHC Bills. *BBC News*, Nairobi, 19 Oct. 2023: Available at: https://www.bbc.com/news/world-africa-67154659.

ARKSEY, Hillary; O'MALLEY, Lisa. Scoping Studies: Towards a Methodological Framework. *International Journal of Social Research Methodology*, [*s.l.*], v. 8, n. 1, p. 19-32, 2005.

BAMBRA, Clare; FOX, Debbie; SCOTT-SAMUEL, Alex. Towards a Politics of Health Promotion. *Health Promotion International*, [*s.l.*], v. 20, n. 2, p. 187-93, Jun. 2005.

BARASA, Edwine W. *et al*. Setting Healthcare Priorities: A Description and Evaluation of the Budgeting and Planning Process in County Hospitals in Kenya. *Health Policy Plan*, [*s.l.*], v. 32, n. 3, p. 329-337, April 2017. DOI: 10.1093/heapol/czw132

BOHREN, Meghan A. *et al*. Facilitators and Barriers to Facility-Based Delivery in Low-and Middle-Income Countries: A Qualitative Evidence Synthesis. *Reproductive Health*, [*s.l.*], v. 11, n. 71, p. 1-17, Sept. 2014.

BORGHI, Jo *et al*. Mobilising Financial Resources for Maternal Health. *Lancet*, [*s.l.*], v. 368, p. 1457-1465, 2006.

BOWSER, Diana. Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis. Washington, DC: Harvard School of Public Health; University Research, 2010.

BRAVEMAN, Paula. Health Disparities and Health Equity: Concepts and Measurement. *Annual Review of Public Health*, [*s.l.*], v. 27, p. 167-194, Apr. 2006.

CENTER FOR REPRODUCTIVE RIGHTS (CRR); THE FEDERATION OF WOMEN LAWYERS-KENYA (FIDA). Failure to Deliver, Violations of Women's Human Rights in Kenyan Health Facilities. New York: CRR; Nairobi: FIDA, 2007.

CHUMA, Jane; MAINA, Thomas. *Free Maternal Care and Removal of User Fees at Primary-Level Facilities in Kenya*: Monitoring the Implementation and Impact—Baseline Report. Washington, DC: Health Policy Project, Futures Group, 2013.

CHUMA, Jane; MAINA, Thomas. Catastrophic Healthcare Spending and Impoverishment in Kenya. *BMC Health Services Research*, [*s.l.*], v. 21, n. 12, Nov. 2012. DOI: 10.1186/1472-6963-12-413

CHUMA, Jane; OKUNGU, Vincent. Viewing the Kenyan Health System through an Equity Lens: Implications for Universal Coverage. *International Journal for Equity in Health*, [*s.l.*], v. 10, n. 22, p. 1-14, May 2011.

COMMISSION ON SOCIAL DETERMINANTS OF HEALTH. *Closing the Gap in a Generation*: Health Equity Through Action on the Social Determinants of Health. Geneva: WHO, 2008. Available at: https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1. Accessed on: Nov. 7th, 2024.

COWGILL, Karen D.; NTAMBUE, Abel Mukengeshayi. Hospital Detention of Mothers and their Infants at a Large Provincial Hospital: A Mixed-Methods Descriptive Case Study, Lubumbashi, Democratic Republic of the Congo. *Reproductive Health*, [*s.l.*], v. 16, n. 111, p. 1-15, Jul. 2019.

COWLING, Natalie. Extreme Poverty Rate in Kenya 2016-2030. *Statista*, Mar. 2024. Available at: https://www.statista.com/statistics/1227076/extreme-poverty-rate-in-kenya/.

DAWES, Daniel. *The Political Determinants of Health*. Baltimore, MD: Johns Hopkins University Press Books, 2020. Available at: https://jhupbooks.press.jhu.edu/title/political-determinants-health.

Emmah Muthoni Njeri v. Nairobi Women's Hospital, 2021.

Gideon Kilundo & Daniel Kilundo Mwenga v. Nairobi Women's Hospital. eKRL, 2018.

GITOBU, C. M.; GICHANGI, P. B.; MWANDA, W. O. The Effect of Kenya's Free Maternal Health Care Policy on the Utilization of Health Facility Delivery Services and Maternal and Neonatal Mortality in Public Health Facilities. *BMC Pregnancy Childbirth*, [*s.l.*], v. 18, n. 77 p. 1-11, 2018.

GREEN, Duncan. What's Your Link to Bereaved Kenyan Mother, Judith Amoit? *From Poverty to Power*, Jan. 17, 2018. Available at: https://frompoverty.oxfam.org.uk/whats-your-link-to-bereaved-kenyan-mother-judith-amoit/. Accessed on: Nov 7th, 2024.

KENYA. *Report on the Consideration of the Estimates of Revenue and Expenditure FY 2024 2025 and the Medium Term*. Nairobi, Jun. 2024. Available at: http://parliament.go.ke/sites/default/files/2024-06/Report%20on%20the%20Consideration%20of%20the%20Estimates%20of%20Revenue%20and%20Expenditure%20FY%202024%202025.pdf.pdf. Accessed on: Nov. 7th, 2024.

KENYA. *The Social Health Insurance Act*, 2023a.

KENYA. *The Primary Health Care Act 13*, 2023b.

KENYA. *Digital Health Act 15*, 2023c.

KENYA. *The Facilities Improvement Financing Act,* 2023d.

KENYA. *Health Act No. 21*, 2017.

KENYA. *County Governments Act No. 17*, 2012a.

KENYA. *The Public Finance Management Act*, 2012b.

KENYA. *Intergovernmental Relations Act*, 2012c.

KENYA. *The Constitution of Kenya*, 2010.

KENYA MINISTRY OF HEALTH. *Linda Mama Implementation Manual for Programme Managers*. Dec. 2016. Available at: http://guidelines.health.go.ke/#/category/27/304/meta. Accessed on: Nov. 7th, 2024.

KENYA MINISTRY OF HEALTH. Status of Implementation of Free Maternity Services (FMS) Program in the Devolved Health System in Kenya: A Comprehensive Assessment Report. Jan. 2015.

KIAGE, Nyaboga. Pupil New Mothers Hit Hard by Nurses' Strike. *Nation* [online], Sep. 17, 2017. Available at: https://www.nation.co.ke/news/Pupil—new-mOthers-hit-hard-by-nurses—strike/1056-4099320-l2107f/index.html. Accessed on: Nov. 7th, 2024.

KICKBUSCH, Ilona. The Political Determinants of Health—10 years on. *BMJ*, [*s.l.*], v. 350, p. 1-2, Jan. 2005. DOI: 10.1136/bmj.h81

KRUK, Margaret E. *et al.* High-Quality Health systems in the Sustainable Development Goals Era: Time for a Revolution. *The Lancet Global Health Commission*, [*s.l.*], v. 6, p. 1196-1252, 2018. DOI: http://dx.doi.org/10.1016/ S2214-109X(18)30386-3

KUTZIN, Joseph; YIP, Winnie; CASHIN, Cheryl. Alternative Financing Strategies for Universal Health Coverage. *In*: SHEFFLER, Richard M. (ed.). *World Scientific Handbook of Global Health Economics and Public Policy*. [*S.l.*]: World Scientific, 2016. v. 1. DOI: https://doi.org/10.1142/9789813140493_0005

KYEI-NIMAKOH, Minerva *et al*. Access barriers to obstetric care at health facilities in sub-Saharan Africa—a systematic review. *Systematic Reviews*, v. 6, n. 110, June 2017. DOI:10.1186/s13643-017-0503-x

MASABA, Brian Barasa; MMUSI-PHETOE, Rose M. Free Maternal Health Care Policy in Kenya; Level of Utilisation and Barriers. *International Journal of Africa Nursing Sciences*, [*s.l.*]. v. 13, 100234, 2020.

MUCHIRI, Karanja *et al.* Shame of Newborns Detained in Kenyan Hospitals. *Nation* [online], Oct. 8, 2010 (updated in Jul. 2020). Available at: https://nation.africa/kenya/news/shame-of-newborns-detained-in-kenyan-hospitals-740516#google_vignette. Accessed on: Nov. 7th, 2024.

MWABU, Germano Mwiga *et al*. User Charges in Government Health Facilities in Kenya: Effect on Attendance and Revenue. *Health Policy and Planning*, [*s.l.*], v. 10, n. 2, jun. 1995.

MWAWASI, Mkamburi. Premature Triplets Detained at a Mombasa Hospital over Ksh2m Bill. *The Standard* [online], Aug. 2017. Available at: https://www.standardmedia.co.ke/health/article/2001251641/woman-and-triplets-held-over-sh2m-bill. Accessed on: Nov. 7th, 2024.

MWERE, David. New Blow to Ruto Health Plan as Senate Rejects New Regulations. *The Standard*, Jun. 2024.

NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE; HEALTH AND MEDICINE DIVISION; BOARD ON POPULATION HEALTH AND PUBLIC HEALTH PRACTICE; COMMITTEE ON COMMUNITY-BASED SOLUTIONS TO PROMOTE HEALTH EQUITY IN THE UNITED STATES. *Communities in Action*: Pathways to Health Equity. Edited by BACIU A et al. Washington, DC: National Academies Press, 11 Jan. 2017. Chapter 3, The Root Causes of Health Inequity. Available at: https://www.ncbi.nlm.nih.gov/books/NBK425845/.

NJUGUNA, John; KAMAU, Njoroge; MURUKA, Charles. Impact of Free Delivery Policy on Utilization of Maternal Health Services in County Referral Hospitals in Kenya. *BMC Health Services Research*, [*s.l.*], v. 17, n. 1, 2017.

OKAFOR, Innocent I.; UGWU, Emmanuel O.; OBI, Samuel N. Disrespect and Abuse During Facility-Based Childbirth in a Low-Income Country. *International Journal of Gynaecology and Obstetrics*. [*s.l.*], v. 2, n. 128, p. 110-113, 2015.

OKECH, Timothy Chrispinus; LELEGWE, Steve Ltumbesi. Analysis of Universal Health Coverage and Equity on Health Care in Kenya. *Global Journal of Health Science*, Ontario, v. 8, n. 7, p. 218-227, Dec. 2015. DOI: 10.5539/gjhs.v8n7p218

Omuya and Oliele v. Attorney General, 2012.

ONAMBELE, Luc *et al*. Trends, Projections, and Regional Disparities of Maternal Mortality in Africa (1990-2030): An ARIMA Forecasting Approach. *Epidemiologia*, Basel, v. 4, n. 3, p. 322-351, Aug. 2023. DOI: 10.3390/epidemiologia4030032

ORGANIZATION OF AFRICAN UNITY. *African Charter on Human and Peoples' Rights*. 1981. Available at: https://au.int/sites/default/files/treaties/36390-treaty-0011_-_african_charter_on_human_and_peoples_rights_e.pdf. Accessed on: Nov. 7th, 2024.

PETTICREW, Mark *et al.* Cochrane Update: Better Evidence about Wicked Issues in Tackling Health Inequities. *Journal Public Health*, [*s.l.*], v. 31, p. 453-456, 2009.

REPUBLIC OF KENYA NATIONAL ASSEMBLY. Report on the Budget Policy Statement for Financial Year 2024/2025 and the Medium Term. Nairobi, Mar. 2024. Available at: http://www.parliament.go.ke/sites/default/files/2024-03/Report%20of%20the%20Budget%20Policy%20Statement%20for%20FY%202024-25%20and%20the%20Medium%20Term_0.pdf. Accessed on: Nov. 7th, 2024.

SAYA, Magdaline. Health Sector Gets Sh5.6bn Funding Cut In 2023-24 Budget. *The Star Newspaper*, Jun. 2023. Available at: https://www.the-star.co.ke/news/realtime/2023-06-15-health-sector-receives-sh56bn-funding-cut-in-2023-24-budget/.

SELLAH, Maris. Injustices against Delivering Mothers Still Rife. *Health Business* [online], Dec. 21th, 2017. Available at: https://healthbusiness.co.ke/342/injustices-against-delivering-mothers-still-rife-report/. Accessed on: Nov. 7th, 2024.

SPARKES, Susan P. *et al.* Political Economy Analysis for Health Financing Reform. *Health System & Reform*, [*s.l.*], v. 5, n. 3, p. 183-194, 2019.

TAMA, Eric *et al.* Examining the Implementation of the Free Maternity Services Policy in Kenya: A Mixed Methods Process Evaluation. *International Journal of Health Policy and Management*, Kerman, v. 7, n. 7, p. 603-613, Jul. 2018.

Tryphosa Jebet Kosgey v. Elgon View Hospital, 2016.

UNITED NATIONS GENERAL ASSEMBLY. *International Covenant on Economic, Social and Cultural Rights*. Dec. 16, 1966. United Nations Treaty Series 13. Available at: https://www.ohchr.org/sites/default/files/cescr.pdf. Accessed on: Nov 7th, 2024.

VELASQUEZ, David E.; FIGUEROA, José F.; DAWES, Daniel E. Health Institutions and the Political Determinants of Health. *American Journal of Preventive Medicine*, Ann Arbor, v. 63, n. 5, p. 861-864, Nov. 2022. DOI: 10.1016/j.amepre.2022.04.033

VICTORA, Cesar G. *et al*. How Changes in Coverage Affect Equity in Maternal and Child Health Interventions in 35 Countdown to 2015 Countries: An Analysis of National Surveys. *Lancet*, [*s.l.*], v. 380, p. 1149-1156, 2012. DOI: 10.1016/S0140-6736(12)61427-5

WAMALWA, Emmanuel Wekesa. Implementation Challenges of Free Maternity Services Policy in Kenya: The Health Workers' Perspective. *Pan African Medicine Journal*, [*s.l.*], v. 14, n. 22, p. 375, Dec. 2015. DOI: 10.11604/pamj.2015.22.375.6708

WANJIRU, Monica; MAINA, Thomas. Supporting the Launch of Kenya's Free Maternity Care Programme. Washington, DC: Palladium, Health Policy Plus, 2017. Available at: http://www.healthpolicyplus.com/pubs.cfm?get=11287. Accessed on: Nov. 7th, 2024.

WANYORO, Charles. Four Mothers, Newborns Locked in Basement Room over Sh400k Bill – VIDEO. *Nairobi News* [online], Jan. 31th, 2017. Available at: https://nairobinews.nation.co.ke/news/four-mOthers-newborns-locked-in-basement-room-over-sh400k-bill-video. Accessed on: Nov. 7th, 2024.

WARIS, Attiya; LATIF, Laila Abdul. Towards Establishing Fiscal Legitimacy Through Settled Fiscal Principles in Global Health Financing. *Health Care Analysis*, [*s.l.*], v. 23, n. 4 p. 376-90, Dec. 2015. DOI: 10.1007/s10728-015-0305-z

WHITE RIBBON ALLIANCE. *Building a Movement*: A History of White Ribbon Alliance 1999-2019. Liverpool: White Ribbon Alliance, 2022. Available at: https://whiteribbonalliance.org/wp-content/uploads/2022/10/WRA-Book-of-Wins_10.10.22.pdf.

WHITEHEAD, Margaret. The Concepts and Principles of Equity and Health. *International Journal of Health Services*, [*s.l.*], v. 22, n. 3, p. 429-445, 1992.

WORLD HEALTH ORGANIZATION (WHO). *Statement on the Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth*. World Health Organization, 2015.

WORLD HEALTH ORGANIZATION (WHO). *The World Health Report*: Health Systems Financing: The Path to Universal Coverage. World Health Organization, 2010. Available at: https://iris.who.int/handle/10665/44371. Accessed on: Nov. 7th, 2024.

WORLD HEALTH ORGANIZATION (WHO). *Sustainable Health financing, Universal Coverage and Social Health Insurance*: World Health Assembly Resolution WHA58.33, 2005.

WORLD HEALTH ORGANIZATION (WHO). *The World Health Report 2000: Health Systems*: Improving Performance. Fifty-Third World Health Assembly A53/4. [*S.l.*]: World Health Organization, 2000.

YATES, Robert; BROOKES, Tom; WHITAKER, Eloise. *Hospital Detentions for Non-payment of Fees*: A Denial of Rights and Dignity. Research Paper. London: Chatham House, 2017.

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