

**Local Perceptions of Social Protection Schemes in Maternal Health in Kenya: Ethnography
in Coastal Kenya**



PhD Thesis of

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Abstract

The long-term goal of social protection programmes in the developing world is to reduce the intergenerational transmission of poverty, which depends on household investing in human capital, labour, and productive assets. The purpose of this thesis was to explore local perceptions of social protection schemes in maternal health in Kenya. It is based on nine months of ethnographic fieldwork conducted in rural villages in Kilifi County in Coastal Kenya. The focus was on the poor women's and health practitioners' views and experiences on maternal health care initiatives and its contradictions. The focus on maternal health care initiatives focused on the two social protection schemes that are maternal vouchers and free maternity. From the poor women's and health practitioners' perspective the thesis critically explored variation in experiences in utilizing social protection schemes in maternal health care. Through the analysis of such perceptions, the thesis shows different coping mechanisms that poor women resort to if they cannot afford health care. The thesis furthermore explores whether those coping strategies enhance social protection objectives or push women further into poverty. Moreover, health practitioners' coping mechanisms amidst changing approaches in financing maternal health care are also discussed.

The thesis is divided into nine chapters, grouped into two parts. The first part contains an introduction which contains a description of social protection schemes in Kenya, theoretical framework and data collection, ethical considerations and ethical dilemmas in the field. The second part contains the eight ethnographic chapters and conclusion of the thesis. This thesis has described how the international actors shaped the adoption of social protection schemes in Kenya with the aim of reducing maternal and child mortality rates. Such schemes also were to prevent households from sinking deeper into poverty. The main social protection schemes discussed in this thesis are the free maternity services and the maternal vouchers also known as out-put-based aid (OBA). Indeed, from the emic perspective, these programmes had good intentions. However, there were an array of challenges that hindered smooth operations of the two programs. While OBA was introduced in 2006 allowed the poor pregnant women to utilize all antenatal and postnatal services in accredited public and private health facilities, it emerged that free maternity introduced in 2013 helped all pregnant women to access free delivery in public health facilities. From this thesis, it is clear that OBA was not accessible to the poorest women as they had low bargaining power while the wealthy women shaped the rule-of-game of access to OBA hence accessed it easily.

Nevertheless, health workers noted that despite challenges in maternal health, they preferred OBA to free maternity. Both health workers, policy implementers at the county level, and the mothers in this study noted that free maternity was never free as mothers had to incur hidden costs which led to catastrophic health expenditure hence making them sink deeper into poverty. Health workers expressed their displeasure with non-clear policy guidelines on the package of free maternity and that they were not aware of which components the policy covered apart from the free deliveries. Delays in reimbursement of funds, massive corruption in the health sector, burnouts, shifting blame, long-term health workers' strike and politicization of free maternity made the policy ineffective in achieving the sustainable development goals. Free maternity was labeled what James Ferguson referred to as an anti-politics machine where the respondents accused the state as using free distribution of things not out of trying to bring betterment but for the reason to buy votes. Additionally, James Scott's (1985) arguments also help in explaining how health workers used the weapons of the weak to deal with frustrating situations.

More mothers sought services in public health facilities since OBA was no longer there. After realizing that free maternity was expensive, mothers retreated from seeking services in the public health facilities or instead some mothers attended clinics once and resorted to traditional midwives and sometimes only re-appears for delivery with complicated labour. Apart from catastrophic health expenditures, gender dynamics also played a critical role in skilled deliveries. The poor mothers negotiated continuous access to maternal health care by adopting different mechanisms of access as discussed in this thesis. Therefore, women choose maternal health programs that were advantageous to them based on their knowledge and power to re-negotiate for access to such services. Peasant economic and feminist theories have been used to analyze household relation and gender roles further and how women bore 'triple burden' responsibilities which led to unequal distribution of unpaid care work between women and men which then represent a brake on women's economic empowerment and influences gender gaps in social protection outcomes in maternal health care. In this regards, therefore, this thesis presents at least five ideal typologies of emic alternatives to financing health care which sheds more light on institutionalized gendered strategies, and types of resistance mothers develop to still profit from the maternal health services. The theoretical categorization of the five cases were about the husband's availability or not and their efforts in supporting the woman. This thesis also describes the socio-cultural meaning of giving birth and practices related to giving birth and the

implications of the cultural practices such as those discouraging giving birth in the hospitals and their effects on social protection practices. It emerged that majority of women preferred delivering their first born babies at home to bury their placenta in the ancestral soil. Therefore, homebirth processes were considered a cultural practice in its own right. However, this had its effects on social protection in maternal healthcare. Despite drawbacks and to make social protection in maternal health programmes in Kenya contribute to the inclusive development and based on the general outlook of this thesis, to restore ‘trust’ there is a need to make maternal healthcare participatory in Kenya. This calls for a bottom-up institution building approach which is a conscious process of initiating institution building from below which does not suffer from the drawbacks of top-down imposed processes of democratization, devolution, and participation, which are often subject to processes of elite capture. This, therefore, anchors my arguments on a recent anthropological theory of bottom-up institution building process called constitutionality. Additionally, I also suggest that social accountability and modification of roles of the TBAs from ‘unrecognized village TBAs’ to ‘village maternal health workers (VMHWs)’ whose responsibilities would mainly be to promote perinatal care and institution-based delivery of pregnant women would also be ideal to strengthen social protection through maternal health. Therefore, the empirical findings of this thesis may contribute to an emic understanding of social protection in maternal health in contexts with almost similar characteristics as villages in Kilifi County in Kenya.

Table of Contents

Acknowledgments.....	ii
Abstract.....	v
Table of Contents.....	viii
List of Figures.....	xi
Acronyms.....	xii
CHAPTER ONE: Introduction.....	1
1.1 Background Information.....	1
1.2 Social Protection in Maternal Health.....	5
1.3 Emergence of Healthcare Financing and Free Maternity in Kenya.....	10
1.4 Maternal Voucher Services-Output Based Aid (OBA).....	15
1.5 Theoretical Orientations.....	18
1.5.1 New Institutionalism.....	18
1.5.2 Peasant Economic Theory and Neo-Marxist Approaches.....	21
1.5.3 Constitutionality.....	23
1.6 Research Context and Methodology.....	25
1.6.1 Study Area.....	25
1.6.2 Data Collection Methods.....	28
1.6.3 Ethical Considerations, Data Analysis and Presentation.....	30
1.7 My Position in the Field and Ethical Dilemmas Interviewing Poor Mothers.....	30
1.8 Specific Research Questions.....	33
1.9 Hypothesis.....	34
CHAPTER TWO: How Free are Free Maternity Services in Kenya? Playing the Anti-Politics Machine in the New Politics of Distribution.....	35
2.0 Introduction.....	35
2.1 The Influence of International Actors on Maternal Healthcare in sub-Saharan Africa Today.....	36

2.2 Perspectives of the Economically Disadvantaged Women and Local Households on Free Maternity Services	42
2.3 Perspectives of Health Workers in the Health Facilities and the Policy Makers	47
2.3.1 Likelihood of Compromised Quality of Care	51
2.4 Shifting the Blame	57
CHAPTER THREE: The Politics of New Distribution as Undermining Public and Developing Private Health Services	61
3.0 Introduction.....	61
3.1 New Institutional Development in Financing Maternal Healthcare in Kenya	61
3.2 Perspectives of Local People on Changing Approaches to Maternal Health Financing.....	64
3.3 Perspectives of Health Workers on Changing Approaches to Maternal Healthcare Financing.....	67
CHAPTER FOUR: Emically Recognizing the Anti-Politics Machine: Perceptions of Maternal Healthcare Programs as a Social Protection mechanism in Kenya	74
4.0 Introduction.....	74
4.1 Views of Frontline Health Workers and Policymakers.....	74
4.1.1 Devolution of Healthcare is Good but also Politicized.....	80
4.2 Views of the Poor Women’s and Households in the Village on Maternal Healthcare Programs as Social Protection Schemes.....	84
CHAPTER FIVE: Alternatives to Financing Maternal Health: An Emic Household and Gendered Perspective	91
5.0 Introduction.....	91
5.1 Resources Allocation in a Poor Household in Giriama Community	92
5.2 Reciprocal Arrangement with Neighbours based on Reliable Migrant Husband (.....	96
5.3 Multiple Reproduction Roles and Selling own Production with Present Non-helping Husband ...	101
5.4 Relying on TBA with Husband not Present and not Helping	104
5.5 Relying on Resources from Reliable Migrant Husband	108
5.6 Using own Limited Resources and Help of Present Husband	110
CHAPTER SIX: Contesting and Shopping Institutional Options on the Utilization of Maternal Healthcare	115

6.0 Introduction.....	115
6.1 Gender Lens and Social Protection	115
6.2 The Impacts of Gender Roles on the Utilization of Maternal Health Care Services	118
CHAPTER SEVEN: The Socio-Cultural Conceptualization of Birthing: Reflections from the Field	131
7.0 Introduction.....	131
7.1 Socio-Cultural Practices and Beliefs on Birthing	132
7.1.1 Pregnancy as a Journey Embedded on Cultural Beliefs	133
CHAPTER EIGHT: An outlook: How to Make Maternal Healthcare More Participatory in Kenya	139
8.1 Introduction	139
8.3 Constitutionality.....	143
8.4 Ways Forward	151
CHAPTER NINE: Conclusions	156
9.1 Summary of the Empirical Chapters	156
References.....	163

List of Figures

Figure 1. 1 History of user fees policies in Kenya.....	14
Figure 1. 2 Modeling Change	20
Figure 1. 3 Map of Kilifi County	26
Figure 1. 4 Coconut Palm Trees and Other Crops	184
Figure 2. 1 Media Publication Report.....	50
Figure 2. 2 Circular from the Ministry of Health on Free maternity Policy	56
Figure 2. 3 Publication Depicting Shifting the Blame	59
Figure 2. 4 Key political pledges of the ruling government in 2017 campaigns	183
Figure 4. 1 Stolen Millions of shillings	79

Acronyms

AAA: The American Anthropological Association

CHVs: Community Health Volunteers

EAC: East African Community

FGD: Focus Group Discussion

FHCF: Free Health Care Financing

FMS: Free Maternity Services

FP: Family Planning

GBVRS: Gender-Based Violence Recovery Services

GDP: Gross Domestic Product

GoK: Government of Kenya

ILO: The International Labour Organization

IFRA: French Institute for Research in Africa

KII: Key Informant Interview

KNBS: Kenya National Bureau of Statistics

MCH: Maternal Child Health

MoH: Ministry of Health

NHIF: National Hospital Insurance Fund

OBA: Output-Based Aid/ Maternal voucher

OOP: Out-of-Pocket

SDGs: Sustainable Development Goals

SHI: Social Health Insurance

SM: Motherhood

SPFI: Social Protection Floor Initiative

SPIKE: Social Protection in Maternal Health Programs in Kenya

TBAs: Traditional Birth Attendants

TFR: Total Fertility Rate

UHC: Universal Health Coverage

UN: United Nations

UNDP: The United Nations Development Programme

UNICEF: The United Nations Children's Fund

UNSDSN: United Nations Sustainable Development Solutions Network

WHA: World Health Assembly

WHO: World Health Organization

CHAPTER ONE: Introduction

1.1 Background Information

The local perceptions of health risk and prevention influence an individual's decision-making and choices to use biomedical health services (Obermeyer, 2001). However, the biomedical models of health do not necessarily account for the impact of the cultural factors (i.e., beliefs, values, and gender) that shape reproductive behaviour and practices. Cultural beliefs shape a range of factors that affect reproductive health, including fertility patterns, contraceptive use, maternal health-seeking behaviour, and choice of birth attendant (Helman, 2007). As a result, different cultures understand and manage birth in their ways (Tremayne, 2001; Obermeyer, 2001). Therefore, in this dissertation, an emic perspective, a perspective that analyzes people's choices using their cultural concepts and categories helps to explore the locals' understandings of social protection schemes in maternal health on the basis that different cultures understand maternal healthcare and manage birth in their ways.

About 830 women die from either pregnancy or childbirth-related complications around the world every day. In 2015, approximately 303 000 women died during and following pregnancy and childbirth. Almost all of these deaths occurred in low-resource settings, yet most could have been prevented (WHO, 2016). All people aspire to receive quality and affordable health care. Universal health coverage (UHC)¹ therefore, has been a priority policy agenda worldwide and is one of the Sustainable Development Goals (SDGs) (World Health Organization [WHO], 2010).

¹ Universal health coverage is a priority on the global development agenda, as demonstrated by its inclusion in the Sustainable Development Goals. Despite the global support for universal health coverage, how to reach this objective in poor countries remains highly debated (WHO 2010).

The World Health Organization (2010) defined UHC as “ensuring that all people can use the promotive, preventative, curative and rehabilitative health services they need, of sufficient quality to be effective, while ensuring that the use of these services does not expose the user to financial hardship” (Prince, 2017). Recognising its importance, Prince (2017) identifies UHC as the single unique model that has the ability to “move countries away from cost-sharing policies...towards universal access to free or heavily subsidized health care”. She conceives UHC as both progressive and comprehensive in its approach in that it can enhance social protection and welfare mechanisms of the poor people. This is because it “announces solidarity”, accomplishes redistribution means by the government, and models health as a public good. To her, UHC largely imposes a responsibility on the state by ensuring that health care is accessible to all without suffering financial hardship when paying for them (Walker et al, 2009).

The SDG3, where UHC falls, is driven by the need for improved access to quality health services for all and protection of the population from catastrophic and impoverishing health care costs (United Nations, 2015). UHC has two primary goals: enhance financial risk protection and increase access to needed care for citizens (WHO, 2010).

Improving maternal health is one of WHO's top priorities and also embedded in the objectives of the UHC (WHO, 2010). During the seventieth World Health Assembly meeting in Geneva in May 2017, preventing maternal deaths was one of the priority agenda (WHO, 2017). There was a strong recommendation that all States should develop national and sub-national financing strategies with clear timelines that contribute directly to the realization of rights, including Universal Health Coverage. These policies should apply the human rights principles of equality, inclusiveness, non-discrimination, and participation. Redress should be available where these universal standards were not reasonably met. States should take steps to allocate at least 5% of GDP for public health spending, which is the recognized prerequisite for Universal Health Coverage (WHO, 2017).

Due to an international call for a possible reduction of maternal deaths and seeing that it is feasible to accelerate the decline, countries have now united behind a new target to reduce maternal mortality even further. One target under Sustainable Development Goal 3 is to reduce the global maternal mortality ratio (chance of dying during pregnancy or within 42 days of delivery) to less than 70 per 100 000 births, with no country having a maternal mortality ratio of more than twice the global average (WHO, 2015). Today, different countries have adopted various health financing strategies. One of such approaches is Free Health Care Financing (FHCF) policies aiming to reduce the financial barriers that people experience when trying to access health services. An FHCF policy eliminates formal user fees at the point of service this can be for all services, for primary health care, for selected population groups, for selected services for everyone or selected services for specific population groups, usually characterized by medical or economic vulnerability (WHO, 2017). Therefore, by 2030, no country should have a maternal mortality ratio higher than 140 maternal deaths per 100,000 live births, a number

twice the global target. It, therefore, means that each country should have mechanisms for reducing maternal mortality.

Despite historical achievements in maternal and child health in the past decade (WHO, 2015), many low- and middle-income countries remain far behind their high-income counterparts. Although the global maternal mortality ratio dropped from 385 deaths per 100 000 live births in 1990 to 216 per 100 000 live births in 2015 (Alkema et al. 2016), such a statistic masks substantial regional variability. In sub-Saharan Africa, the number of countries has reduced by a half the levels of maternal mortality since 1990. In 2015, the maternal mortality ratio in sub-Saharan Africa was 546 per 100 000 live births, nearly 50 times the rate in high-income countries (WHO, 2015; Alkema et al. 2016).

In many developing countries, the quantity and quality of maternity care within public health systems is low and therefore economically disadvantaged populations, who are at higher risk of maternal mortality, underutilize them (Huntingdon, 2008; Koblinsky, Campbell and Heichelheim, 1999). Women in these settings face many barriers to accessing care including distance, transportation, cost, perceived poor quality or actual poor quality (World Bank, 1999; WHO, 2015). Perceived or actual poor quality of services leads to low levels of utilization, and that low utilization of services contributes to decreased investment in the quality of the services (Parkhurst and Ssengooba, 2009). While these issues are not exclusive to public systems, they are exacerbated at public facilities where overworked and underpaid health workers struggle to provide services without adequate supplies. Patients who seek services at these facilities are often faced with long queues, unavailable medication or supplies, and unmotivated or absent providers and end up using public facilities only in dire emergencies (Mackintosh and Tibandebage, 2006).

In many countries, the quality of a public health system is influenced by the amount of funding from international donors. International aid is traditionally funneled through local ministries of health and into the public health system with the hopes of reaching the poor and underserved. Through international aid, many sub-Saharan Africa introduced different health financing

programs to increase access to responsive and quality maternal and perinatal health care while providing financial protection. However, the unpredictability of costs related to maternal health care has remained one of the major barriers to seeking health care in many low-income sections of the society (Ensor and Ronoh, 2005; Amin, Shah, and Becker, 2010; Kifle et al. 2017).

Today, many countries especially in Africa, have introduced fee exemptions or subsidies targeting deliveries and emergency obstetric care (Richard et al. 2013; Witter, Garshong and Ridde, 2013). The emphasis on reducing and removing costs was driven by the international call to reduce maternal mortality and a growing awareness of the importance in many contexts of financial barriers, as well as of the impoverishing effects of catastrophic payments for health care, especially for poorer households (Witter, Drame and Cross, 2009). There are several countries offering delivery fee exception in Africa some of them include: Ghana, Senegal, Burkina Faso, Niger, Burundi, Uganda, Sierra Leone, Madagascar, and Kenya among many others. However, fee exception for service package varies from one country to another.

Despite advocacy for UHC, studies conducted in sub-Saharan Africa describes how out-of-pocket expenditure and unpredictability of costs related to fee exception maternity remain one of the major barriers to seeking maternal health care as they absorb a significant amount of the financial capital in the household, sometimes generating catastrophic financial expenditure (Kruk et al. 2008; Perkins et al. 2009; Dalaba et al. 2015; Séne and Cissé, 2015). Research from other studies suggests that households employ different strategies to cope with health financing shocks and such coping strategies are geared towards attaining UHC (Xu et al. 2007; Dalaba et al. 2015). However, there is scant literature describing emic perceptions and the economic consequences of such coping mechanisms for poor households. Therefore, there is a need to explore either direct or in-direct multiple factors that act as barriers to seeking maternal health care among the poor mothers using social, political, cultural and economic lenses and this calls for an anthropological study. This study, therefore, contributes to closing the gap in the literature by exploring the emic perceptions of the economically disadvantaged households on the available social protection schemes in maternal health programmes in Coastal Kenya and whether such programs contribute towards the objectives of social protection.

The Kenyan government recognizes that good health is a prerequisite to socio-economic development. A number of government policy documents and successive national development plans, including Vision 2030, states that health services should meet the basic needs of the population, that health facilities should be situated within reach of all Kenyans, and that there should be a focus on preventive, promotive, and rehabilitative services without ignoring curative services (GoK, 2010). Notably, Kenya still faces major health system challenges including non-communicable diseases, a high population growth rate and a high maternal mortality rate. Maternal morbidity and mortality in Kenya result from the interplay of social, cultural, economic and logistical barriers, coupled with a high fertility rate and inadequate and under-funded health services (Ukachukwu et al. 2009). Access to priority health services in Kenya remains vastly inadequate. Nowhere is this more obvious than in maternal health. In 2014, skilled birth attendance increased to 62% while antenatal care attendance was 95% (Kenya National Bureau of Statistics (KNBS) and ICF International, 2015). Nevertheless, the maternal mortality rate remains high at 360 maternal deaths per 100,000 live births (Ministry of Health, 2018). While this is below the sub-Saharan average of 640 deaths per 100,000, Kenya experiences a very slow progression in maternal health. There is a need to address challenges for the choice of utilization of maternal health care and this might need a thick description of how institutional factors influence mothers and their families' choice for free maternity or maternal vouchers in Coastal Kenya.

1.2 Social Protection in Maternal Health

The long-term goal of social protection in the developing world is to reduce the intergenerational transmission of poverty, which depends on household investing in human capital, labour, and productive assets. Social protection programs in sub-Saharan Africa show large variation in structure and scope across countries, reflecting differences in demographic characteristics, financial capacity, and social and political circumstances. The role of social protection as an effective tool for sustainable development is reaffirmed in Agenda 2030 and explicitly cited as a target under Goals 1 and 10 (poverty and inequality respectively), with inevitable linkages across the goals on health, employment, labour laws and unpaid care work, among others (OECD, 2017). However, social protection is subject to numerous different definitions which vary not only between individual countries but also among international organizations. The International

Labour Organization (ILO) defines social protection as “the set of public measures that a society provides for its members to protect them against economic and social distress that would be caused by the absence of a substantial reduction of income from work as a result of various contingencies (sickness, maternity, employment injury, unemployment, invalidity, old age, and death of the breadwinner); the provision of health care; and the provision of benefits for families with children.” The ILO’s definition is not appropriate for every country in the world; as the ILO acknowledges, “Differing cultures, values, traditions, and institutional and political structures affect definitions of social protection as well as the choice of how protection should be provided” (Garcia and Gruat, 2003).

Globally, social protection is increasingly seen as an essential policy tool to reduce poverty and inequality while stimulating inclusive growth² by boosting the health and capacity of vulnerable segments of society, increasing their productivity, supporting domestic demand and facilitating the structural transformation of national economies (International Institute of Labour Studies, 2014, World Bank, 2015). Evidence from middle- and low-income countries have demonstrated that social protection programmes support the poorest households in numerous ways, including smoothing consumption, increasing household investments in health and education, and promoting income-generating activities (IGAs) (Barrientos, 2012; Fiszbein and Schady, 2009; Holmes and Jones, 2013).

Health care forms a cornerstone of social protection as a protective, preventative and promotive element of the livelihood and well-being of vulnerable populations (UNICEF Division of Communication, 2009). Health financing mechanisms have profound impacts on the functioning of the health sector, particularly regarding the equity of the financial burden of health care and the accessibility of health services for different groups of the population. Over the past decade, there has been an increasing focus on health insurance and other forms of social protection as a potentially promising way to deal more effectively with health risks in developing countries

² Inclusive growth refers to growth that is broad-based and inclusive of the poorer segments of society (Lanchovichina and Lundström, 2009).

(UNICEF Division of Communication, 2009). However, contextual analysis of the extent to which social health insurance (SHI) and other health financing and social protection mechanisms can play a role in reducing poverty and vulnerability among children and their caretakers is scarce (UNICEF Division of Communication, 2009). This study, therefore, aims to fill this knowledge gap based on evidence from the very poor mothers in Kilifi County who are the beneficiaries of social protection and in this case the maternal vouchers and the free maternity services.

However, social protection is not new to Africa (Mchomvuet, Tungaraza and Maghimbi, 2002). For instance, in the traditional African setting, this concept was defined by solidarity and mutual support among societies, and it had the primary aim of helping individuals to maintain a certain minimum standard of living when faced with social as well as economic and general livelihood contingencies (Mchomvu et al. 2002). Since the turn of the century, social protection has emerged as a critical area of development policy and practice. There has been unprecedented growth in social assistance programmes, particularly in low- and middle-income countries over the past twenty years (Barrientos, 2013; Cecchini and Madariaga, 2011; Garcia and Moore, 2013; Weber, 2010). Similarly, the last decade has seen social protection gaining centrality in the development agenda of many African countries, and social protection programmes are among the most successful development experiences the world has seen in recent years (UNDP, 2016). Therefore, many countries increasingly perceive social protection as an essential component of effective national development strategies that combine inclusive economic growth and necessary social service and assistance provision (UNDP, 2016).

Social protection initiatives in Africa increasingly aim to institutionalize systems that guarantee assistance for the poor and protect the vulnerable against livelihood risks (Devereux and Philip, 2010). In African countries, the leading social protection instruments implemented tend to align with the needs of particularly vulnerable groups (UNICEF Division of Communication, 2009). Social protection as an essential component of poverty reduction strategies is especially important for the most vulnerable members of society, which are often women and children (UNICEF Division of Communication, 2009). Investing in maternal health programs as social protection initiatives have, therefore, a double impact, as it protects mothers and children alike.

The social protection programmes in Kenya are currently under the Ministry of East African Community (EAC), Labour and Social Protection. It is in the state department of social protection. Social protection is divided into three categories. These are social assistance, social security, and health insurance. The Constitution underpins social protection in Kenya. Specifically, Article 43 which guarantees all Kenyans their economic, social and cultural rights, including rights to health, education, food, and decent livelihoods. The right to social security is explicitly stated, binding the State to “provide appropriate social security to persons who are unable to support themselves and their dependents” (Government of Kenya, 2010).

Following a broad consultative process, the Kenya National Social Protection Policy was finalized in 2011 (Ministry of Gender, Children and Social Development, 2011). It states that the primary goal of social protection is “to ensure that all Kenyans live in dignity and exploit their human capabilities for their own social and economic development.” In order to achieve this goal, the Policy asserts that focus will be given to at least five broad policy objectives which can be summarized as: Protecting individuals and households from the impact of adverse shocks, cushion workers and their dependents from the consequences of income-threatening risks such as sickness, poor health and promoting synergies and integration among social protection providers as well as positive interactions among stakeholders for the optimal functioning of the policy.

Additionally, the Constitution emphasizes the direct application of international agreements ratified by Kenya. These include the Universal Declaration of Human Rights (1948), which recognizes social protection as a fundamental human right for all citizens of the world. This is reinforced by many UN and ILO conventions as well as regional agreements including the African Charter on Human and Peoples’ Rights (1981) and the East African Community Common Market Protocol. The UN/ILO Social Protection Floor Initiative (SPFI) guarantees a universal minimum package of social transfers and services within a lifecycle approach to social protection. Within Kenya itself, Vision 2030 envisages an equitable society to which social protection can contribute. Therefore, social protection in Kenya is defined as:

Policies and actions, including legislative measures, that enhance the capacity of and opportunities for the poor and vulnerable to improve and sustain their lives, livelihoods, and welfare, that enable income-earners and their dependents to maintain a reasonable level of

income through decent work, and that ensure access to affordable health care, social security, and social assistance.

Although there have been several social protection schemes in the field of healthcare financing in Kenya, the primary scheme is the National Hospital Insurance Fund (NHIF). NHIF was established by an act of parliament in 1966 as a contributory scheme under the Ministry of Health to provide health insurance for salaried public and private sector employees earning a monthly salary of KES 1,000 and above, while the government subsidized health provision for those outside the fund (Muiya and Kamau, 2013). Since its inception, however, the NHIF has undergone several changes over the years to include more benefits, target informal sector households, and to introduce outpatient care. In 1998, relevant laws were repealed and replaced by the NHIF Act No. 9 of 1998 (Deolitte, 2011). This led to the transformation of the Fund into an autonomous State Corporation managed by a Board of Management (Kamau and Holst, 2008). Affiliation to NHIF is according to households, and the insurance unit comprises the whole family and dependent relatives. The number of spouses is limited to one, but there is no limit on the number of children and other dependents. It is only the breadwinner who contributes to the scheme. In families where two (or more) members are working and earning own salaries, they all have to pay contributions to NHIF. Entitlement to health care services includes all dependent household members. Children under 18 automatically benefit from NHIF through their parents' affiliation. Children over 18 years must proof their economic dependency through schooling or university certificates.

In 2006, a voucher system was introduced in selected areas to provide vulnerable women with free access to reproductive health care competitively in both the public and the private sector. This intervention allowed women to choose the healthcare provider and targets the most vulnerable population explicitly. It led to an increase in skilled deliveries among women with low income who could otherwise not have accessed such services (KFW, 2012). A recent review confirms that vouchers can significantly improve maternal and child health outcomes in Low-Income Countries by increasing the use of services for antenatal care, skilled birth attendance, institutional delivery, complicated delivery and postnatal care (Meyer, Bellows, Campbell and Potts, 2011; Salam, Lassi, Das and Bhutta, 2014). One review found a more significant impact of

vouchers on these outcomes as compared to free maternal services (Salam et al. 2014). However, the previous studies did not look at the perspectives of the service beneficiaries.

In 2013 following a Presidential policy directive for the immediate removal of all user fees for maternity care in public health facilities in Kenya, the government declared reproductive health services in all public facilities for free. The policy uses pay for performance mechanism that is payments for deliveries provided are made to the facility, serving as incentives for the effort by providers. It is, however, unclear how the local people perceive such initiatives and whether the new social policy directive is more cost-effective as compared to the free maternity voucher system. Similarly, public health facilities are often viewed as of low quality in the population, which has been shown to be an important barrier to access (Austin et al. 2014).

1.3 Emergence of Healthcare Financing and Free Maternity in Kenya

The World Bank explicitly recommended user fees in its strategy “Agenda for Reform” in 1987. User fees implemented through health sector reforms and specifically health financing reforms aimed to improve efficiency and equity in health systems (Breman and Shelton, 2001). User fees have also been implemented as part of the Bamako Initiative in 1988, following the commitment to “Health for All by 2000” undertaken at Alma Ata. In contrast to the top-down user-fee model initiated through structural adjustment, the goals of the Bamako Initiative were to raise and control revenues at the primary health level through community-based activities and the development of community management capacities (Gilson, 1997).

Nevertheless, from 1966, for about 25 years, the Government of Kenya provided health services in public clinics and hospitals free of charge by its social policy (Republic of Kenya, 1989a). In the 1980s the Government began to review this practice, as its fiscal deficits worsened and like its ability to meet recurrent health expenditures of the public declined. The research information available to the Government at that time indicated that moderate user charges in public health facilities would alleviate the budgetary constraints of the ministry of health and, at the same time, rationalize the use of medical services without significantly reducing clinic attendance (REACH, 1988; World Bank, 1987). In addition to change impetus from research, the

government was facing pressure from external donors to introduce market-oriented reforms in the health sector as a condition for development assistance (Mwabu and Wang'ombe, 1997).

Following independence in 1963, the post-colonial government made universal health care a major policy goal. Two years after independence, the government abolished user fees, which had been implemented by the colonialists, and began providing free health care for all in government facilities. This continued up to 1988 when the Kenyan government yielded to international pressure to introduce user fees and other major reforms in the health sector. Poor economic performance, inadequate financial resources, and declining budget were some of the reasons given to justify the re-introduction of user fees (GoK, 2001).

In February 10-13, 1987, Kenya held the first International Safe Motherhood Conference in Nairobi whose central theme was to heighten awareness and concern among governments, agencies and non-governmental organizations about the neglect of women's health, particularly in the developing world, and to elaborate strategies to remedy this desperate situation (Cohen, 1987). At the opening plenary session, the then Kenya's president Daniel Arap Moi, who was already a strong proponent of family planning, set the tone for the conference by pledging Kenya's continued commitment to efforts to improve standards of maternal health (Cohen, 1987). Consequently, in the 1980s, after two decades of free but poor quality health services, nearly all African countries introduced user fees for public health care services. This decision, taken by governments with the support of the World Bank, was nevertheless contested by many in civil society and the scientific community (Lancet, 1988; UNICEF et al. 1989). Many studies in Africa confirmed their fears and showed that, while increasing access to drugs (Knippenberg et al. 1997), user fees reduced access to services for the more vulnerable, resulting in reduced service utilization (James et al. 2006; Lagarde and Palmer, 2006).

In August 2010, Kenya promulgated a new constitution (Government of Kenya, 2010). The new constitution was fully implemented in 2013 and brought into existence a two-tier government structure with one national government and 47 counties government which are semi-autonomous (Government of Kenya-GoK, 2013). Devolution has recognized the right of communities to manage their affairs and to further their development (Government of Kenya, 2013). Constitution

of Kenya gives every person a right to the highest attainable standard of health, including reproductive health rights and that includes; right to basic nutrition, shelter and health care for every child. Regarding health care, the constitution then gives the state three crosscutting obligations which include: *To respect a right, to protect a right, and to fulfill a right* (GoK, 2010).

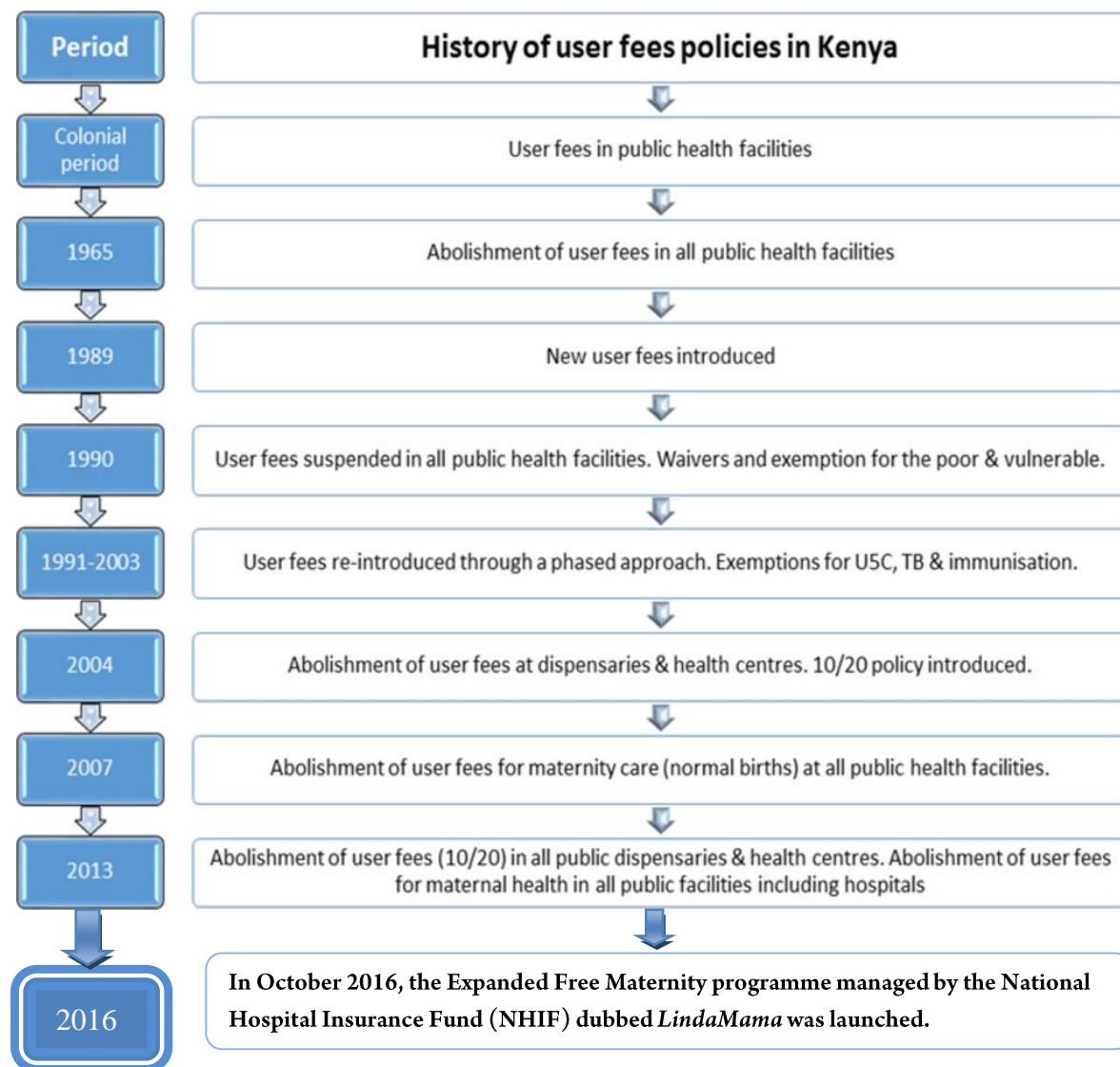
Under Kenya's constitution, the health function has been devolved to the county governments, with distinct roles being assigned to the national and county governments (Government of Kenya, 2010). The national government is responsible for leadership in health policy development, management of national referral health facilities, capacity building and technical assistance to counties, and consumer protection, including the development of norms, standards, and guidelines (Government of Kenya, 2013). The county governments are responsible for county health services and pharmacies; ambulance services; promotion of primary health care; licensing and control of establishments that sell food to the public; cemeteries, funeral parlors, and crematoria; and refuse removal, refuse dumps, and solid waste disposal. About their functions, the county governments have undertaken new strategies and initiatives to address the health needs of their populations, including the construction of more health facilities, the acquisition of new equipment and medication at these facilities, and the addition of ambulances and more medical staff (Government of Kenya, 2013).

In 2012, during general elections campaign, Uhuru Kenyatta and his running mate William Ruto pledged to facilitate progress towards universal health care by providing free maternity services (FMS) to all pregnant mothers if elected. On June 1, 2013, President Uhuru Kenyatta announced that the Jubilee Government had abolished all maternity charges in all public health facilities. To keep the promises made by the Jubilee Alliance during the election campaigns, the President said that scrapping of the fees would help all expectant mothers access maternal care, alleviate poverty and would also help reduce maternal and neonatal mortality. The government also waived the Sh. 20 charged for registration in the same health centers (See Figure 2.3). The FMS policy was introduced when the Kenyan health system was undergoing devolution. This meant that responsibility for healthcare governance had been devolved from national government to the county. Free maternity is implemented by a Pay for Performance mechanism that is payments by

the national government for deliveries conducted by the facility, serving as incentives for the effort by health service providers. Hence, free maternity was presented as a first step towards achieving free primary health care for all Kenyans. “Free” means every pregnant mother walks into any public health facility maternity ward delivers by the assistance of a health professional and walks out freely.

Even though today, Kenya has adopted a free maternity services policy, funds are retained at the national level and are only reimbursable to counties based on the number of deliveries conducted. Nevertheless, insufficient or slow re-distribution of the funds has created bottlenecks. Health facilities have remained in limbo, uncertain of how to balance the new policy for free care with their need to cover costs. In recent (2017) general elections campaign, Jubilee Coalition government still used free maternity programme as one of their most significant achievement over the last four years as a government. According to the government records, free maternity programme doubled access to maternal health care for Kenyan mothers from approximately 600,000 in 2013 to about 1.2 million by the end of 2016. Therefore, still, during Jubilee campaigns for re-election in 2017, they pledged to expand free maternity services in all public health facilities to include government-funded national health insurance fund (NHIF) cover for every expectant mother for one year. Despite all these good pledges, in reality, the maternal mortality rate in Kenya is still high at 360 per 100,000 (Kenya National Bureau of Statistics et al. 2015). Description of the history of user fees policies in Kenya is summarized in figure 1.1.

Figure 1. 1 History of user fees policies in Kenya



Source (Author's creation, 2018).

Charging user fees and other out-of-pocket payments have been noted to negatively affect the use of health care services in Kenya (Mwabu, 1986; Mbugua et al., 1995; MoH, 2004; MoMS and MoPH, 2009). The majority of the population cannot afford to pay for healthcare, and the poor are less likely to utilize health services when they are ill. Also, wide disparities in utilization exist between geographical regions and between urban and rural areas (MoH, 2004; MoMS and MoPH, 2009). Socio-economic and geographic inequities are broader for inpatient care than outpatient care. Those who pay for care incur high costs that are sometimes catastrophic and

adopt coping strategies with negative implications for their socio-economic status, while others just fail to seek care (Chuma et al. 2007; Chuma, Gilson and Molyneux, 2007). Currently, health services in Kenya are provided by both the public and private sector, with the government owning 51.0 percent of all health facilities in the country. The private for-profit and not-for-profit sectors hold 34.3 percent and 14.8 percent of all facilities, respectively. The health system relies heavily on out-of-pocket (OOP) payments as the primary source of health care funding. In 2009/2010, OOP payments accounted for 36.7 percent of total health expenditure (Jane and Maina, 2014).

Additionally, the Kenya Health Policy 2014-2030 has a target to reduce Maternal Mortality Rate (per 100,000 births) from 488 to 113 by 2030 (MoH, 2012). Improving maternal health including reducing maternal mortality remains a major challenge in Kenya. Prevention of death from a complication of pregnancy or childbirth requires access to a skilled health worker backed up by a functional referral system. The three delay model; delay associated with the decision to seek care; delay in arrival at the point of care; and delay in the provision of adequate care, outlines the risks mothers face in accessing the necessary care (Thaddeus and Maine, 1994).

1.4 Maternal Voucher Services-Output Based Aid (OBA)

Output-based health care vouchers were first used in low-income countries on a large scale for family planning services in Taiwan and Korea in the 1960s and 1970s (Cernada and Chow, 1969; Ross et al. 1970; Lin and Huang, 1981). Globally, voucher programs have been associated with increased skilled birth attendance, uptake of long-acting family planning methods, reduction in out-of-pocket expenditure, improved the quality of care and improved access to care (Schellenberg et al. 2013; Murray et al. 2014). Today, voucher programmes for health services are of increasing interest to governments, practitioners, and funders.

Based on the general global requirements for access to and equity of health care services, in June 2006, the Kenya Ministry of Planning launched maternal health care and family planning voucher services or output-based aid (OBA) program funded by the German Development Bank (KfW) and the Government of Kenya. The vouchers were a social protection mechanism

targeting the economically disadvantaged populations. The vouchers in the form of paper or electronic tickets were distributed or sold at a subsidized price to segments of the population who exchange them for health services at accredited facilities. The vouchers targeted subsidies for safe motherhood (SM), family planning (FP) and gender-based violence recovery services (GBVRS) to promote quality care and maximize healthcare utilization by people living in poverty. The SM and FP vouchers were sold through distributors to poor women in rural districts and low-income areas for a highly subsidized price while the gender-based violence recovery services (GBVRS) vouchers were provided for free in GBVRS accredited facilities regardless of socioeconomic status. The program was launched to generate health sector experience in targeting, accreditation, claims, reimbursement, and quality for the proposed National Social Health Insurance Fund. The program operated in Kisumu, Kitui, Kiambu and Kilifi counties, and Korogocho and Viwandani informal settlements in Nairobi. These sites were seen as representative of different regions of Kenya with poor populations found in both urban and rural settings (Bellows, Matthew, and Francis, 2009; Janisch et al. 2010).

Voucher distributors from communities where the programme intended to target services screened expectant women on a 14-item poverty grading tool women against socio-demographic characteristics such as geographical location, marital status, parity, place of last delivery for those who had delivered before, access to services such as healthcare, water, land and livestock ownership, housing structure, sources of income, average number of meals a day and ownership of household assets. The scores ranged from 0 to 21 points with an individual being ranked as poor if she scored 0 and 9 points, middle income if she scored 10 and 15 points and rich if she scored 16 and 21 points. Women scoring 0 and 12 points were eligible to purchase the voucher for 200 Ksh (US\$2.00). Community-based targeting was the preferred method to minimize inclusion biases (Porksen, 2003; Ridde et al. 2010).

The voucher covered four antenatal care visits, a facility-based delivery including caesarian section and treatment of the mother and neonatal complications if necessary, and postnatal care. Facilities were reimbursed 1,000 Ksh. an equivalent of 10 USD for clients who completed four antenatal care (ANC) visits, 4,000 Ksh. (40 USD) for a normal delivery and 20,000 Ksh. (200

USD) for a caesarian section. Additional complications were reimbursed on a fee-for-service basis (Bellows et al. 2009). All reimbursements required a claim for treatment according to contractually agreed and nationally established standards of care (Janisch et al. 2010). The voucher programs were associated with increased skilled birth attendance, uptake of long-acting family planning methods, reduction in out-of-pocket expenditure, improved quality of care and improved access to care, but current estimates of health spending in Kenya show that households remain the most significant contributors to health financing (35.9%) (KNBS and ICF Macro, 2009). Little is known about other strategies households, and women use to meet additional financial obligations which are not covered by the vouchers for maternal health. Those strategies used by women and households to finance maternal health care are discussed in the later chapters of this thesis.

Today, it is still unclear how free maternity program and maternal vouchers are perceived locally as the social protection schemes. Although Lang'at and Mwanri (2015) conducted a qualitative study in Malindi District on healthcare service providers' and facility administrators' perspectives of the free maternal healthcare service policy, their study did not explore households, service providers' and mothers' perspectives on free maternity and maternal vouchers as social protection schemes. This longitudinal study aimed at filling this gap by describing local perceptions in Coastal Kenya. Next section describes key theoretical orientations that this study is anchored in and how they informed data collection and analysis.

1.5 Theoretical Orientations

This section describes key theoretical orientations and how such theories help in describing local perceptions of social protection schemes in maternal health programs in Coastal Kenya.

1.5.1 New Institutionalism

The term “New” Institutionalism implies an “Old” school of thought (Haller, 2007). This is usually brought up in connection with economists such as Veblen, Commons, and Mitchell. Veblen’s position in particular (Veblen, 1919) was that institutions play an important role in economic actions. However, the roles of institutions in the decisions of actors were never systematically presented by the old school of institutionalism.

For long, it has been acknowledged that processes of development are dependent not only on economic and political institutions but also on informal institutions (Weber, 1904). Most institutionalists understand informal institutions as shared ideas and mental models, social norms, moral values, and habits and routines. Often subsumed under the label of ‘culture’ (North, 1994; Sjöstrand, 1993), informal institutions are even said to make “almost all the difference” in economic development (Landes, 2000). However, how institutions evolve and change, and the influence they have on the economic strategies of individuals and groups of actors, are issues debated by different theories in economic history, political science, and anthropology. Various approaches can be listed under the label of New Institutionalism (Olson, 1965; North, 1990; Ostrom, 1990; Ensminger, 1992; Becker and Ostrom, 1995; Gibson, 1999). Institutions are seen here as formal and informal “rules of the game,” such as constraints, norms, values, and rules. These give motivations to groups and individuals, and also structure human action and interaction, especially in economic activities, collective action, and in sustainable resource use. They help individuals form expectations about the conduct of others and thereby enable coordination and cooperation (North, 1990; Ostrom, 1990; Ensminger, 1992; 1998).

An anthropologist Jean Ensminger who did her leading work in Kenya, among the Ormas, who form a semi-sedentary pastoralist ethnicity in Kenya, showed how external factors can make the prices of cattle higher and can change the way the pastures were managed. Her work is on the other hand rooted in the anthropological work of Fredrik Barth (1981) who investigated the

relationship between individual behaviour and the generation of institutions. On the other hand, Ensminger draws strongly on insights from New Institutional Economics, particularly from North (1990). Her approach departs from the point that institutions, on the one hand, determine economic performance and distribution, and are on the other hand changed by the action of individuals. Choices and calculations shape these actions in the context of changing prices, but also social incentives, goals, strategies, and constraints. The Ormas had to shift to a private property regime under the change imposed by the newly arriving market economy. Ensminger was very interested in the process itself: how certain actors used ideology, what was the bargaining power change. For example, the manipulation of the term “modernity” by sedentary cattle owners in their competition against mobile pastoralists.

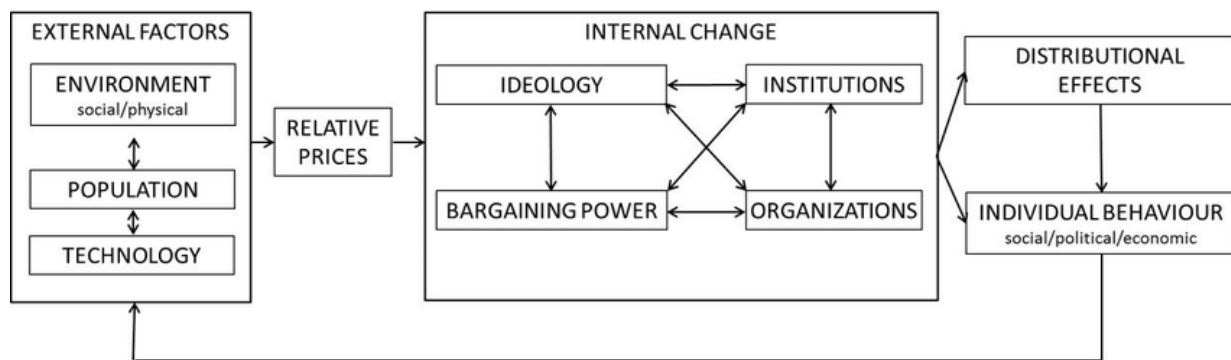
Also in her book *Making a Market*, Ensminger shows a model of how people think about their needs in the larger economic and political context, thus acting the way they do. However, new institutionalism emphasizes the role of outside forces in today’s market economy, which changes the way resources have been distributed and affects the (relative) prices³ of commodities, which then shape the bargaining power. In her model, she argues that interaction among the endogenous aspects of a society in which individuals live is composed of *institutions, ideology, organization, and bargaining power* (see Figure 1.2). **Ideology** consists of the way people explain the world based on their values and beliefs thus determine their goals and shape their choices. **Institutions**, as Douglas North (1990) sees it, are the “rules of the game” in society, the formal and informal rules, values, norms and constraints, which provide incentives for individual action and reliability. Institutions reduce uncertainty by providing a structure to everyday life thus is a guide to human interactions. Institutions, therefore, consist of formal rules (these can be political or legal rules such as constitutions, policies, and contracts) and informal rules (such as code of conduct, behavioural norms and conventions). **Organization** comprises groups of individuals with common objectives. In this study, organization refers to the health workers, the locals and the poor mothers. North’s principal argument is that the actions, decisions and

³ Prices of commodities are relative and choices depend on the value of something in relation to what an individual must give for it. For instance, change in terms of healthcare, the out-of-pocket expenditure incurred by the patients may decrease utilization of such services than an option that offers less or nil extra expenses (such prices shape the ability to get something an individual want).

relations of individuals within an organization are both enabled and constrained by formal and informal rules which constitute the institutions (North, 1990).

Bargaining power means the ability of an actor to get something he or she wants from someone. But this is a bargaining process. The bargaining power of individuals can come from social status, wealth or the ability to manipulate ideology (Ensminger, 1992). These four endogenous spheres (ideology, institutions, organization and bargaining power) influence one another and are themselves influenced by external factors. These external factors are the social and physical environment (changes in the socio-political structure and natural environment), population (demographic changes) and technology (technological changes), which together influence so-called “relative prices.” By this term, Ensminger means externally influenced changes in prices for goods in relation to other goods. In the case of the Orma, lower transportation and communication costs have opened up more possibilities to trade cattle due to close markets and slaughter-houses, and also brought higher prices for cattle. Ensminger speaks of relative prices because the decision taken by an individual depends on the value of a good in relation to another good. Since the market economy offers different incentives to families and individuals, this then motivates them to change their political, economic and social institutions. Ensminger thinks that at this point we need anthropological work to be done, to understand the process of change as a result of individual motivations of the different actors.

Figure 1. 2 Modeling Change



The original version of the Framework for Modeling Institutional Change (Ensminger, 1992)

In a nutshell, Ensminger's framework distinguishes three main elements and steps which aids in exploring local perceptions of social protection schemes in maternal health in this study. It is evident from the framework that changes in 'external factors' trigger 'internal change' which then has 'distributive consequences' (e.g. regarding resources) for individuals and their 'behaviour'. In the form of a feedback loop, the variation in individual behaviour triggers a change in the 'external factors'. At the heart of the framework lies the unpacking of the box of 'internal change' into the elements ideology, institutions, bargaining power and organizations, and their interplay.

In this thesis it is therefore, central to understand how the institutions as the rules of the game of getting access to resources or property rights are shaped by differences in bargaining power of actors and this case;- pregnant women versus husbands and relatives in order to select and shape the institutional setting, which is in favor for them. This selection, however, has to be legitimized in order to be accepted by other related actors with more or less bargaining power and this is done by for example pregnant women by using ideology of (the right to modern medical treatment) and discourses (type of access related to quality; family and husband related responsible support) related to norms and values for instance, on how pregnant women should be treated. The approach, therefore, mediates the way institutions and power in the local social setting influences perception of the social protection programmes in maternal health and helps to understand otherwise hidden processes in the social, cultural and economic arenas regarding their perception and selection. This theory also enables this thesis to explore how such institutions shape the choices of maternal health programmes by economically disadvantaged mothers.

1.5.2 Peasant Economic Theory and Neo-Marxist Approaches

A Russian agricultural economist, Chayanov championed the peasant economic theory in 1924. Chayanov developed this theory by focusing on the real family farm, employing no wage labour. 'Most peasant farms in Russia, China, India and in most non-European and even many European states are unacquainted with the categories of wage labour and wages' (Chayanov, 1966). Peasant economic theorists argue that actors are focused on the balance of household needs and the drudgery of work to meet their needs. This economic calculation has to be extended by the link

to a market economy and the demand for cash. This means that producers cannot just work as much as material subsistence needs for direct consumption of them and their dependent consumers are met but producers have to work additionally to produce goods that give them enough cash under market demand and supply constellations. Things being equal households in agrarian contexts are viewed to be equal, and inequality of land used refers to differences in the family life cycle of a unit. However, there are differences in the success and access to assets between households and differences in coping strategies (see Chayanov in Cancian, 1989; Netting, 1993).

Chayanov intended to identify the determinants of resource allocation in peasant households and the distribution of income among them. Its main features are as follows:- Production and consumption decisions in the household economy are interrelated. Each household works to the point where the household's subjective evaluation of the marginal disutility of work equals its estimate of the marginal utility of the output gained. The capitalist concept of profit cannot be applied because there are no actual wage costs for family labour. Optimum resource allocation can only be subjectively determined (Chayanov, 1989).

Anthropologists have long recognized that even the simple economies not only fulfill biological needs but also contribute to the social needs as determined by socially prescribed norms. In this thesis, the peasant economic theory offers potential insights into peasant household (poor households) resources allocation which may, if accurate, contribute to the ability of households development and good healthcare. Chayanov saw the family as a vital determinant of the productive capacity and economic performance of the household.

Most households, therefore, have minimax strategies (diversification of choices made or a means of having a wide range of access to resources, which can minimize the risk of being without resources) to buffer risk in production (Lipton, 1988) but not all of them can cope with changes in weather, soil, and other social conditions as well as political processes (Sahlins, 1972; Netting, 1993). This means that under the demand to produce goods for getting access to cash, different households are better or worse to produce goods and sell them for money as many products have to be obtained on the market. This is part of the differences in the domestic mode of production in which households find themselves, but the Neo-Marxist approach looks in addition to

production processes within the households as a domestic unit of production. They argue that exploitation takes place within the household in which husbands own and control land, women, and kin (workforce), while women work on the fields of the husband and help to reproduce his family's workforce by reproductive work as well as looking after children in the form of care work. Women thus perform multiple roles which exert more pressure hence become more vulnerable therefore they become the "exploited class" in the African domestic mode of production.

Neo-Marxist approaches can, therefore, be used to describe how the introduction of the cash economy adds pressure on women's reproductive work as they are needed not just for consumption but they also help to create cash wealth for the husband via this process of 'exploitation' and if the husband is doing wage labour (for example on a commercial farm or a mine) is also exploited by the capitalist system for providing free female work for the reproduction of the husbands' workforce. Therefore, peasant economic theory and neo-Marxist theory will be used to explore gender relations at the household level and whether such relations are perceived to give the poor women economic advantage and power to get access to these perhaps not so free health systems. Peasant economic theory will however specifically look at the other local alternatives adopted by the poor households to meet the extra healthcare costs and how mothers perceive such strategies in term of reducing or increasing vulnerability at the household level.

1.5.3 Constitutionality

In her argument, Jean Ensminger emphasized the role of the bargaining power and ideology in the process of institution building and on the other hand Ostrom described the principles for well-functioning institutions (Ostrom, 1990; Ensminger, 1992, 1998; Haller ed., 2010). However, there is little anthropological research on the emic perceptions of stakeholders who were involved in such processes in retrospect. As a result, Haller, Acciaioli and Rist (2016) introduced a new theoretical perspective called constitutionality, which refers to a successful bottom-up institution building processes and communicative-strategic actions for resource management which emphasizes local actors' views on participation, strategies they use in negotiating such initiatives and the extent to which they can develop a related sense of ownership

in the institution-building process for common pool resources. This perspective was based on the work done in four case studies in Mali, Zambia, Bolivia, and Indonesia. These cases showed the potential to create such new institutions when the local actors are given the “freedom” and space to empower themselves based on their perspectives, and that the state is providing such opportunity for them (bylaws, policies or political circumstances).

The theory tries to show the extensive possibilities used by local actors to deal with their problems, negotiating their roles and statuses with other players and claims that they are not restricted in their actions. However, bargaining-power issues are crucial in the process of “local institution building” because local communities are heterogeneous regarding internal power distribution and also often characterized by a relative lack of power in dealing with outside actors, whether the state or immigrants (Haller, 2010; 2013).

Constitutionality, therefore, help us to use all the different theoretical frameworks to understand local perceptions, interests, positions, practices, and processes, and at the same time keeping in mind the role of external interventions, like the state or international organizations, in affecting the local institutional set-up (Ibid.). This theory will also help in explaining how a more participatory approach can be achieved through a new institutional arrangement by incorporating local (poor mothers and health providers) needs and decisions and how such local perspectives can be recognized by the government in line with existing laws, regulations and other policies that accommodate local actions. This theory also will echo for participatory approaches through the incorporation of local needs and decisions as a way of restoring trust in Kenya’s health care system in the current decentralized healthcare system in Kenya. Next section describes the research context and methodology used in this study.

1.6 Research Context and Methodology

This section provides an account of the fieldwork process and the setting within which the data for this thesis were collected. It describes ethnographic⁴ aspects of local settings as peasants and gender-specific institutions as well as social protection networks. It also describes research approaches and the choice of data collection methods for this study. I furthermore explain my position in the field and the methodological difficulties during my research period. Additionally, I also describe my relationships in the field and my experiences of studying the poor women, as well as how I handled the daily expectations of vulnerable research subjects in the study as an ethical challenge.

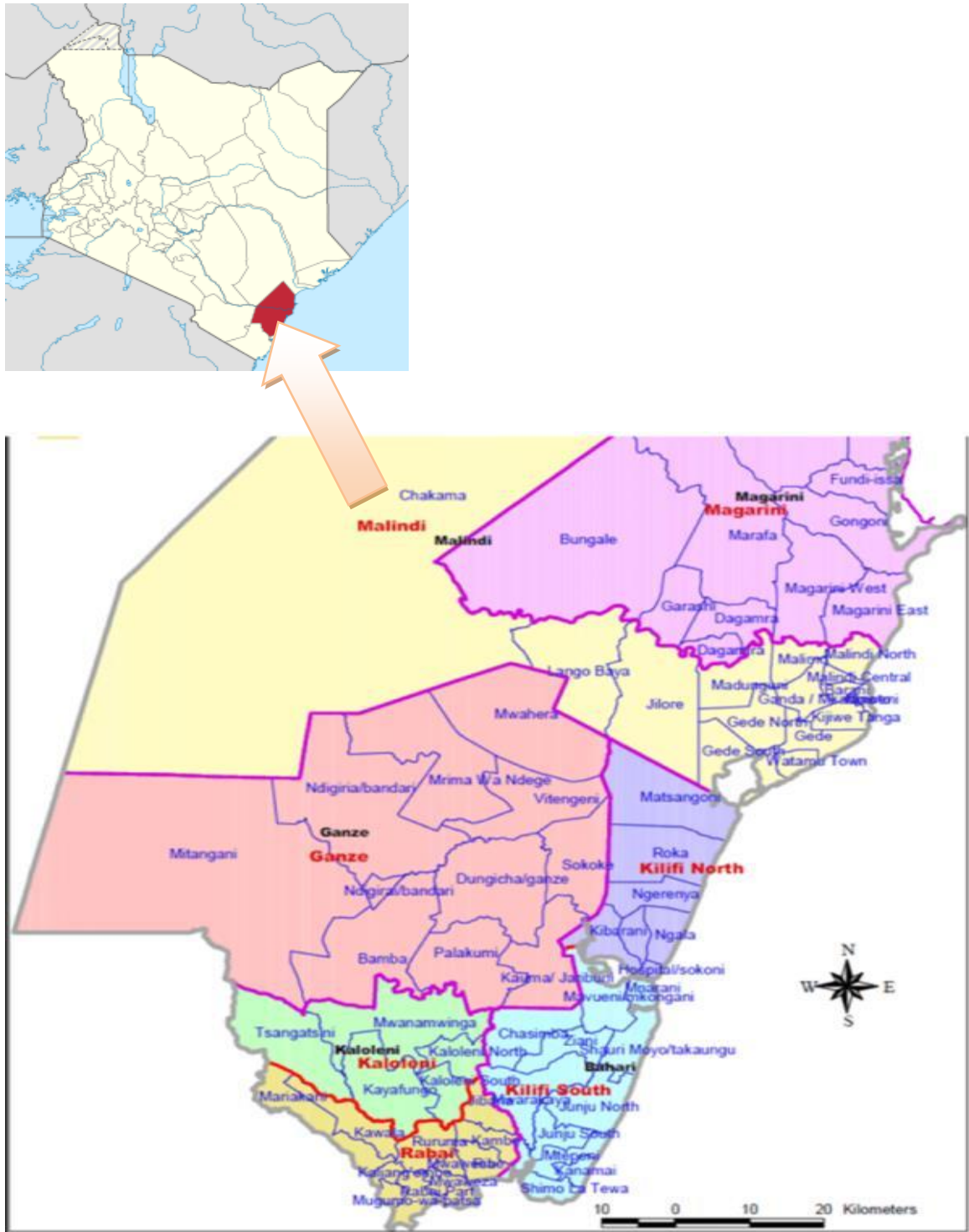
This PhD project was nested in the “Inclusive growth through social protection in maternal health programs in Kenya”-Project (Acronym SPIKE). The project was funded by the Netherlands Organization for Scientific Research (WOTRO Science for Global Development). The project was a consortium led by the Swiss Tropical and Public Health Institute, University of Bern and Maseno University in Collaboration with the Ministry of Health, Kenya.

1.6.1 Study Area

This qualitative study was conducted in Kilifi County in Coastal Kenya. Kilifi County is one of the 47 counties in Kenya. The county lies between latitude 20” and 4 0” South, and between longitude 39 05” and 40 14” East. It borders Kwale County to the south-west, Taita Taveta County to the west, Tana River County to the north, Mombasa County to the south and the Indian Ocean to the east. The county covers an area of 12,609.7Km. It has seven administrative sub-counties namely; Kilifi south, Kilifi north, Ganze, Malindi, Magarini, Kaloleni, and Rabai. It is sub-divided into seven Political Constituencies namely Kilifi North, Kilifi South, Ganze, Malindi, Magarini, Kaloleni, and Rabai. *See Figure 1.3.*

⁴ Unlike other methodologies that rely on people’s selective memories, ethnography entails being there and being able to describe what actually transpired and this is indispensable in anthropological study.

Figure 1. 3 Map of Kilifi County



Source: (<https://softkenya.com/kenya/kilifi-county/kilifi-county-map>),

Almost 68% of the population is living below the poverty line and the main economic activities being subsistence farming (maize and cassava farming), fishing in the Indian Ocean and tourism. The county has nine level 4 public hospitals, 20 level 3 public health Centres, 197 level 2 public dispensaries, one mission hospital, two private hospitals, one armed force hospital, five private nursing homes, and 107 private clinics. Level 4 public hospitals are the primary hospitals; level 3 are health centers, maternities or nursing homes and level 2 are Dispensaries or clinics (www.kilifi.go.ke/index). Kenya has fairly a low total fertility rate-TFR (3.9) while Kilifi County has a TFR of 7.1 for women aged 15-49. Kilifi is one of the fifteen counties with the highest number of maternal deaths and the highest maternal mortality ratio contributing to over 60% of the national total (KNBS et al. 2015).

However, the nine months longitudinal study was conducted among the Giriama people in Kilifi County (Specifically in the following sub-counties: Kilifi North, Kilifi South, Ganze, Malindi, and Magarini). The Giriama is one of the nine sub-tribes that make up Mijikenda (literally in Swahili means 'nine homesteads'). Their language is *Kigiriama* which is a sub-language of the *Kimijikenda*. The nine Mijikenda groups speak a closely related language which is related to widely known Bantu language Swahili. The main source of livelihood of the Giriama is agriculture supplemented locally by wage labour in the salt mines, small trade, the business of palm wine and animal husbandry. The main types of livestock in the county include cattle, sheep, goats, and poultry. The main crops grown are maize, beans, and cassava. The most important cash crops include coconut palm tree (see fig 1.4) whose products include oil extracts and palm wine, and its fronds are used for roofing and as materials for making baskets, mats, broom and other weaved products among others; cashew nuts, oranges, and mangoes. The county's arid zone is a significant source of charcoal for Mombasa, Malindi, Kilifi and Mtwapa towns leading to widespread destruction of the environment through uncontrolled felling of trees. The areas most affected by this are Ganze, Kaloleni, and Magarini. Another contributor to this is sand harvesting in Marereni and quarries in Ganze.

Just like in most tribal cultures, Giriama men are mainly responsible for providing food and protection to the family, while the mother is left all domestic responsibilities. However, when

men spend a lot of their time at *Mangweni* where they drink local brew, politic and make a lot of stories, women are forced to play multiple roles including those meant for men. For instance, farming and doing other casual work to feed the family. The mud-wood and stone combined walled houses for the poor in the villages are built by men and are usually thatched with coconut leaves locally known as *makuti*. These houses are commonly referred to as ‘Makuti houses’.

1.6.2 Data Collection Methods

This qualitative study was conducted in phases. The first phase in August 2015 was the exploratory phase to check on types of available maternal health care programs in the study area. One month exploratory phase entailed visiting various health facilities in Coastal Kenya to ascertain the availability of various maternal health programs. Results from the exploratory phase enhanced the purposeful selection of different health facilities in Kilifi County that offered maternal vouchers and free maternity. Then was followed by entry point for in-depth interviews with pregnant women which took place at purposively selected health facilities between March-July 2016. Expectant mothers and those who had delivered six months before the study aged between 18-45 years were purposefully selected at the health facilities.

In-depth interviews at the health facility with mothers provided information on their perceptions on maternal vouchers and free maternity and whether the two programs enhanced social protection. Information was also gathered on the preferred scheme and reasons for preference. Later, between February-July 2017 mothers were followed to the community for participant observation⁵ and additional individual interviews for five months. Initially, there were 60 mothers who were purposefully selected at the health facilities to participate in this study. However, during community follow up for more in-depth interviews and participant observations, only 40 mothers (who were the poor of the poorest) qualified for a longitudinal qualitative study in Kilifi County. Out of 40 mothers who were followed for nine months,

⁵ Ethnography participant observation is, in particular, suitable to investigating sensitive issues because such work can provide rich, detailed descriptions about the unknown or the little known. As the only field method that allows researchers to observe what people do in “real life” contexts, not what they say what they do, ethnographic participant observation can supply detailed, authentic information unattainable by any other research method (Gans, 1999).

qualitative expenditure diaries were also conducted with 20 mothers to gather data on expenditure and allocation of scarce resources. The aim of the qualitative data was not representativeness of mother's views, actions, and of the cost of childbirth. Instead, it aimed at better understanding on what type of birth subsidy were preferred by women and whether the preferred birth-support was cost-effective regarding social protection in the local context as well as their perceptions regarding the different birth-support. Therefore, in total, 40 women participated in the qualitative study.

Key informant interviews (KIIs) with health service providers and other key health officials were also conducted. KIIs provided information on health worker's perceptions of maternal health care as a social protection mechanism. Informal conversations with community members and households and other health workers were also done. I also did participant observation in the selected health facilities and households of chosen women, 40 in-depth interviews with women, 25 key informant interviews with key decision makers in the county and health facilities, 6 focus group discussions with (6 to 9)mothers in the villages and 5 round-table discussions 2 with women and 3 health workers at the health centres. Participants were provided refreshments during the focus groups, as is standard practice in similar community meetings in Giriama. In the villages, to avoid disrupting my main study participants, I found it convenient to talk to women while they were doing daily chores (such as cooking, washing utensils, farming, and washing clothes at home). I also had informal conversations with two traditional birth attendants and two community health workers. Interviews were either conducted in English, Swahili (the national language) or the local language (*Giriama*). Interview and discussion guides were used.

I engaged two female field assistants, who helped in the interpretation of local language and also follow up women in the villages. Walking in the villages with these two field assistants made women build confidence in this study and provided in-depth information on their experiences on maternal health and how such experiences affected their relationship at the household level. The two field assistants helped in the latter task because of their knowledge of the history of relations in *Mijikenda*. They also assisted in taking notes during the interviews and focus group

discussions. My main work was to lead the entire fieldwork research and as well as to do participant observations.

1.6.3 Ethical Considerations, Data Analysis and Presentation

Permission to proceed with the study and to guarantee respect for human subjects was obtained from the National Commission for Science, Technology and Innovation, (NACOSTI) and the county health office. Ethical clearance was obtained from Maseno University Ethical Review Committee and the University of Basel Research Ethics Review Committee. Furthermore, research participants were informed of the nature of the study and that participation in the study was entirely voluntary. Informed consent was obtained from all participants, and the respondents were assured of confidentiality. Respect for human privacy and dignity was maintained throughout the data collection and analysis process. Where individual's responses were reported qualitatively during the research period, no identifying name tags are used.

The transcripts of audio recorded interviews were downloaded into a computer. Transcription was done with a computer-aided transcription software F5 transcription-free. Two steps data coding was done manually to identify main themes and sub-themes emerging from the available data. I used grounded analysis to determine the underlying themes in this study whereby during initial coding, transcripts were studied line-by-line for analytic possibilities and create codes that best suited the qualitative data collected. After that, focused coding was done to select the most useful initial codes and test them against extensive data. Qualitative findings are presented in textual descriptions and illustrated using verbatim quotations. Results of this study were disseminated to various actors in the dissemination process.

1.7 My Position in the Field and Ethical Dilemmas Interviewing Poor Mothers

Indeed, my position in the field was much more than a set of intellectual pursuit of an academic study of maternal health and social protection. Fieldwork took place during an electioneering year, and I had to engage in informal conversations about local and national politics, and this had to play a role in my relationship with many other local people that I encountered in the field. Nevertheless, I had to remain sensitive to some political issues that emerged during a conversation with the locals which on the face of it could not have any relevance to social

protection and maternal health. I also had to remain sensitive to such matters of field relations and my position when doing ethnography because they influenced my relationship with the study participants as well as the type of information they were prepared to give me in response to research questions. In the health facilities, some practitioners saw me as a counselor who could talk to women who lost their children during delivery or those who had a stillbirth. I could spend time talking to such women because most hospitals did not have any psychosocial support for such mothers. However, I kept reminding the health practitioner that I was doing ethnography and talking to women and health workers was also a prerequisite for my study.

Occasionally, my research assistant (s) would remind me of the community values and norms. For instance, greeting any adult, we met during our walk in the villages was a gesture of respect and concern about other people's affairs,⁶ how to engage with women without evading their privacy and how to seek informed consent from women.⁷ Since the Mijikenda community is patriarchal and men are always superior and their decisions final, when present, I had to ask permission from the husband to talk to a mother. Until the husband permits us, then we⁸ could not interview the mother. In cases where the husband could not understand me due to the language barrier, then my research assistants could explicitly explain in the local language, and this made the husband permit us to proceed with our interviews.

Most of my main informants⁹ had low levels of education while a few of them were illiterate. I had to protect them by sticking to good ethical conducts. For instance, the code of ethics for anthropological work (AAA, 2009) focuses mainly on the ethical acquisition of knowledge, informed consent, knowledge, and information, confidentiality and anonymity in the

⁶ Among the *Mijikenda*, greetings are very important way of showing good intentions and also a way of creating good social relations. The *Mijikenda* easily identifies a stranger in their communities if he/she fails to greet an elder or fails to respond back to the greetings from a community member.

⁷ I remember during in-depth interviews in the health facilities, some women refused written consent to the study and some who agreed to the written consent did not carry their copies home. Next day after the interviews I could find signed consent forms thrown within the hospital compound or left at the maternity ward. This was due to fear of their husbands. In most cases they told me they had to consult their *Mwenye* which means husband.

⁸ I use the word 'we' to refer to myself and the other two research assistants.

⁹ In this case they were the poorest women in villages within Giriama community.

representation of knowledge and dissemination of knowledge and making knowledge available to research participants. The codes suggest resolving the problem of exploitation versus reciprocity by returning knowledge and information to those from whom it was received.

The moral dilemma I encountered during fieldwork were, however, of a rather different kind and related specifically to money, friendship, and other resources. During my fieldwork, I met a limited demand among the locals and the poor women households. Moreover, my interaction with different actors at different levels exposed various issues which to me were ‘sensitive.’ The dilemma was whether to write these problems or not bearing in mind how this could affect my relationship with these health actors, the locals, and the households. This resulted in what Ortner (1995) referred to as ethnographic refusal¹⁰.

I could visit women in the villages and find some had not eaten any food for the last two days. I was torn in thought about whether to help them buy food or assume that everything was all right. Therefore, on most occasions, I resorted to eating my meals in the villages with the poor households something that made Baba Hassan’s family see me as their first son. Being the first son comes with some essential roles. Sometimes I could work with households in the neighbour’s farms to get some money for food¹¹. However, I was cautious not to overstep my mandate in such situations. This shows the dilemmas anthropologists get into when studying ‘their people,’ I was torn between obligations to the discipline of anthropology and to the people I studied.

In the course of my fieldwork, I received phone calls and text messages from some of my Giriama friends and my participants asking for money and requesting me to engage in their

¹⁰ Ethnographic refusal is a practice by which researchers and research participants *together* decide not to make particular information available for use within the academy. Its purpose is not to bury information, but to ensure that communities are able to respond to issues on their own terms. It is a method centrally concerned with a community’s right to self-representation.

¹¹ Working on other people’s farms for money either by clearing the bushes, weeding, digging or harvesting is called *Kipande* (plural *vipande*). As a way of exploring poor women’s world, occasionally I accompanied them to the farms where I was given my portion to work on and voluntarily surrendered all my payments to the mother to add to what she earned with her children to either buy food or cater for other needs.

problems and neither any phone call nor text message demanding for the research results. My reactions were somewhat inconsistent, and I wavered between irritation, frustration and empathy. I did not want to build patron-client relationships with the people, which deemed inappropriate to my work, but when I turned some people down, I felt I was rather unethical. To my surprise, those that I turned down took it quite easy and continued shopping around in their social network for help. Within the webs of such expectations, I built lasting relationships with individuals and families in Giriama community. Even after leaving the field families sent me text messages on my phone to know how I was fairing on. To me, this meant that anthropologists' obligation to informants with regard to reciprocity of relations are more demanding when working at home. As opposed to foreign anthropologists who can easily engage in what I call 'quick-fix' anthropology, local anthropologists are bound to have a lifelong engagement with their field informants. For the outsider, the demand for the balanced reciprocity of information and relationship may be limited to the fieldwork period or continue only through sporadic correspondence with a few natives in the post-fieldwork period. However, the local anthropologist like me is expected by informants to continue with those reciprocal relations long after fieldwork. According to Onyango-Ouma (2003), the post-fieldwork period appears to be 'payback time' for local anthropologists who are often confronted with past informants' demands for gifts, favors and recognition in public places. Such demands are difficult to ignore when doing anthropology at home or in your own community.

1.8 Specific Research Questions

- i. How do externally imposed healthcare institutions impact on local care and livelihood systems?
- ii. How does the emical and practical experiences shape actors (families/households) decision on the program (maternal vouchers or free maternity) selection?
- iii. How do institutions (rules and regulations) on what levels but especially regarding access to vital cash resources for getting access to the systems impact the decision (at household and health facilities level)?

- iv. How does the bargaining power of women shape decision-making and how do women try to legitimize their choice of system or mobilize support?
- v. What is considered to be a good or bad support of maternal health social protection and why?

1.9 Hypothesis

- i. Women are in a rather weak bargaining power position and do face a double exploited position in care/reproductive and productive work (on the fields of their husbands), and this weakens their institutional choice regarding the maternal health care systems selection
- ii. Women try to increase their bargaining power and option to select institutions for the maternal health care by using ideologies of generalized reciprocity and husbands/families obligations and discourse of threat of the careless husbands/father/relative etc.).
- iii. Hidden costs and issues of quality lead women to diversify their strategies by including traditional midwives and other options as they do not trust either the voucher or the government.
- iv. Healthcare providers in the public health facilities face challenges in delivering services of the two interlinked systems which none seem better than the other.

CHAPTER TWO: How Free are Free Maternity Services in Kenya? Playing the Anti-Politics Machine in the New Politics of Distribution

2.0 Introduction

Currently, equity and universal coverage dominate policy debates worldwide. Health financing approaches are central to universal coverage. The way funds are collected, pooled, and used to purchase or provide services should be carefully considered to ensure that population needs are addressed under a universal health system. Despite the 58th World Health Assembly called for universal health coverage, the Kenyan health system is highly inequitable, and policies aimed at promoting equity and addressing the needs of the poor and vulnerable have not been successful (WHO, 2015). Some progress has been made towards addressing equity challenges, but universal coverage will not be achieved unless the country adopts a systemic approach to health financing reforms. Such an approach should also be informed by the people's perceptions of wider health system goals of equity and efficiency.

This chapter also presents the idea that health care resources might be distributed according to the notion of “a rightful share,” and particularly that such resources might amount to anything more than very small sums, does seem remarkably idealist. Moreover, in this chapter, I describe how international actors and organizations influenced adoption of free maternal healthcare services with the aim of reaching the vulnerable in the society, then describe how different actors perceive the free maternity services policy in Kenya. First, I will outline the perspectives of the economically disadvantaged women and local households then, later on, describe the views of health workers in the health facilities and the policymakers. The chapter also presents how Kenyan government through international aid has the financial and fiscal resources to provide healthcare for the poor through the distribution of free maternity services but many of the poor are still excluded in utilizing free maternity services, and on the other hand, the health facilities also lament on poor management of free maternity services in terms of reimbursement and facilities upgrade among other factors discussed in this chapter hence the cases for what Ferguson calls the “new politics of distribution.” This section will also explain how political layers and construction of legitimacies are shaping the strategic use of social protection schemes for maternal health care.

2.1 The Influence of International Actors on Maternal Healthcare in sub-Saharan Africa Today

Globally, maternal health services are dependent on the complicated, interdependent functioning of the whole health system. The links between inputs, process, and outcomes are subject to several multiple influences, and confounding factors and each country's context determine many factors that influence the outcomes of maternal health and the performance of the service. The health system becomes incredibly complex due to the difficulty in accessing quality maternal health services, the intermittent nature of demand, and the broad range of influential, as well as stakeholders with different priorities and agendas (WHO, 2017). In addition, international donors may sway the conditions of a country's health programs to satisfy their agenda. Many strategies have been suggested by international actors to reduce maternal mortality, including contraception, antenatal care, referral systems that include basic and comprehensive emergency obstetric care, and postnatal care. A recent review of the evidence shows the significant and successful role of family planning as a preventative strategy in reducing maternal mortality (Ahmed et al. 2012). Therefore, we are dealing with multiple layers of institutions which include the international donors who have their terms and conditions, the Kenyan National government, the County governments and the local people who are the targeted service beneficiaries and have their expectations.

However, universal health coverage (UHC) has been acknowledged as a priority goal of every health system (Garrett and Chowdhury, 2009; WHO, 2010; Kutzin, 2013). The importance of this goal is reflected in the consistent calls by the World Health Organization (WHO) for its member states to implement pooled prepaid health care financing systems that promote access to quality healthcare and provide households with the needed protection from the catastrophic consequences of out-of-pocket (OOP) health-related payments (WHO, 2010; 2013). This call has also been endorsed by the United Nations (UN, 2012). In its simplest form, universal health coverage is a system in which everyone in a society can get the health care services they need without incurring financial hardship. Therefore, the United Nations Sustainable Development

Solutions Network (UNSDSN)¹² advocates for maximization of health well-being for all ages through universal health coverage (UHC) and pro-health policies in all sectors (UNSDSN, 2014).

Nevertheless, today's health system reforms aiming at UHC can be traced back to the emergence of organized health care in Europe in the 19th century, in response to labor agitations calling for the implementation of social security systems (Bärnighausen and Sauerborn, 2002; Savedoff et al. 2012; McKee et al. 2013). This phenomenon first started in Germany under the leadership of Otto von Bismarck, and later spread throughout other parts of Europe such as Britain, France, and Sweden (Bärnighausen and Sauerborn, 2002; Savedoff et al. 2012; McKee et al. 2013). Later in 1948, the concept of UHC was implicitly enshrined in the WHO constitution which recognized that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition” (WHO, 1948). This fundamental human right was reaffirmed in the “Health for all” declaration of the Alma Ata conference on primary health care in 1978.

In 2005, the concept of UHC was once again acknowledged and for the first time explicitly endorsed by the World Health Assembly (WHA) as the goal of sustainable health care financing (WHO, 2005). The World Health Assembly resolution (WHA58.33) explicitly called for the implementation of health care financing systems centered on prepaid and pooling mechanisms aimed at achieving UHC (WHO, 2005). Based on this resolution, WHO defined UHC as “access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access” (WHO, 2005). The move towards UHC offers a unique opportunity for interdisciplinary research to study how governments, policymakers, health workers, patients and citizens in various countries are addressing questions of health equity, economic inequality, social solidarity, and the public good. Thus, UHC appears to represent a new approach and new ways of thinking about poverty and redistribution, the state

¹² UNSDSN defines UHC as equitable access to affordable, accountable, appropriate health services of assured quality by all people, including promotive, preventive, curative, palliative and rehabilitative services (UNSDSN, 2014).

and citizenship, health and development. UHC is innovative in its approach to social protection in relation to health, firstly, in its ambitions concerning social solidarity, and secondly, in its vision of the central role of the state. UHC represents a move away from the market-based model of healthcare toward a more central role for the state, and recognition of the need for new ways of tackling inequality and inequity.

Currently, the momentum around the Sustainable Development Goals (SDGs) and UHC have created new demands and opportunities for strengthening primary health care. The United Nations General Assembly adopted the SDGs in September 2015. They set the global direction for 17 development goals, one of which, SDG 3, focuses on health (United Nations, 2015). Improving maternal health will contribute to the health of the family and the community at large. This will also translate to the achievement of Sustainable Development Goal (SDG) 3 whose focus is to reduce maternal mortality to 70 per 100000 live births globally by the year 2030 (UN, 2015).

However, to reduce maternal mortality, one of the focus has been the removal of user fees for health care services in developing countries which has been the subject of much debate in the past decade (Hutton, 2004; Pearson, 2004; Gilson and McIntyre, 2005; Witter 2005; James et al. 2006; Yates, 2009). Free Health Care (FHC) policies aim to reduce the financial barriers that people experience when trying to access health services. An FHC policy eliminates formal user fees at the point of service; this can be for all services, for primary health care, for selected population groups, for selected services for everyone or selected services for specific population groups, usually characterized by the medical or economic vulnerability. However, studies examining the effects of fee abolition in Africa (Lagarde and Palmer, 2008; Lagarde et al. 2012) showed that after user-fee elimination there was an abrupt increase in utilization of services, but the increases were not sustained over time. Lack of sustainability in the health facilities, delayed decision making, little decision making power, political instability, poor transport infrastructure, long distance to the health facilities, disappointing long waiting time for service, shortages of service (e.g. drug), unfriendly handling by service givers, and generally low trust in the

healthcare services available at formal health care facilities and widespread of poverty were also attributed to decrease in facility-based deliveries (Wild et al., 2010; Hou and Ma, 2012).

Despite the adoption of the FHC policy, the international actors still admit that among many other factors, payment of user fees and other out-of-pocket expenses have had a negative impact on utilization of health care services in several countries in Africa (Leive and Xu, 2008). Therefore, following international organizations recommendations and financial support for countries to reduce health inequalities by extending coverage to the poorest, while increasing public investment in health through the development of sustainable health financing arrangements, several African countries adopted maternal delivery fee exemption policies as a way of reducing the global maternal mortality rate to less than 70 per 100 000 births, with no country having a maternal mortality rate of more than twice the global average (WHO, 2010; 2015). Today, over seventeen African nations either provide free maternal healthcare or a subsidized program for pregnant mothers to access skilled care.

In Burundi, for example, free services for pregnant women and the under-fives were introduced in 2006, and utilization appears to have increased as a result of free services. In Zambia, fees were suspended for rural districts in 2006. In Burkina Faso, an 80% subsidy policy for deliveries was launched in 2006. Liberia suspended payments for primary care in 2007. Niger announced free care for children late in 2007. Sudan announced free care for cesarean sections and children in January 2008. In Ghana, an exemptions policy for delivery fees was introduced in 2004. It was intended to cover all facility costs for intrapartum care in both public and private facilities (Manthalu et al. 2016). In Senegal, the government introduced the policy exempting users from delivery fees in 2006 (Witter et al. 2010). Not excluding other countries in Africa that offer fee exemption maternal care, almost all the policies were driven by some political momentum which was a response to donor and other international actors 'pressure' (Meessen, 2009). For instance, in Burundi, Liberia, and Uganda, the decision to abolish user fees was a decision by the President; in Burkina Faso, the decision was taken by the Council of Ministers. In Burundi, it was a top-down and sudden decision while in Uganda, the decisions were made during the

campaign for the presidential election. In Senegal, Ghana, and Liberia more actors have been involved in the decision (Meessen, 2009).

Protecting households from catastrophic health care expenditures has been a desirable objective of health systems worldwide. The literature on health expenses and economic status has grown over the past decade. Several studies in different countries have shown that the catastrophic out-of-pocket health spending has impoverished many households: India (Flores et al. 2008; Garg and Karan, 2009; Pal, 2012; Gupta and Joe, 2013), United States (Bennett and Dismuke, 2010), Turkey (Yardim et al. 2010), China (Yi et al. 2009), Colombia (Lara and Gomez, 2011), Zambia (Hjortsberg, 2003), Kenya (Chuma and Maina, 2012), Tanzania (Brinda et al. 2014). In a worldwide study, Xu et al. (2003) explored the determinants of catastrophic health expenditures in 59 countries and found that the share of government spending in total health spending was the primary explanation for the prevalence of catastrophic health expenditures. Free maternity policy in Kenya as a social protection mechanism has still not achieved its twin objective of reducing out-of-pocket payments for the mothers.

In Kenya, maternal mortality remains high at 360 maternal deaths per 100,000 live births (Ministry of Health, 2017; World Population Data Sheet, 2017). While this is below the Sub-Saharan average of 640 deaths per 100,000, Kenya experiences a slow progression in maternal health. Health services in Kenya are provided by both the public and private sector, with the government owning 51.0 percent of all health facilities in the country. The private for-profit and non-profit sectors hold 34.3 percent and 14.8 percent of all facilities, respectively. Still, the health system relies heavily on out-of-pocket (OOP) payments as the primary source of health care funding. In 2009/2010, OOP payments accounted for 36.7 percent of total health expenditure (THE) (Chuma and Maina, 2014). The government removed user fees in all public dispensaries and health centres, effective June 1, 2013 as a way of addressing the barriers to access to primary health care caused by OOP payments and to facilitate progress towards universal health coverage.

The free maternity services (FMS) program was meant to encourage women to give birth at health facilities under skilled personnel. This was also in keeping with the resolutions of the African Union favouring the point of service user fees exemptions for pregnant women and children under the age of five years (African Union, 2010). The policy aims at reducing maternal complications as well as maternal mortality by increasing access and utilization of maternal health services. The program is meant to eliminate all the charges for intrapartum care in public health facilities (*ibid.*). Surprisingly, since the introduction of the FMS program, In 2016 Kenya had approximately 61% of births delivered in a health facility. The central question that arises is, therefore, if all mothers and households had the message that ‘free maternity was free’ then what other issues were, at stake that hindered mothers from delivering under skilled personnel? Therefore, provoking one to question how free are free maternity services in Kenya?

Governments and international organizations are recognizing that equitable health systems are essential to achieving health-related sustainable development goals, that financing approaches are critical for the performance of any health system and for achieving universal coverage. However, global imbalances in income and distribution jeopardize coverage and equitable access to health care and fairness of financing of social (health) protection. Health systems in Africa and other low-income countries are predominantly funded through OOP payments. Out-of-pocket payments do not offer any financial risk protection; many households incur high health expenditure, while others are impoverished due to health care costs (Chuma and Okungu, 2011). Hidden costs in the free maternity services implied that households fell into unsuspected catastrophic spending in the wake of free maternity services utilization and the poor mothers fell back to poverty traps. As such out-of-pocket financing of the costs of facility delivery have substantial financial repercussions on households and makes low-income families more vulnerable to impoverishment after spending all money, they have in healthcare. Therefore, households were forced to come up with coping strategies which included borrowing money or sell valuable household items which also exposed families to the risk of assets depletion as discussed in detail in chapter five of this thesis.

Next section will now describe the perspectives of economically disadvantaged women and local households on free maternity services. It explains how free maternity services are not free and have led to catastrophic health expenditure in poor households.

2.2 Perspectives of the Economically Disadvantaged Women and Local Households on Free Maternity Services

Nothing is free. If in free primary education parents still pay, so you think this maternity is free? No, first clinic visit we pay for laboratory tests and the small book for clinic and of course if there are drugs to be bought I have to buy and like me I come from far so I have to cater for transport, but sometimes I walk if there is no money (In-depth interview Dagmar, 38 years old).

The excerpt above derived from an in-depth interview with the mother draws attention to realities on the ground of how poor mothers in the village perceive free maternity. The central overriding theme that emerged from this study was: “how free are free maternity services in Kenya?” Understanding how health services are perceived and accordingly utilized or not utilized is the first step toward identifying limitations and taking actions to improve the efficacy and accessibility of services. Removal of all user fees for maternity care in all public health facilities in Kenya was expected to increase maternal health service utilization and prevent mothers from the catastrophic expenditure. However, findings from this study show that free maternity care in Kilifi County is far from removing all financial barriers to accessing skilled birth care. Non-medical and medical expenses such as transportation cost for pregnant mothers and persons accompanying them, laboratory tests, antenatal profile, and medicine are for example not covered by free maternity. Therefore, mothers had to meet these expenses before getting the services, which means: without payment no “free service” or with other words: No payment - no access.

Most mothers I spoke to during my fieldwork did not buy into the discourse of free service. For them, there was nothing like ‘free’ maternity. Dagmar, for instance, compared free maternity services with free primary education policy, which works in a similar logic. Free primary education policy in Kenya was introduced in 2003 by the Kenyan government however it has also had its challenges. Mothers in this study were poor of the poorest in the community, and

every single cent meant a lot to them. Thus, the poor mothers noted that free maternity was too costly for them and it ‘ate’ into their little resources. Although user fees were once believed to promote higher quality health services and provides an important source of revenue for resource-strained health systems, nearly all global health actors (e.g. intergovernmental organizations, non-governmental organizations, etc.) now agree that user fees represent an inefficient funding mechanism that negatively affects the utilization of essential health services (Robert and Ridde, 2013). This led to the promotion of user free service declarations. In this study, some mothers also labeled FMS as the ‘president’s programme’ meant to help women to deliver for free which turned to be expensive for mothers.

Like I know Uhuru said we deliver for free. But in reality, free maternity is a bit expensive because we have to pay some money (Field notes, May 2016).

As the study will show, later on, paying for health might either lead to catastrophic expenditures or the mothers not using the services at all leading the majority of the women who delivered at home being assisted by their mothers-in-law or their biological mothers, some by TBA or skilled birth attendants. This posed a great danger to the pregnant woman and the baby since the untrained birth attendants ‘delivery services’ are informed by some detrimental cultural practices like massaging of the abdomen before delivery. Massaging is done to align the baby in the right position in readiness for delivery. Most of the massaged women are unaware of the dangers associated with it that include placenta previa and abruption, asphyxiating the foetus and increased chances of trauma to the baby and premature delivery or even in worse cases maternal death. However, it was evident from participant observation that the TBAs were working closely with the health facilities by referring pregnant mothers with obstetric complications to health facilities. Training TBAs, therefore, may result to increase of referral for complications, immunizations, and any other maternal health care problem. Thus, if TBAs had the appropriate skills required, they could deliver proper care to save the lives of many women living in hard to reach settings, and this too would help in achieving the social protection goals.

As I stated earlier in chapter one, I did my fieldwork when Kenya was preparing for 2017 general elections, and each presidential candidate for both the opposition and the ruling government were selling out their pledges to the Kenyan people. During political parties' campaigns, health care agenda especially expansion free maternity was one of the key political pledges for the ruling government (see Fig. 2.0). In the villages, poor mothers argued that free maternity had been used by the Jubilee government (the incumbent government) to gain political mileage in coastal region which then has been one of the opposition government's stronghold. However, from the voices of poor mothers, 'free' is not free but it has been used as a mechanism and a way of expanding the power of the state, and this took vulnerability of poor pregnant mothers as an entry point. It was launched as an intervention which could also prevent poor mothers from incurring catastrophic expenditures, but this was not the case as mothers had to spend more money on things that ought to have been provided for free by the government. For instance:-

But the government knows very well that we are very poor so when they make those promises they believe the poor will vote for them. I tell you it is just all politics. We voted, but in the hospital, we still pay (in-depth interview, Malkia 39 years old, March 2017).

I tell you we have been paying money when we deliver in health facility X. we cannot question them because they are right. That free maternity thing was to convince us to vote which worked now I hear about it again because it is time for politics. I don't trust the president words. How can it be free if we don't have enough doctors and beds in the maternity? And now the doctors are on strike I know because of poor salaries (Informal conversation with 38 years old Ndanzema in Usoni B village).

Additionally, from these narratives, poor mothers were aware that the government took advantage of their poor condition to make a promise and they also wondered why a government would offer free maternity if there were no adequate personnel and infrastructure regarding beds and other equipment such as essential drugs. Doctors and nurses are always on strike due to poor pay and heavy workload¹³. Until July 2017 when I was leaving the field, nurses were still on

¹³ Field Notes 2017:

strike. During focus group discussions with mothers, it was commonly mentioned that free maternity was an excellent initiative which enabled mothers to access skilled delivery but on the other hand it had a strong attachment to politics. This follows how it was introduced as a fulfilled pledge by the Jubilee government in 2013. Some of the citations from the focus group discussions held in June 2017 and individual interviews with women aged 30-49 indicate this strategic notion of the initiative:

It is not a bad thing; it has helped most poor women deliver in hospitals. I know it was jubilee government promise to mothers however as much as it helped Uhuru to get more votes, I wonder why we don't have adequate medicine, beds, and doctors in the hospitals. Today see it is constant nurses and doctors strike surely this free maternity was purely political (Zuhura FGD Participant).

Another mother during an in-depth interview added that:

It was the president who said it during the campaign that we deliver for free, and yet sometimes we pay. I think it is just pure politics as usual during campaigns to get votes. Now you hear doctors strike so why is it free if even doctors cannot be paid you see (In-depth interview Mother 35 years old).

From the discourses presented here, it is clear that free maternity policy had helped poor women access skilled deliveries but was also political which means it was not taken seriously by some of the beneficiaries or it was not trustworthy to be taken. There was the narrative of the obvious contradiction between free and payment. In addition, the women argue that there was a link of the strike of the health workers and the free delivery issue. To the women, strike meant that the health personnel were not paid, so free maternity was not a serious policy initiative.

Some of the health team from the county described how they had had to make their own arrangements to overcome the challenges faced in implementing the FMS policy. Of particular concern was about the effect of the policy on the workload of existing staffs due to the increased numbers of women attending services. They make their own arrangements by hiring locums or postgraduate doctors (whose over-time work was not paid) to deal with the shortage of medical doctors, and part-time nurses or student nurses to ensure sufficient nursing staff.

Based on poor mothers voices, I argue that FMS, in this case, a neo-liberal policy that fakes government's involvement in development and decentralization, masks low financial basis and independence of counties and gains the elite political meeting global health development expectations and goals. Ferguson (2015) refers to such policies as an anti-politics machine. In this case, FMS has been used as a blueprint to reduce maternal mortality in Kenya following international call to reduce maternal mortality. FMS has become visible as a development project where for instance there has been an increase in skilled birth in Kenya courtesy of free maternity and other maternal health care programs. As perceived by the local women in some cases FMS ended up performing extremely sensitive political operations which also involved expansion of institutional state powers which are so invisible and hidden under cover of neutral, technical mission and nobody can notice or object (Ferguson, 2003; 2015). Indeed, government services as Ferguson (2003) put it are never merely "services." Instead, such "services" have 'hidden' goals to achieve at the end of it all. In this case, free maternity service is perceived as producing 'hidden' costs that mothers are not told hence proves to be more expensive for poor mothers with the strategic use of gaining votes. Despite free maternity being expensive for the poor mothers, Kenyan government receives a lot of funds from donors to support the program. However, these funds are also pegged on achieving some political goals by the 'powerful' state agents. For example:

Donors know that Kenya is a proactive country in maternal health or health in general. Free maternity attracted a lot of funds, but I know it has performed many political functions. No government rolls out a project without a hidden agenda (Informal conversation with a senior health official, March 2017).

Next section will now discuss the perceptions of the frontline health workers in the health facilities and policymakers at the County level. It also shows how free maternity services could have led to a compromised quality of care due to inadequate supplies and human resource among other factors.

2.3 Perspectives of Health Workers in the Health Facilities and the Policy Makers

Steve: *How have you been? It is a long time seeing you?*

Zubeda: *I am fine*

Steve: *I am also fine. So the reason why I have come back here is to have some brief discussion on issues of free maternity and OBA and maternal health services that you people offer here and how they affect lives of the poor mothers in this region, poor of the poorest. So generally, I wanted to know how FM and OBA operate in your section here and how you perceive it.*

Zubeda: *But I had told you, I can't keep on repeating the same thing, and there are no changes please come with another thing.*

Steve: *You know sometimes these things keep on changing*

Zubeda: *They have not changed because now I think I had told you we don't have FM here, OBA has no funds now. Right now the clients pay then we offer services.*

This excerpt is from one of the key informant interviews with one Matron in-charge of Maternal Child Health (MCH) department in a public health facility in Kilifi County. We had first met in August 2015 during the exploratory phase of this study. She is one of the primary decision makers at health facility level who also sits with the policymakers on health matters in the county. During my second phase of fieldwork, I had an appointment with her, and she was delighted to talk to me once more. However, she did not know the kind of questions I was going to ask her. When I arrived for the interview at 10.00 a.m I had to be patient because she was busy. Zubeda¹⁴ came after one hour and invited me to her office. The excerpt was precisely from the start of our conversation when I explained to Zubeda that I was interested in her opinion and perception on free maternity and the maternal voucher system. As one can see from the excerpt her reaction was extraordinarily un-polite and harsh – “*I can't keep on repeating (...), please come with another thing*”, which was in great contrast to the first moment when we saw each other in August 2015.

Her reaction, however, can be interpreted as an incredible frustration. Health workers are the fundamental pillars of realizing the potential for increased quality maternal health care. Without them, mothers and newborns will not receive the care they need. I was shocked by the harsh

¹⁴ The name is fictitious

reception I got from Zubeda the moment I asked about how free maternity program operates. However, I had to convince her and make her express her frustrations out of which she answered all that I asked her. The matron became so harsh at me revealing how together with other health workers they were helpless and frustrated by the system and how the word “free” has been used to deceive pregnant women in Kenya. According to her, if the policy does not cover antenatal and post-natal services, then there was no free maternity. According to Zubeda, in maternal and child clinic, mothers had to pay a minimum of Kshs. 200 an equivalent of 2 USD for prenatal profiling and additional costs for laboratory fees, medicine and for the subsequent visits mothers spend at least Kshs. 20. Therefore, health workers struggle to deliver an absent service by using a wrong label of ‘free.’

Free maternity covers delivery only. Here in MCH, we charge mothers, but I wonder why only free delivery and not free antenatal and postnatal care (Zubeda).

When expressing her frustrations, she wonders why free maternity covered delivery only while the entire antenatal period was also critical during pregnancy. Zubeda’s disappointment was also due to the *status quo* of free maternity despite previous research by other organizations and even government agencies. Health workers had been asked almost similar questions that I was asking Zubeda with an assurance of taking into consideration their recommendations, but things have never changed. From a local perspective, therefore, this implied that as a health worker, Zubeda’s reputation was extremely undermined without payments.

When free maternity was introduced in 2013, there was an influx of expectant mothers flocking in for free deliveries in most public health facilities in Kilifi and other Counties. Later, women retreated after realizing there were ‘hidden-costs’ involved and that free was never ‘free’ and it seemed expensive to deliver in a health facility. Other health workers in this study reported cases where mothers never finished their ANC’s due to lack of money for transport to the health facility. It was clear that while the policy led to a rapid increase in facility deliveries, this was not matched by an increase in health facility capacity in term of human resources, supplies, beddings and other equipment and hence compromised the quality of care.

During participant observations in the health centres, I witnessed cases where women came to deliver late when the pregnancy had been complicated, and in some cases, such complications

resulted in either maternal or neonatal deaths. It is evident that despite the increase in facility-based deliveries courtesy of available social protection schemes in maternal health, women still died due to hidden health expenses posed by free and 'not free' programs. One can, therefore, argue that, since there was an early attraction of the 'free service' which led the service to be too successful, and the response overreached the capacity of the health centres before it became clear that there were hidden costs and it was likely that 'free service' was too expensive. It, therefore, implied that the free maternity healthcare policy in Kenya had been interpreted positively in theory but later on negatively in practice. I was surprised to see the media reports concur with my study findings (see figure 2.1). The report was published when I was writing my PhD thesis, during this time nurses and doctors were still on strike. The report summarized why 'free' health care could never be free. It was also noted in the report that free maternity was a political tool used by the government to deceive the electorate and that even in developed states health care was not free. In the publication, possibilities of cost-sharing the healthcare cost between the government and the patients were also proposed. This could possibly be a way of cushioning the expectant mothers from exhausting their resources.

Figure 2. 1 Media Publication Report

State should admit it is unable to run free healthcare

FRIDAY SEPTEMBER 15 2017

In Summary

- The never ending nurses and doctors strikes is a sure testimony that the government has no capacity to provide free healthcare and pay doctors.

That healthcare is free is a lie told so many times by the government. Expectant mothers have been told that maternity services are free. But that has all been a big lie with devastating consequences on the health sector.

The never ending nurses and doctors strikes is a sure testimony that the government has no capacity to

provide free healthcare and pay doctors. Its no use preaching free healthcare, which is a mirage, yet unattended patients continue dying.

The solution is to revert back to cost sharing. The government can subsidise healthcare and patients can pay a flat fee, say Sh200 per visit.

Free healthcare was a political gimmick and its time to sober up. Even in developed economies, healthcare is not free.

Source: (www.nation.co.ke).

The media publication in figure 2.1 and the study findings clearly reflects James Ferguson's explanations that instead of conceiving the government as purposed to provide services, one may just as appropriately think of these services' purposed to govern. Any government service can be turned into a political, controlling purpose through the use of restriction of service, propaganda along with service, or the granting of extra service to supporters. Moreover, this insertion of the bureaucracy could not have been done except under cover of a political development project. Therefore, Ferguson proposed a direct cash payment for all as people can decide themselves on what to do, therefore, unconditional direct health payments to the poor mothers would be best because free service can never be provided (Ferguson, 2015).

In all health facilities, health workers in MCH and maternity unit section noted that free was only for delivery for all expectant mothers regardless of their socio-economic status. FMS did not cover antenatal profile registration, transport to the health facility and other additional costs such as drugs or other necessary supplies such as cotton, sanitary towels needed during delivery.

Furthermore, health providers also expressed their concerns about the cost-effectiveness of free maternity services to poor pregnant mothers. Poor expectant mothers with complication could sink into poverty because they had to feel the pinch of high-cost implications of free service. However, the health facilities waived hospital fees for the poor mothers who could not meet the costs for other supplies and medicine and as an alternative to cope with free maternity and encourage skilled care deliveries. Waiving the hospital fee lied at the discretion of the health workers to give or not to give thus access to facility delivery becomes unintentional. For instance:

Yes, it is not free as such but what happens to those who cannot pay is that we do have a waiver system. We ensure that the mother maybe who cannot afford anti-D is given or those who cannot afford things like ultrasound get those services (KII Matron Zena, Public health facility).

2.3.1 Likelihood of Compromised Quality of Care

Other health workers also felt that free was expensive for the health facility. This was due to inadequate staffing, inadequate supplies, equipment, and poor infrastructure. During participant observation which included many visits to the hospitals and clinics, I noted several mothers sharing small beds in the hospital. Sometimes hospitals had many deliveries, and the bedding spaces were low to accommodate such a number. Mothers were therefore forced to either sleep on one bed in turns or sleep on a chair or sit till morning to ensure their newborns sleep on the beds. As a result, some health workers felt that there could be chances of compromised quality of care due to such policy. For instance, I also observed one of the maternity ward having only two qualified nurses who also assisted a midwife during deliveries and also had to check on the mothers and their newborn. Mothers who had normal deliveries were under observation for some hours and if in stable condition and no complications they were discharged in less than the WHO recommended duration for discharge.¹⁵ Such practices were likely to compromise the quality of care, and worse could result in more maternal deaths in case of later complications.

¹⁵ World Health Organization recommends that after an uncomplicated vaginal birth in a health facility, healthy mothers and newborns should receive care in the facility for at least 24 hours after birth and for the newborn this includes an immediate assessment at birth, a full clinical examination around one hour after birth and before discharge (WHO,2014).

I also had informal conversations with the health workers of both cadre, and most of them acknowledged that free maternity indeed led to increase in facility deliveries across the country, but there were ‘hidden’¹⁶ teething problems which affected the health workers as well as the service beneficiaries. Most health workers felt that the policy did not set correct incentives for health workers and reduced their motivation. This led to a loss in quality of care which had an opposite effect to that intended by the policy. Some conversations also concurred with my observation for instance:

Sometimes mothers who deliver safely and with no much complications are discharged earlier provided they have been observed, and their condition and the baby is okay. They have to leave room for other mothers because we don’t have enough beds and the more they stay here they can contract other diseases (Informal conversation with a female matron-public health facility)

The discourse above depicts a sort of treatment which was very risky because free was not very free and adequate quality of service could not be given to the mothers who delivered their babies as they had to be prematurely discharged to give room for others.

During roundtable discussions with the county officials, where the participants were the main actors in policy formulation at the county level, the narrative of ‘free’ not being free also emerged. County officials could frankly talk about how free maternity policy works in theory, and they were able to show me the circular from the Ministry of Health (MoH) following presidential policy directive on maternal health in 2013 (see fig 2.2). However, some health workers had not seen a written circular from MoH and it was difficult (for them) to know what was free and they explained their dilemma regarding the public expectation versus the actual content of the policy, for instance, the public expected that when they walk through the (facility) gate, everything should be free which was not the case. Policy document stipulates that all maternity deliveries including cesarean section are offered free without any charges in all public

¹⁶ One health worker said ‘free maternity has led to massive facility delivery not only in Kilifi County but in the entire nation. However, there are hidden problems, I mean problems that the government seems not to care about and see them as less valuable. Unless someone comes and sit down with us here then you will see these hidden problems. For example, a lot of burn outs, inadequate equipment, delay in reimbursing free maternity funds and lack of interest in expanding maternity wards.’ Therefore, quality of care is likely to be compromised in a way (conversation with health worker, May 2017).

health facilities. Also that user fees charges under 10/20 policy were abolished and that dispensaries were reimbursed Ksh. 2,500 while hospitals get Kshs. 5,000 per delivery. The discussants, however, expressed dilemma on how free maternity policy operates in practice since it was still not clear for them when the policy begin covering the expectant mother and when such cover stopped¹⁷. In our discussions, there was a unanimous agreement that free maternity was mainly for free delivery only. However, just like other health workers in the health facilities, the county officials also felt that free maternity should give cover to pregnant mothers from antenatal visits to post-natal care. But they were also helpless on how to ensure that the health facilities implemented pre-natal and post-natal care amidst meager resources and delayed reimbursement of funds claimed after provision of free maternity services. From our discussions, it was evident that the health officials were not only in a dilemma and helpless about the free maternity policy, but also expressed lack of clear guidelines on how to operate in stressful situations. For example:

*Actually, in policy, free maternity is supposed to be free for all pregnant women from antenatal (ANC) profile to delivery. However, in practice, the mothers pay some little amount for ANC profile. So basically free is only for delivery, and we don't have a clear free maternity policy document giving our health facilities clear guideline on all the components it covers. We are also helpless because we cannot tell a health facility not to take some little money when the national government does not send reimbursements for free maternity in time (Participant 2, **Roundtable discussion with County officials**).*

Another discussant added that:

*We can say here that free maternity service covers ANC profile and delivery. But in reality, this is not the case. What of the laboratory and other things such as drugs? We don't have a policy directing hospitals to offer free lab services for the pregnant mothers. So mothers will have to pay (Participant 1, **Roundtable discussion with County officials**).*

¹⁷ Field Notes April 2017:

In some facilities, the FMS package covered the continuum of care, including antenatal, delivery and postnatal care for up to 6 months or so, whereas elsewhere, the policy covered only delivery services. Other health workers questioned whether complications during pregnancy, such as ectopic pregnancy and abortion, should be included as part of the policy, others mentioned charging a woman who returned to the facility with complications after she had been discharged.

From informal discussion with one of the busiest health facility managers, he said:

If mothers come to the clinic, they have to pay some little money. And let us say a mother delivers and is discharged for free, if anything happens within the puerperium period¹⁸ I believe the free maternity policy should cover her, however, this has not been the case but they get admitted at paediatrics ward, and they have to pay, or the hospital will waive some women in extreme cases. And as top management, we cannot do anything outside the policy parameters, but circumstances make such happen. So free maternity is preached but in the actual sense, some costs are still incurred, and as management, we are in a dilemma on such issues (Field notes, March 2017).

Mothers once discharged from the hospital, then let us say some complications arise at home or on her way home, if she comes back here she will not benefit from the free maternity policy but will be admitted at the pediatrics ward or the female ward. Now you see free maternity is only for delivery but not post-delivery. I feel free maternity is good theoretically but practically it has a lot of gaps which are a big challenge to health workers. That is why they could not take it to private health facilities (Field Notes, May 2016).

From the above excerpts, it is apparent that the policy does not cover mothers up to puerperium period which is very critical because many of the complications leading to postpartum maternal morbidity arise during labour and delivery and in the first 1–2 weeks following delivery. According to the excerpt, however, when such complications occur then the family members have to cater for the health expenses. Where there is no money then, important household assets had to be sold to cater for healthcare, and in extreme cases, lack of money resulted in maternal death. Therefore, such gaps in free maternity policy in Kenya negatively affect service delivery hence labeling the policy ‘good theoretically and poor in practice’.

I had a candid conversation with one of the top county health officials, and according to him, free maternity which he referred to as a politically instigated policy was an outstanding initiative but had led to the uneven implementation of the policy regarding equipment and drugs supply and this varied from one region to another. And that ‘free’ services had cost implications either

¹⁸ WHO defines the postpartum period, or puerperium, as beginning one hour after the delivery of the placenta and continuing until 6 weeks (42 days) after the birth of the infant.

to the service providers or the poor mothers. Therefore, reducing financial barriers to the poor could be impossible if healthcare standards were inadequate or ‘free’ service itself was absent. He said:

It is a good initiative but even fee exemption policies that appear comprehensive on paper can cause high costs for households due to poor quality, uneven implementation, and lack of monitoring of such programs. There are recurrent shortages of drugs in the public hospital pharmacies that require families to buy drugs from private pharmacies, and this is too expensive. In short, it will be impossible to fully reduce financial barriers and reduce maternal mortality if healthcare standards remain inadequate or services are simply unavailable (Field notes May 2017).

Figure 2. 2 Circular from the Ministry of Health on Free maternity Policy



From the desk of

**Cabinet Secretary
Ministry of Health**

P. O. Box 30016-00100 Nairobi Tel: 254 20 2717077

Fax. 254 20 2248552 E-mail: cabsecretary@health.go.ke

MMS/FIN/1/39 Vol I (35)

1st June, 2013

Chief Executive Officer
Kenyatta National Hospital

Chief Executive Officer
Moi Teaching and Referral Hospital

Interim County Health Coordinators

RE: FREE MATERNITY DELIVERY PROGRAMME/HEALTH CENTRES AND DISPENSARIES SERVICES

In line with the Presidential directive on free maternity services, the Ministry has made the following policy changes with effect from 1st June 2013.

1. All maternity deliveries including caesarian sections in all public health facilities shall be offered without any charges.
2. User fee charges under 10/20 policy are abolished.

The Ministry shall reimburse Health Centres and Dispensaries Kshs 2,500.00 per delivery and Hospitals Kshs 5,000.00 per delivery.

The Health Centres and Dispensaries will be reimbursed for loss of your users' fees and maternity charges through Hospital Sector Services Fund and the hospitals through Hospital Management Service Fund.


James W. Macharia
CABINET SECRETARY

Copy to: Mr. Francis Kimemia, EGH
Secretary to the Cabinet

Circular from the Ministry of Health following presidential free maternity policy directive (Retrieved from Kilifi County Government Department of Health Services 2017).

2.4 Shifting the Blame

In this study, shifting blame emerged as a ‘scapegoating’ mechanism and no health worker wanted to be associated with anything that undermined healthcare delivery in their health facilities. This was cross-cutting on all respondents in this study; women also accused the government of lying to them about a service which eats into their resources. Such blame portrayed clear expectations from the state by the citizens. For instance:

They charged me during my first antenatal Kshs. 300 so the president lied to us about free maternity? (A mother in a maternity ward, May 2016).

During my fieldwork, most health workers were not willing to talk about issues that could label them as rebels against the government.¹⁹ Therefore, nearly all health workers interviewed in this study shifted blames on failures of free maternity services from one level of management to another. For instance, delays in reimbursement of free maternity funds from the national government to the county government then eventually to the health facilities, created a state of the blame. Health workers blamed county government for not releasing the funds in time, and the county also accused the national government of not telling the health workers that delay was from the national offices. Evidently, during my fieldwork such blames were one of the reasons that led to health workers strike where late reimbursement²⁰ of free maternity funds to the health

¹⁹ During initial phase of my field work most of the health workers were not willing to talk about free maternity services in Kilifi County on recorded interviews and even when I resorted to informal conversation and notes taking, some could keep on reminding me to protect their identity as agreed earlier.

²⁰ Late reimbursement was based on the institutional arrangements for reimbursement and the complexity of the process. Facilities must request funding through the county health department which, in turn, submits facility data (eg, the number of births) to support the claim to the National Health Treasury. The National Health Treasury verifies the county requests by triangulating the data received with routine District Health Information System data. Funds are then transferred to the relevant county health treasury where further processing takes place before the funds reach the health facility. Most health facilities had encountered challenges because of inefficiencies in the reimbursement processes, including delays in receiving disbursements and the receipt of insufficient funds. These challenges frequently affected planning at the health facility level. Thus, through crafting informal institutional arrangements, County health officials also encouraged some health facilities to make use of the NHIF to alleviate the burden of the poor reimbursement processes under the new policy that is to ask women participating in the NHIF scheme to cover the costs of maternity care using their insurance scheme requiring out-of-pocket co-payments. But the women were reluctant to pay for maternity care using their insurance as they assumed the services were free for all.

facilities, failure to honor collective bargain agreement for salary increments among others were also some of the issues that health workers wanted the county government to address before they resume work. Doctors' strike which began in December 2016 went for 100 days and led to the closure of every public health facility in Kenya. For 100 days, the taxpayers, whose taxes were meant to cater for their health, were denied a fundamental right. As patients died, the health custodians played hardball and ignored the silent genocide they had set up.

Eventually, the strike ended, but the respite was short, and a few weeks later, nurses also went on strike, paralyzing operations of every health facility in Kenya. By the time I began writing this PhD thesis in 2017, the nurses' strike had crossed the 100-day mark, and maternity wards in all public health facilities across the country were closed. During participant observation, in the villages, I could see women so devastated when their children fell sick. Some women resorted to traditional herbal medicine, local medicine men and local TBAs for delivery and blamed the government for not resolving health workers' strike. In the villages, I was also informed that health workers strike led to rising in infant mortality although the number cannot be evaluated. The narrative was that there must have been many cases of infant mortality, leading to harsh reactions from the county government that threatened to sack nurses who were still on strike, but such threats fell on deaf ears. Nurses stood their ground only to return to work once their grievances were sorted out. This was the only way to send a message to the national government that free was not free if health workers too could not be paid. James Scott (1985) argued that the powerless groups, in this case, the health workers, engage in everyday resistance against situations they deem unfair. They use the ordinary weapons of relatively powerless groups: such as foot-dragging, dissimulation, false compliance, pilfering, feigned ignorance, slander, arson, sabotage, and so forth. Such resistances are not necessarily directed at the immediate source of appropriation, in this case, the pregnant mothers, and they often avoid any confrontations with authority or with elite norms. The advantage of such means of resistance required little or no coordination or planning. The hospital staff used the nationwide health workers strike as weapons of the weak and one of the ways to deal with frustrating situations as nobody could find out whereabouts of the released free maternity funds for the hospital and nobody was ready to


fulfill the agreed salary increment which led to a blame game discourse. Each actor blamed the other up and down and in the different scales of administration for not delivering the service. For instance, the lower level of less bargaining power argued that the higher level did not take them seriously:

When you go to the county, they tell you the national government has not released funds and when you call someone from the headquarters in Nairobi they again tell you money had been released to the county. A total blame game because the mothers also end up blaming the hospital for not providing some essential drugs and commodities. I cannot also force nurses to work without some essential commodities, and this result in blame from the service beneficiaries in this hospital (KII, Chenzo hospital matron June 2016).

At the top health management level, blame was evident for instance, the county government also blamed the national government for not releasing funds in time and this made offering free maternity difficult in most counties. During my fieldwork, the council of governors had a meeting, and through the chairperson of the council, the governors threatened that before offering services to expectant mothers, all public health facilities could start charging services fee due to frustrations from the national government and lack of funding for the programme (see figure. 2.3).

Figure 2. 3 Publication Depicting Shifting the Blame

“Everything the women use in hospital, including the food they eat and the medicine they use, requires money,” he added.

Mr  said county governments had borrowed funds from other sources but are now overwhelmed.

“I am afraid that we might have to charge the women before we offer our services. It appears the national government is not taking us seriously,” he said.

Source: *The Daily Nation Newspaper on 24/06/2016*

In summary, free maternity policy was meant to address the cost barrier associated with accessing maternal health services to encourage women to give birth at health facilities under skilled personnel. However, from the perspectives of the economically disadvantaged women and health workers, there was nothing like ‘free’ maternity. Non-medical and medical expenses such as transportation cost for pregnant mothers and persons accompanying them, laboratory tests, antenatal profiling, postnatal care, and some essential medicines were for example not covered by the free maternity policy.

Additionally, the free maternity policy acted as a political tool used by the government to get the votes. James Ferguson referred to such policies that fake government’s involvement in development and decentralization of services which in the long run benefits a few political elites as an anti-politics machine. Moreover, due to inadequate staffing, inadequate equipment, lack of infrastructure and low medical supplies, quality of services were compromised as the health workers had to cope with stressful situations and lack of clear policy guidelines to ensure that expectant mother delivers safely and leave maternity wards happily. Amidst such frustrations and blame games, the hospital staffs used weapons of the weak as the only way to express their dissatisfaction with free maternity policy.

Lastly, free maternity policy as social protection programs can either facilitate or incentivize the utilization of health care services. For example, many conditional cash transfer programs such as OBA and free maternity make cash payments conditional upon the use of immunization, antenatal care, or other similar preventive health services. Therefore, the Kenyan government and the donors should think of a way of providing unconditional cash transfers because unconditional cash transfers which do not make a direct linkage to service utilization, may also facilitate the use of health care services, for example, by enabling people to pay the user fees demanded by some health systems or mobilizing resources and prioritizing on maternal healthcare. Moreover, to ensure that the social protection goals for pregnant mothers are met, the Kenyan Government needs to improve maternal health services in public hospitals so that an adequate level of quality services are provided, without externalizing costs to the users of free maternity services.

CHAPTER THREE: The Politics of New Distribution as Undermining Public and Developing Private Health Services

3.0 Introduction

Stemming from arguments in the anti-politics machine and on how free maternity service are not, this chapter describes the evolution in approaches to maternal health care financing and what such changes mean to the local people and service providers. Political goodwill plays a critical role in the growth of health care financing in Kenya therefore how political layers construct the legitimacies and shape the strategic use of resources between public and private health facilities is also discussed in this chapter. This section also explains the new institutional developments in financing maternal health care in Kenya. The focus will also be on perspectives of local people and service providers and to show whether they are acquitted of these new approaches and what this means to them as far as social protection is concerned. The chapter also discusses who benefits in terms of getting services and resources allocation when there is a change in health care financing strategies. The section, therefore, exposes whether such ‘new distributions undermine’ social protection efforts through maternal health care in Kenya. The chapter also highlights how the service providers use the weapons of the weak against the state to survive the changes in policy approach.

3.1 New Institutional Development in Financing Maternal Healthcare in Kenya

A health system that functions appropriately must have the necessary ingredients. Such ingredients are the six world health organization’s health system building block, and they include; health workforce, service delivery, health technologies (medical products, vaccines & technologies), financing, information, and leadership and governance (WHO, 2009). Such building blocks must have a leadership that is committed to a vision that focuses mainly on the people, particularly the poor, the sick and the disabled and through various initiatives encourages change on individual behaviors and also clear institutions such as guidelines, all factors that render health challenging and complex to manage. The Government of Kenya is committed to the improvement of health and welfare of its citizens. Over the years, the government has taken necessary steps towards this goal, underscoring that the provision of health services should meet

the basic needs of the population and be geared towards providing quality health services within easy reach of Kenyans (Kenya National Bureau of Statistics et al. 2015).

Healthcare financing should be equitable. In many developing countries such as Kenya, changes to healthcare financing systems are being implemented as a means of providing equitable access to healthcare with the aim of attaining universal health coverage (Munge and Briggs, 2013; WHO, 2016). Kenya is also a signatory to some regional and international mandates to guide the formulation and implementation of maternal health policy. Therefore, Kenya has been seen among development agencies and the Global North as a proactive African country regarding new maternal health policies. However, the central question is then what does change in maternal health care policy approaches mean to local people and service providers regarding social protection, and who benefits from such policies?

In Kenya, there are other social protection schemes in the field of healthcare financing. Since 2006 to mid-2015 maternal vouchers also known as Output-Based Aid (OBA) had been providing vulnerable women with free access to reproductive healthcare competitively in both the public and the private accredited health facilities in Kilifi County. The intervention targeted the most vulnerable population explicitly and allowed the poor women to choose the healthcare provider. It led to an increase in skilled deliveries among women with low income who could otherwise not have accessed such services. In Kilifi County, an increase in skilled deliveries in public health facilities was also attributed to the free maternity services which have been operating since June 2013 following presidential directives. Unfortunately, due to lack of funds and other reasons, OBA ended its operations in Kilifi County and other parts of Kenya in November 2015.

Despite the unavailability of OBA, free maternity still operates in Kilifi County and other parts of the county. The main aim of free maternal health services policy in Kenya is to improve access to skilled care for all women, especially the economically disadvantaged rural populations. Despite the progress that has been made in child and maternal mortality since the inception of the free maternal care programme in 2013, the numbers currently recorded are still wanting. As a result, in October 2016 the National Government unveiled an expanded Free

Maternity Care Programme at the cost of Sh5.4 billion. The programme is meant to reduce maternal morbidity and mortality rates in the country. The expanded programme dubbed "*Linda Mama, Boresha Jamii*"²¹ meaning (protect the mother to improve the society) extends its services beyond normal delivery to include antenatal care, delivery through cesarean section and postnatal care free of charge. New-borns will also have access to free health services for a year since enrollment (www.standard.co.ke). This package also includes both out-patient and in-patient services for both mother and baby. The Expanded Free Maternity programme will be managed by the National Hospital Insurance Fund (NHIF), to increase the efficiency of processing and payment of claims as opposed to the previous mode of direct reimbursement by the national government. This also strengthens the role of NHIF in healthcare financing. The redesigned initiative expands the network of health providers to include faith-based facilities through a direct reimbursement mechanism that pays for a number of deliveries reported, to a health insurance plan to be administered by NHIF. The system is expected to improve efficiency, accountability and minimize complains associated with delays in disbursement of free maternity money. The benefits package includes both outpatient and inpatient services for the mother and newborn for one year, and it will include Antenatal Care, Delivery, Postnatal Care and Emergency referrals for pregnancy-related conditions as well as complications.

Moreover, expectant mothers seeking to benefit from the free maternity programme will have to register with the National Hospital Insurance Fund. According to a directive by the NHIF, those who fail to register will be required to pay cash should they show up for the free delivery services. It is therefore assumed that this new institutional transformation would lead to the improvement of maternal health by increasing access to skilled care. However, it was important to explore local people's reactions to such changing approaches in maternal health care financing and what such strategies mean regarding social protection in strengthening access to and demand for high-quality essential services by the poorest mothers in Kilifi County.

²¹ *Linda Mama* provides a package of basic health services accessed by all in the targeted population on the basis of need and not ability to pay, positioning Kenya on the pathway to Universal Health Coverage (UHC). A public funded health scheme that will ensure that pregnant women and infants have access to quality and affordable health services. *Linda mama's* goal is to "Achieve universal cases to maternal and child health services and contributes to the country's progress towards UHC".

3.2 Perspectives of Local People on Changing Approaches to Maternal Health Financing

Distribution of goods and services is a crucial social activity that is constitutive of the social and not only the economic order. Therefore, there is always a need to pay attention to the idea of distribution as necessary and valuable social activity within the human economy (Hart, Laville, and Cattani, 2010; Ferguson, 2015). When I began fieldwork, maternal vouchers also referred to as OBA, and free maternity were the leading maternal health programmes available in Kilifi County. However, OBA had been discontinued due to depletion of the donors' funds while free maternity which targeted the general population of expectant mothers was very active. In the process of fieldwork, it became very challenging discussing OBA and free maternity with the locals. It was perhaps not the discussion of free maternity versus OBA but the discontinuation of OBA and non-existence of 'free' maternal health services.

The maternal voucher system was introduced in Kilifi County in 2006 to provide vulnerable women with free access to reproductive healthcare competitively in both the public and the private sector. Most women preferred OBA because apart from the public health facilities, they could also use the vouchers to deliver in accredited private health facilities too. Moreover, OBA enabled women to seek maternal health care in time because they could at least save some little money for boarding motorbike to the nearest health facility. However, most poor women also narrated how OBA became inaccessible and how wealthy women, some who were employed by the government and other organizations had both OBA and other private insurance covers hence making the vouchers unavailable to the poor women. The poor women also attributed inaccessibility of OBA to the corruption of the wealthy women and some OBA field officers. The poor women mentioned that targeting of vouchers became ineffective as the programme matured because many poor women were not reached. The main discourse, therefore, was that the rich and the corrupt could secure the services defined to be used for the very poor.

From in-depth interviews and informal conversation for instance:

I could not get OBA I tried my best, but it was not there, however, I know some few rich women who got OBA just after I was told the vouchers are no longer there. It was just corruption. Anyway they know how the system works and they also have their people in the hospital (in-depth interview, Zubeda)

Another woman added;

Corruption and other bad behaviours spoil the OBA as it matured. The poor like me cannot get the voucher. My aunt who is a teacher in the local primary school has both private insurance and OBA including NHIF, but I was told that OBA is no longer there. So it depended on whom do you know (In-depth interview, Mama Charo).

Inaccessibility to OBA also made some poor mothers resort to home delivery this was after realizing that free maternity was too expensive for them than delivering at home. For instance:

But I did not get OBA and other four children I delivered at home where I could pay the person who assisted me in installment, but in hospital, they need a whole 300/= in cash at once for the first visit (in-depth interview with Fatma).

Kenya is currently exploring new financing mechanisms designed to promote access to efficient and affordable healthcare for its population, especially the poor. Today, for instance, there is an expanded free maternity program which is yet to trickle down to the people. Most mothers that I talked to relied on local chief's meetings, neighbours, trusted extended family members and their husbands to get information on issues of health. In the course of fieldwork, it emerged that the locals were not aware of the new expanded free maternity program. Moreover, some mothers didn't know how the existing free maternity policy operates.

A mother in the maternity ward said that:

I mean message doesn't reach the mothers in the villages especially this free maternity, how it operates and even us here I think we know very little from our peers and friends who have delivered here and those who delivered a few days ago(in-depth interview, Saida 38 years old).

Some men I talked to in the villages, appreciated free maternity and the efforts the government had made to ensure that all women deliver in the health facility. There were also adverse reactions where some men felt that corruption killed OBA and that OBA did not benefit every poor woman and the adolescent girls. Men explained that social protection is absent if the households have to cater for transport cost and also buy some commodities during delivery. The main concern was lack of access and unequal access to essential maternal health care services by women in Giriama community. The men also argued that sometimes politically charged policies

ended up benefiting a few people who know how the system works, for this reason, men believed OBA, and free maternity helped the rich more than the poor. In this case, the rich women shaped the accessibility of maternal health care programs because they had more bargaining power and knew the ‘rules of the game.’ A few men who had heard of the expanded free maternity program wondered why NHIF²² is involved and how the poor mothers can register for such services when they don’t have the mobile phones. Men viewed the change in approach to maternal healthcare as more beneficial to the educated, the wealthy and those who stay in urban areas. For instance:

Talking about OBA and free maternity is good. They helped our women but corruption evaded these programs, today OBA is not there, but it was such a wonderful thing we ever had. Free maternity is a bit not free, if mothers pay for a lab test, buy gloves, jik/bleaching agent and sometimes pay for deliveries. I wonder whether the new NHIF maternal health care will be possible (Field notes May 2017).

Another man added:

OBA and free maternity mainly benefit the rich women who mostly have good connections and influence in many sectors. Women in rural areas at some point feel the pain of even buying a glove because they are very poor. I hope you have seen how people are poor in this village. The way I heard of NHIF and free maternity program as a new way of doing things, I fell our expectant mothers will not benefit much. It needs thorough community sensitization (Informal conversation with Baba Zani).

These discourses also show that access to health facilities also depended on an individual’s social network and to the buying power they have for access. Therefore, the free maternity and OBA were also Anti-politics Machines thus local men and women perceived these programs to hide the unequal distribution of resources and services. Uneven distribution has been evident on how OBA led to the prosperity of healthcare in private health facilities, and this led to the decline of health care in public facilities.

²² Men perceive insurance to be too expensive and wondered whether poor households would be able to cater for NHIF.

3.3 Perspectives of Health Workers on Changing Approaches to Maternal Healthcare Financing

They (OBA) has helped the private to expanded within a short period today I go around I see how they have improved, but here we are just the same, but we still help the poor. So those poor who cannot access the private health facilities some still deliver at home (KII, Hospital matron, April 2016).

The excerpt stems from a key informant interview with the matron-in-charge of maternal and child health department in a public health facility. This passage expresses a form of lamentation on taking away what rightfully belongs to the public health facilities. Maternal vouchers had operated in Kilifi County from 2006 till late 2015 when it was discontinued due to insufficient funds. Most health workers in the public health facilities appreciated maternal vouchers as one of the most effective maternal health programmes that led to an increase in facility deliveries and improvement in health facility infrastructure. According to health workers in the health facilities, along the way, OBA programme became broke the moment private health facilities were accredited by NHIF to offer maternal health services to the expectant mothers. Public hospital health workers felt that a lot of funds were siphoned by the private facilities which expanded so quickly courtesy of OBA. During OBA tenure and when more private health facilities were accredited to offer services, the public hospital did not get more expectant mothers compared to private facilities, therefore, could not expand at the same rate as the private health facilities. It, thus, forced the health workers to act collectively with the little resources they had to adapt to the changes.

Even today OBA is not there they got broke a long time ago. The moment more private health facilities were added in phase two, funds got depleted faster. It ended abruptly, and nobody told us that it was ending (KII, Public Hospital matron, April 2016).

The health workers in private health facilities had a divergent opinion about OBA. According to them, OBA was an excellent program for social protection because it targeted mainly the poor and they had a prompt reimbursement after offering their services to the mothers. However, there was a delay in payment towards the end of the OBA tenure when the donor was handing over the program to the Kenyan government. They also felt intimidated by the national government when they tried pursuing the payments. During my fieldwork, a hospital administrator received a letter

from the government inviting them for a meeting at the ministry of health headquarters in Nairobi. However, according to the administrator, such meetings were ways of silencing and intimidating them and also delaying reimbursement process and timeframe after providing services to the mothers.

OBA has been an excellent program for both the community and the health facility in general. Reimbursement used to be so fast after submitting a claim. But today, since OBA ended, there has been so much delay, and when we raise the alarm, we get letters from the Ministry of health explaining why there is a delay. But reimbursement takes long. Now have a look at this letter from the ministry, next week they want to meet us (administrators from all accredited private health facilities). This to me, is just so intimidating and a delaying tactic (KII, Administrator in a Private health facility).

During participant observation in early March 2016 when the last bunch of OBA cards were still in circulation in the health facilities, it became evident that the rules defining who should have the vouchers had already been altered verbally by some few individual OBA field officers who were friends to some senior officers in the government whose negotiations deprived the written regulations of OBA. Informal conversation with one junior OBA field officer revealed that some senior officers in the county government coerced them to give vouchers to their relatives who did not qualify for the voucher. According to him, such coercions disadvantaged some poor mothers. Therefore, such powers from the county represented tactics of the more powerful to shape an informal institution that played regulatory roles that defined who was allowed to use what kind of resource at what time and under what circumstances²³.

When I was called by some seniors in the county to help their relatives get vouchers, I could not refuse, and it was kind of in-direct coercion which I did not like. But it disadvantaged some poor mothers who deserved such vouchers. I could do nothing anyway hope you understand (Field notes March 2016).

Using Ensminger (1992) and Haller (2010) arguments then it is evident in this study that political, demographic, technological, and social changes affected the value of OBA and free

²³ Haller (2007) looking at how local institutions govern resources referred to such institutions as regulatory devices that define who is allowed to use what kind of resource at what time and under what circumstances. It includes the way the more powerful actors shape the formal or informal rules of the game.

maternity and this led to change in relative prices of maternal health. Haller (2010) argued that change in relative prices alters economic incentives which are likely to prompt institutional change. The direction of change is not agreed upon but negotiated and depends on the bargaining power of actors, in this case, the power to get what they want (the poor and rich women) and the 'rule of the game' used to legitimize the institutional design highlighting the central aspect of power relations and the influence of internal variables on institutional outcomes. The state argued that there are equity and access to maternal health services through free maternity. However, from the findings, there exists inequity in maternal healthcare where the wealthy women shaped the 'rule of the game' for access to the free maternity care. However, I argue here that the increase in the value of healthcare services that one gets for free attracted the more powerful actors to secure the service by using their informal networks and kinship rules as an institutional setting to gain access to a service which is restricted. They used rules within their networks on reciprocity and mutual help to justify their demands and get access, which the citation above shows.

A roundtable discussion with the county department of health revealed that OBA had increased facility deliveries and was an excellent social protection program for the poor mothers in Kilifi County.

Like OBA was very good we saw it changing our infrastructure and indicators. For instance, hospitals purchased many equipment that were very expensive. Moreover, It changed our indicators for instance delivery by skilled attendants. They were able to motivate the CHVs through OBA where CHVs could refer or bring mothers for family planning. OBA funds were also used to mobilize the community members to come for facility delivery. But OBA ended abruptly, and we have no option but to wait for any new intervention for maternal health (Roundtable discussion, Participant 4).

Despite good indicators and community mobilization through community health volunteers, health workers attributed many mothers delivering under OBA in private health facilities because many mothers often perceived the quality of health services in public facilities as poor compared to private health facilities. In most cases, therefore, this made women prefer the vouchers, due to quality concerns and more services were covered. However, women without a network to increase their bargaining power were not able to get access to the facilities, and this was the

major problem of the OBA. When OBA discontinued offering services, the poorest still strongly preferred the free maternity services scheme, or, if there were high hidden costs, they resorted to giving birth at home. Even the county health officials confirmed that since the discontinuation of OBA, some the poor expectant mothers resorted to home deliveries when they realized they incurred expenses under free maternity programme.

I can say we had the good maternal health indicators courtesy of the two maternal health programs, but many mothers preferred private health facilities because of high-quality health care. In public hospitals, we have tried to put good modern equipment, but during OBA many women still went to deliver in private hospitals. But again when OBA discontinued its services, poor mothers flocked to public health facilities only to retreat as free maternity picked up because the mothers had to pay something (Participant 1: roundtable discussion).

The health workers were not very sure how the new expanded free maternity program was going to work and whether it could be beneficial to the most impoverished mothers or not. Many doubted NHIF involvement in the financing of maternal health due to previous delays in reimbursements of claimed funds from the national and county governments signs of weak enforcement mechanisms, for instance, delayed reimbursement to health facilities, which led to the continued levying of service charges. Being an electioneering year, most health workers in this study labeled the introduction of the new expanded maternal health care program as political and a way of looking for votes by the Jubilee government. Additionally, lack of transparency in the previous maternity policy regarding funds reimbursement raised doubts about the fairness of the distribution of costs and benefits county government who will receive the money from NHIF and the hospitals that offer services.

How will this policy work if the previous policy had a lot of issues and many blame games? I wonder why such politically driven policies never consider the need to ask health workers their opinion. Let them rectify the reimbursement process and many other hiccups in the entire policy (KII, Health worker, Public health facility).

The fact that the health workers opinions were not considered before implementing the expanded maternal health policy made them realize their marginalized position during policy formulation hence accusing the government of undermining them:

When we are threatened or undermined by the bosses, who are we to say no, you know these policies are made up there, and we have to implement them whether they are good or bad (KII private health facility)

Despite being undermined, the health workers have been in the bargaining process for their inclusion in the policy-making process, but this has not been successful. Complains about late reimbursement of funds from the government to health facilities, increased workload amidst staff shortage, stock-outs of essential supplies and drugs in the health facilities and lack of consultation of the primary stakeholders had not yielded fruits in the recent past. Therefore, health workers employed what Scott refers to as ‘weapons of the weak’ to make the authorities at the county, and national government listen to them. One of such strategies has been a nationwide strike and reduced efforts to work by the health workers among other strategies as a way of expressing resistance against situations they deemed unfair.²⁴ A hospital matron for instance said:

We do experience stock out of essential drugs like say anti-D. Mothers will have to buy it if recommended, we try to negotiate with the government for timely and quarterly reimbursement, and through our union, we also bargain for salary increments, but all these have failed, and the next thing is to go on strike. That is the only language this government understand (Key Informant interview, Hospital matron June 2017).

Since there were no maternal vouchers and free maternity was not ‘free’, most health workers at maternal and child health department (s) in Kilifi county, narrated how they were delivering an absent service and in most occasions mothers accused them for charging them services fee unfairly for what ought to be free as the government directed. One can say that there was a lack of clarity about the policy, for instance, it was unclear which services were free, leading to cases of service user exploitation. Sometimes the health workers from their own pockets could assist poor mothers to get clinic book during prenatal clinics. In some cases, expectant mothers would

²⁴ The ordinary weapons of relatively powerless groups: foot dragging, dissimulation, false compliance, pilfering, feigned ignorance, slander, arson, sabotage, and so forth. They require little or no coordination or planning; they often represent a form of individual self-help; and they typically avoid any direct symbolic confrontation with authority or with elite norms (Scott, 1985).

come to the clinic once and disappear only to re-appear with a child either delivered at home or on the way to the hospital. More complications arose when mothers don't attend the antenatal clinic at least four times as recommended by WHO guidelines. According to health workers, failure to visit hospital due to tough economic times and lack of enough resources to cater for transport expenses, such mothers were likely to experience complications during delivery.

Now that there is no OBA, there is no free maternity. Poor women come to the clinic, and they have no money to pay for laboratory and antenatal profile, we sometimes assist them but they always accuse us of charging them, yet the government said the services are free. But we don't care about their accusations (Informal conversation with a health worker, MCH April 2016).

Another health worker added:

Mother comes for ANC maybe once then due to cost they disappear and only reappear maybe during the last visit or with a newborn. Sometimes their birth becomes complicated, and this endangers the life of the mother and the child (informal conversation at MCH Department March 2017).

In summary, it is evident in this chapter that despite the changing approaches in maternal health care financing, the health providers and the locals argued that OBA would have been good, but the rules of access were not in favor of the poor. As a result, the wealthy women could get access via their informal networks as they had more bargaining power and this led to the exclusion of the poor from benefiting from the social protection programs in maternal health. Additionally, a lot of OBA money was not directed to the public health services but to the private clinics which could capitalize on the services paid while the public hospitals only had little money and did not get it in time. As a result, the private health facilities quickly improved their infrastructure which attracted the poor mother to seek health care in such facilities. However, after the introduction of free maternity policy, which was just directed to the public health facilities the programme was swamped and overloaded entirely with facility deliveries. More mothers sought services in public health facilities since OBA was no longer there. After realizing that free maternity was expensive, mothers retreated from seeking services in the public health facilities or rather some

mothers attended clinics once then only re-appear for delivery with complicated labour. Some mothers used alternatives to finance maternal health care as discussed in chapter five of this thesis. Health workers were frustrated with the changing approaches to funding of maternal health care due to unclear policy guidelines, status quo in the human resources, false accusation by the mothers, and infrastructure among other more frustrating conditions. As a counter to such frustrating situations, the health workers devised a resistance mechanisms what James Scott referred to as (weapons of the weak) in the administration.

CHAPTER FOUR: Emically Recognizing the Anti-Politics Machine: Perceptions of Maternal Healthcare Programs as a Social Protection mechanism in Kenya

4.0 Introduction

In this chapter, I will discuss how local perceptions of maternal vouchers and free maternity influences decisions to choose a particular social protection scheme in maternal healthcare and what factors influence such decisions., This chapter anchors arguments on James Ferguson's compelling thesis on the 'anti-politics machine'²⁵ to analyze the state power and the development discourse in maternal healthcare (Ferguson, 1990). In his thesis, Ferguson argued that planned development interventions functioning under the guise of 'neutral' and 'expert' power produce unintended effects, which exceed the originally intended outcomes in their significance. These unintended or 'instrument' effects are of two types: one, the 'institutional' effect of expanding bureaucratic state power, and two, the 'ideological' effect of depoliticizing both poverty and the state. In the first section of this chapter, I describe perceptions of the frontline health workers and policymakers at the county and national level while the second section represents the views of the marginalized women and households in Giriama villages. After that, I briefly discuss the local people versus state relationship and whether such relations led to good or bad healthcare delivery locally.

4.1 Views of Frontline Health Workers and Policymakers

Health worker: *Free maternity has been good for the poor mother. I have to tell you that more mothers come to deliver and we do not have enough space, no beds to accommodate all, there is low equipment supply and lastly nothing more on human resource-no more hiring of nurses. Let me tell you this FM was the baby for the campaign by our president and it worked and many women voted for him because of these promises- such as free laptops for all primary school children, plus free maternity and so on. And soon you will hear in the next campaign free university education. But my question is, in the long run what is the end product of these free*

²⁵ That is setting up pro-poor development policies and programs such as maternal healthcare policies for as social protection strategies, which are in line with global development goals, but such projects cover interests of political actors.

things as in the quality of service, are there enough human resource to manage the free programs? (KII, Senior health worker in a Public health facility, June 2017).

The excerpt above stems from a key informant interview with a senior public health worker who was also one of the key decision makers in policy implementation in the health facility. It mainly contains the narrative that the President used the norm of the free distribution of things not out of trying to bring betterment but mainly for the reason to buy votes, without paying attention for the in this view sustainability of these programs in terms of how they will be financed in future. However, this does not seem to be the case as the strategy was to become voted and promising distribution in this domain appears to have delivered success. Therefore, the discourse prevails that despite free maternity services being a good social protection program, health facilities were still overwhelmed with a large number of mothers who delivered, and there was no enough space to accommodate them. The narrative of the political instigations of the free maternity policy addressed in the citation occurred across all the health facilities health workers, who felt that while the free maternity policy had increased access to supervised deliveries and had benefited the poor, it was not long-term oriented and used as a political resource to gain votes. Findings from this study show that there was a general politicization of the social protection approaches in the field of maternal health in Kenya.

Another issue that appears in the interviews from the perception of the health workers is that the programs were used for reinforcing and expanding bureaucratic state power. According to the anthropologist James Ferguson, who labeled similar processes as ‘anti-politics machine’ (Ferguson,1994), development projects may cover the interests of political actors. They set up pro-poor development policies and programs, which are in line with global development goals and which at the same time serve their political agenda, while on the ground the development approaches may not be functional (i.e. not decrease household expenditure for the poor as intended, jeopardizing household economies, see e.g. Chuma, 2012). I, therefore, argue that if maternal health policies primarily serve political ends, then this may result in blind spots regarding weaknesses of the approach, leading eventually to the suffering of the very poor segment of the society hence negating the objectives of social protection programs. As Ferguson

(1994) puts it, then convincingly the free maternity approach was, therefore, a potent political tool for getting political mileage and did not provocatively aim at delivering social services to the electorates.

There were conflicting views from the health workers who were directly involved in service provision and the policymakers at the Ministry of Health headquarters. Some policymakers argued that free maternity services were efficient as social protection approach for the mothers while the health workers had a contrary opinion by explaining that mothers still engaged in catastrophic spending despite the benefits of free maternity services. Not all expectant women were cushioned against depleting their savings that is if there were any or making them unable to build up savings even when they benefit from free maternity services. During project (SPIKE) findings dissemination at the Ministry of Health headquarters, the policymakers argued that it was not clear if the free maternity promise goes so far to cover other services such as prenatal care and post-natal care. For instance, a policymaker said:

Let us say the truth here; this free maternity at the county level is not clear on pre and postnatal care. I know our health workers in the counties are in a dilemma. Here was a policy I mean a president's directed policy that all mothers should deliver for free in all public health facilities but personally I am not sure if that policy covers pre and postnatal care. I mean mothers still spend a lot of money to cater for maternal health expenses in our hospitals (Meeting at Afya House Nairobi, 31/05/2017).

The health workers also indicated that the free maternity policy and the public health facilities were better positioned to provide universal access to maternal health services through free maternity as compared to the maternal voucher programme if the challenges facing the programme were adequately addressed. Corruption was commonly mentioned as one of the vices that hindered the smooth operations of free maternity services. In October 2016, the media reported cases of corruption in the health care docket, which led to the loss of five billion shillings from the Ministry of Health department out of which 889 million shillings were meant for free maternal health care were also diverted (Figure 4.1). During a candid discussion with a director from one of the busiest private health facilities in the county, he mentioned corruption as

the major undoing for social protection policies. According to him, corrupt people also influenced the government thus, in most cases even if legal action is taken against them, then no stern measures were taken. Donor-funded projects like a case of OBA had to go through the national government then later County governments. Therefore, private health facilities sometimes got such projects after an agreement to participate in corrupt deals with the ‘ruling elites.’ Analytically, corruption has been used as another tool for catalyzing the ‘anti-politics machine’ in Kilifi County for instance, Dutkiewicz and Shenton (1986), argued that due to corruption ‘ruling elites,’ becomes a “‘ruling group,” united by its near total dependence for its social reproduction upon its control of the state apparatus. As the state expanded, so does the power of these ruling groups, which in turn required, for its reproduction, the continued expansion or ‘involution’ of the bureaucracy. But this very process eventually led to a crisis of “diminishing re-distribution”, which in this case prevents maternal health care programs from achieving its objectives. Echoing Gupta (1995) arguments, the discourse of corruption is central to our understanding of the relationship between the state and social groups precisely because it plays the dual role of enabling people to construct the nation symbolically and to define themselves as citizens, who are entitled to the state services. Via such representations, and through public practices of various government agencies, the state comes to be marked and delineated from other organizations and institutions in social life and ends being literally eaten up by the powerful, who use as is metaphorically outlined politics of large stomachs to be filled quickly, as is alluded to in the following citation:

But corruption can never allow our country to progress well. Such good social protection projects may never prosper because we have large stomachs which need to be filled quickly by those in power. Even private health facilities get themselves fixed in such cases. Sometimes we get projects only after promising the big men something in return. That is total corruption. And the corrupt mainly go free. They just arrest people attempting to be corrupt, but the real corruption cartels are outside there walking freely. But the poor suffer so much in this community courtesy of corruption. Nothing more left for these voiceless women and poor men (Director, Private health facility June 2016).

The interesting issue here is the distinction between the small, everyday corruption which is prosecuted and the “real” meaning of big corruption as well as organized that can act freely according to this narrative leaving only plain plates for the poor. To this corruption script, the view is added that the promise of policy is presented that could be of help, but which is then taken away again. That is what scandalizes these health workers as the following statement shows:

Taking away what can help common man let me stop there. You see in Kenya corruption and grabbing things is like the order of the day especially by most people who are wealthy and are in power in this country (Health worker in public health facility, May 2017).

Additionally, from an informal conversation with nurses in public health facility;

Devolution also devolved corruption. The most powerful in those top county offices sometimes dictate what they feel is right for this health facility or if you are in good books with them, then your facility is sometimes considered first. In the recent past, I had to camp at the county office to get the reimbursed funds for free maternity, but it was not a pleasant experience. I felt terrible wasting my time there, and some of my clients had to go un-attended to because we are only two in that department the other person was also overwhelmed (informal conversation, a nurse in public health facility, March 2017).

Figure 4. 1Stolen Millions of shillings



Source: <http://www.businessdailyafrica.com>

In most occasions when I had opportunities to talk to health workers; the politicization of the social protection approaches in the field of maternal health was commonly mentioned during informal conversations and individual interviews. Health workers and policymakers at the county level maintained that maternal health programmes had been highly valued as important development projects initiated by the national government in partnership with counties. However, they stated that the programs were used for reinforcing and expanding bureaucratic state power. Areas that did not fully support the ruling government had challenges in terms of receiving funds in time, and they mainly received equipment late, and some were not most needed equipment for maternal health care. During the first phase of free maternity program,

many expectant mothers sought health care services in the health facilities with high expectations of getting free services, but it turned that only deliveries were free. In the middle of implementation of free maternity, health workers experienced late reimbursement of free maternity funds, burnouts, lack of necessary equipment and medicine hence could not provide some services for free for instance, ultra-sound. Mothers were expected to either go to a private health facility or private practitioner for ultra-sound services or also buy medicine. Later, this led to the deterioration of services altogether and to those who had the information about free maternity it became clear that free was not free. However, health workers tried not to compromise the quality of maternal health care.

Truth is free maternity is a good policy approach, but it is very clear.....you know politics is everything in this country. This is an electioneering year, and I am sure opposition strongholds might face more challenges if the current government retains power. So it is scratch my back I scratch your back (In-depth interview with a health worker in a public health facility March 2017).

Some facility deliveries shot up when free maternity was launched, along the way as the national government and the county government engaged us in games and delaying to release funds, it became so difficult to offer the services because mothers had to buy some materials for example gloves and cotton and they complained. Later it was like mother realized we were charging them and free was not free so facility delivery declined. Even now we have meager resources, but we are trying so much not to compromise the quality of care. Remember if you are in good books with the power then you get your funds and equipment in time and vice versa (Field notes, June 2016).

4.1.1 Devolution of Healthcare is Good but also Politicized

Health service provision in Kenya is centered around four tiers of service provision those are a community, primary care, primary (county) referral and tertiary (national) referral services (Ministry of Medical Services and Ministry of Public Health and Sanitation, 2012). Under the new decentralized strategy, sub-counties are responsible for delivering health services and implementing health programmes, and the national government retained the responsibility of

national referral services (National Coordinating Agency for Population and Development et al. 2010).

Following the introduction of the new constitution in 2010, policy formulation remains a function of the national government alongside developing standards and regulations. Meanwhile, public service provision (including health) was fully decentralized (devolved) from the national level and is being rolled out in the 47 county governments who currently have authority for decision making, adapting the policy to their local context, finance, implementation, and management. The devolved health system is organized around a tiered system with the community, primary care and county referral falling within the county's responsibility. Therefore, devolution was greeted with great anticipation in Kenya as a means of bringing services closer to the people. However, since the implementation of the devolution reforms, criticism has mounted from the health workers, with evidence of corruption, poor management, late payment of county staff and considerable dissatisfaction among service providers leading to unending strikes, especially health professionals. Based on my observations, despite the challenges mentioned during interviews, the county government of Kilifi had invested in the referral system, and this made the referrals system more efficient. Almost each electoral ward unit had an ambulance which served the health facilities within the ward and in some cases, if need be an ambulance from one ward unit could assist other health facilities outside the ward. But according to health care providers, an increase in the presence of state institutions or resources at the local level did not necessarily mean better service delivery or increased access to local communities.

Devolved governance is not bad, today we have a good referral system, and mothers' lives can be saved in time, and sometimes we get support from neighbouring sub-county or ward to ensure that we save lives (In-depth interview, Public facility Health worker, June 2016).

Apart from other teething problems from maternal health policies mentioned in this study, the majority of health workers in the county expressed their satisfaction with the devolution of health care as it brought services closer to the people. They also recognized the fact that devolution of

health services, in particular, has had a visible impact on accessibility to maternal health care. For instance, service providers averred that ambulances were now more available than before devolution and this improved the referral and timely response to emergencies. As much as there was improved accessibility to maternal healthcare, some health workers, however, felt that even at the county level maternal health had been politicized and in the long run mothers suffered a great deal. Procurement of supplies took so long, and in some cases, the county had misplaced priorities whereby they could buy equipment worth millions of shillings courtesy of reimbursed free maternity funds from the national government. Some of such equipment sometimes did not meet the needs of expectant mothers. Health workers felt that some decisions made at the county level did not match the health facilities most felt needs. However, in some cases good political will with the county bosses made some health facilities get a timely supply of appropriate equipment and medicine. There were also cases where health workers had to continuously camp at county offices to get the health facility challenges addressed. Some health workers for instance said;

Devolved governance is good, and it has brought services closer to the people. But decisions made at the county level sometimes contradict what health workers need most in the health facilities. And a good relationship with the county bosses and other politicians make some health facilities benefit in terms of timely procurement and supplies of equipment. For those in a shaky relationship with the big bosses, they have to make several visits to the county offices for action (Hospital matron, Public health facility, June 2016).

From roundtable discussions with health workers;

Yes, money for free maternity goes to the county's common pool account, and I am very sure it is a lot of money. But that money is used to buy things like trucks for carrying garbage, or they buy a hospital a machine worth millions of shillings. They then call media people to air it out. For instance, it will be in the media that hospital X in this county received an MRI or a C-T Scan machine worth millions of shillings while that hospital lack essential drugs such as Anti-D. All that you see on television or read in newspapers is pure politics.they don't ask us our most pressing needs for improving health care here (Nzame, a roundtable participant June 2017).

Devolution is just so good. In this county, we have a good referral system that one I give the county credit, but it is so unfortunate that mothers are referred then you find the recipient referral hospitals lack some of the drugs, or they don't have a specialist for that condition (complicated condition for referral). The hiring of specialists in this county is just a problem. I think the big bosses have other priorities other than mothers' health (Dama, a roundtable discussion participant).

Policymakers felt that the health sector had been politicized and the counties had a significant challenge in handling it anymore. Informal conversations with nurses and other health workers also concurred with what policymakers told me. Most health workers were never willing to participate in a formal interview due to fear of victimization and labeled as rebels to the government. During the nationwide health workers strike, I had an opportunity to talk to one of the county health officials she alluded to me that even the county government was feeling overwhelmed with health workers strike and endless delay in the release of money meant for county's smooth operations including paying health workers. The county official confirmed that the strike affected health negatively and there was a likelihood of an increase in maternal mortality. Lack of political goodwill from the national government was mentioned as one of the major impediments to the smooth operations of maternal health programs. On the other hand, the residents blamed the county for failing to pay health workers, provide free services, and to buy drugs. Other health workers also commonly mentioned political interference with smooth operations of the health sector. During dissemination of the study findings at the Ministry of Health headquarters in Nairobi, stakeholders confirmed that politics played a significant role in the health sector and most cases health policies were politically driven. For instance:

Just like in other countries, in Kenya, it is complicated to disengage the health sector and other projects from politics. But we also know each political party has their agenda to the people, those who make convincing promises to the electorate get elected whether those promises will be fulfilled or not is a nightmare (Stakeholder in a meeting at Afya House Nairobi, 31/05/2017).

From an informal conversation with a county health official:

Precisely, this health sector has become a burden to our county and other counties. I could have a choice then I could have returned it to the national government and let the counties support the national government by the provision of medicine and other infrastructures. Like recent doctors' strike and now nurses are on strike, the residents blame the county for it, yet we don't have control over it. There are also politics in it; I think you know what I mean being an elections period. I can tell you from where I sit that since health workers strike began many expectant mothers have died out there (County Health Official, August 2017).

What emerges from the excerpts above is that although the discourse of development policies such as free maternity programs and maternal vouchers tended to see the provision of services as the purpose of the government, it is clear that the question of power could not be written off quite so easily. Basing my arguments on James Ferguson's ideas, it is clear that the government services are never merely 'services' but instead they are services that have camouflage mechanisms to a government whose purpose is to give services which serve to strengthen and expand the government's power through the locally governing machinery (Ferguson, 1994). Moreover, such decentralized services by the government, mostly act as avenues for an indirect rule on the people but mainly gives an opportunity for the local elites concentration.

4.2 Views of the Poor Women's and Households in the Village on Maternal Healthcare Programs as Social Protection Schemes

Social protection aims at preventing or alleviating sharp reductions in well-being, particularly for the most vulnerable groups in society. Social protection strategies assume particular importance during recessions or crises when a considerable share of the population may become unemployed and fall into poverty, or in the face of sharp movements in the prices of products consumed by lower-income groups. Local perceptions described in this chapter may not conform to an "objective" reality of social protection programs, but they helped in the understanding of how and why the Giriama community perceived the maternal health care programs (free maternity

and maternal vouchers/OBA)²⁶. Moreover, such social protection should enhance inclusive development²⁷ due to its potential to reach the poorest and its catalytic role in redistribution.

In this chapter, an emic perspective compels the recognition and acceptance of several realities. The chapter documents multiple perspectives of facts for understanding why different households and poor mothers think and act in the different ways they do. Differing perceptions of reality on how the local households perceived maternal health care programs as social protection schemes.

Almost every family or household I visited in the ten villages had its fields or piece of land, and family members did most agricultural work as a group based on the household mode of production excluding very old people, children under five years and the physically disabled. In some cases, husbands were also excluded, but all household members participated in one way or the other in economic production. Therefore, in many cases, the family members handled all activities from ploughing the field to harvesting. Giriama is a patriarchal society where the senior adult male always plays the role of leadership in the family. The senior adult male makes decisions on economic matters and supervises family affairs too. Some decisions though minimal, are left to women.

From the talks, I had with men in the villages; it emerged that sometimes maternal health and issues of pregnancies were mainly left for women, and men's key responsibilities were to feed the family and 'hustle' outside their communities. But in other cases, maternal health was a collective responsibility for the husband and wife. From the day I began my fieldwork in the villages, I was very much interested in how women locally referred to the available maternal

²⁶ Fetterman (2010), the insider's perception of reality is instrumental to understanding and accurately describing situations and behaviors. Native perceptions may not conform to an "objective" reality, but they help the fieldworker understand why members of the social group do what they do.

²⁷ Inclusive development here means as a 'pattern and pace in which the poor and most vulnerable groups participate and which is characterized by income growth, increase of productive employment as well as decreasing inequality in both income and non-income dimensions of wellbeing' (NWO, 2014).

health care programs. Almost all women could at least recall how pregnancy was a tough journey amidst poverty and they mainly referred to free maternity in Swahili as *Ile ya Uhuru* meaning the ‘Uhuru’s thing’ some also referred to it like ‘*that for Jubilee.*’ For instance, one mother said:

That president’s thing has been good only for delivery, but we have to buy other things like gloves, cotton and even medicine when you are admitted to the maternity ward. So to me, it was a burden, I could go to my mother’s place and deliver without paying a cent. Even the other seven children I have been giving birth to at home. I just came because I was bleeding too much (in-depth interview, Habiza, 39 years old).

Yes, it is the Uhuru’s thing. Even recently, he mentioned it at a political rally in Malindi that all expectant mothers are delivering for free. I think he doesn’t know that we are paying for it is just usual politics? (Informal conversation with a recently delivered 35 years old woman, Kadzandani village).

Views from FGD also concurred with other interviews I had with women. For instance:

I mean that jubilee project. It has been good, but I know we are paying for what ought to be free; I wonder how this government promised us what is not free. I paid Kshs. 2,000 during delivery. It was hectic getting that money I tell you (Rehema, FGD participant, July, 2017).

In another group discussion:

He (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 only (Zaduni, FGD participant August 2017).

Women agreed that free maternity had been a good social protection program, but only for delivery. On the other side of the coin, free maternity was expensive as women had to incur other expenses, which were burdening the poor households. Furthermore, women perceived free maternity as a political tool that had been used by the president to get votes from the women and therefore the narrative prevails that it is “the president’s thing” with a clear political orientation, which really acts as an Anti-Politics Machine in a double sense: First it hides the political interests, second it adds to the burden of women because one cannot just deliver without paying for all the other services before and after birth and the medication. For women the ideology that free does not mean free, the narrative that it was a political project and the discourse that it involves a burden rather than a help becomes evident. From FGDs it was commonly mentioned

that the absence of OBA for the community members opened an avenue for corruption both at the national and local level. Poor mothers, for instance, could not get access to OBA immediately free maternity was introduced in 2013. Wealthy women easily gained access to OBA because they could give a bribe to the OBA field officers, therefore, shaping the ‘rule of the game’ on access. Therefore, there poorer women argued that there is a lack of equity²⁸. Women felt lied to and charged unfairly for services they ought to have received for free. From this study, it was evident the way in which accountability had been compromised as the free maternity policy indirectly provided opportunities for corruption as described under ‘formal institutional arrangements’, where mothers gave examples of health workers taking advantage of the situation. The outcomes of a system depend on how these rules are enforced and are in line with Gustafsson’s argument, ‘*institutions without enforcement are not institutions at all*’ (Gustafsson, 1998). Kenya may copy examples from Rwanda where the introduction of the institutional delivery initiative was successful owing to rigorous enforcement of the rules, as the Rwandan government used a combination of financial penalty and social mobilization to achieve public compliance with their new rule (Gustafsson, 1998: Booth, 2011). Those activities were complemented by disciplinary actions against staff who engaged in abusive practices towards women. These complementary efforts, institutional arrangements being enforced and sanctions which were backed up by the political pressure, contributed to the fruitful and widespread adoption of institutional delivery in Rwanda. The following citation summarizes a common position:

We are unfairly charged for things like x-ray and laboratory services. OBA ended, and this free maternity is good but is expensive. It was a president promise, and he got our votes, now we deliver for free, but we still pay for other things, are we being cheated or? We also feel rules are not tightened. Somebody can do anything, after all, no action is taken against them (Zainabu, FGD participant, May 2017).

The narrative that “free is expensive” and that the procedure is unfair is a formulation that coins the paradox very well. The interviews also indicate that there was wrong interpretative repertoire with the labeling of free maternity, a type of fake as it is only free delivery and that, as

²⁸ Equity here refers to the fairness or justness with which a certain resource has been distributed.

one woman states, could be also done without help from the clinic system: Due to stress to get money for the expensive part of the free, women used the discourse of the “do it yourself at home and avoid all the hardship to organize the cash”. In addition, the citation reveals another issue of interest: It shows that women use the discourse of reciprocity because the arrangement (votes against free maternity) has also been violated. That aspect adds to the perception of the women regarding the notion of fairness which is another narrative used. Access is there but it is unfairly distributed for programmes such as OBA which is supposed to be for the poor: The narrative that the rich by themselves access to the full-service program is nicely illustrated below:

Yes some OBA officers gave wealthy women those vouchers so some poor mothers missed them. But free maternity is for political campaigns. Nobody cares whether we are charged in the hospital or not (Hamisi, FGD participant, May 2017).

The interesting aspect of this interview part is that women seem to link the unfair access issue with the free but expensive and therefore also inaccessible service of the public health sector and in addition the lack of support when it got evident that the service were not provided as it should. In the citation nobody cares is also enshrined that there was a sentiment of low bargaining power and low attention by the more powerful in the administration. During participant observation in the health facilities, I attended health talks by the health workers to the mothers in maternal and child health clinic in one of the busiest health facilities in the county. The central message to expectant mothers was that giving birth was free in all public health facilities. Mothers were also taken through step by step individual birth plans to prepare them for facility delivery. Mothers were encouraged to keep money for transport costs to the health facility, to be accompanied by an adult who could assist them after birth, have at least telephone number of a reliable motorbike taxi rider for easy transportation to the facility and to buy clothes for the newborn. I keenly followed the talks and on no occasion did the health workers mention buying of any items or commodities like cotton, sanitary towels and medicine among other things. Mothers only realized that they were supposed to buy some of these things when they were admitted to maternity wards. It was evident that not all expectant women were cushioned against depleting their savings even when they benefit from free maternity services. Other women argued that free did not mean it is affordable. During FGDs there was a general feeling that most projects in

Kilifi and other Counties in Kenya were launched during the political campaign period. Many poor mothers felt cheated by the state hence losing trust in state services. Some resorted to home deliveries while others used other alternatives to meet the costs of maternal health care as discussed in next chapter.

Broadly speaking, social protection programs aims at preventing or alleviating sharp reductions in well-being, particularly for the most vulnerable groups in society. This chapter portrays how health workers, policy makers and poor households perceived maternal vouchers and free maternity. Social protection agenda in Kenya has been defined by the extent of accommodation between the underlying clienteles' interests of political actors and the aspirations of external actors. Though Kenya has had relatively stable political institutions since independence, the citizen-state relation has been characterized by political benefaction. In the mode of politics, the president and his close allies sought to control access to state resources to the exclusion of the wider citizenry, as a means of assuring their hold on to power, with the resources used to reward their supporters in society. Thus, the president and his associates are linked to society through the use of public resources that are reserved for those who support them and denied to those who do not. Unfortunately, smooth operations of devolved governance has had challenges in realization of social protection goals to the extent that most of the projects meant to benefit the poor are politically instigated and in the long run such projects end up serving the interest of the government and people are aware of this despite the national government argument that free services are free.

In summary, this chapter has raised a number of issues related to the effectiveness and efficiency of the social protection program through maternal health services. First and foremost is the new institutional development of financing maternal healthcare in Kenya that is the management of free maternity by the National Hospital Insurance Fund (NHIF). Such new institutional transformation is assumed that could lead to the improvement of maternal health by increasing access to skilled care. It was clear that women and their husbands were not conversant with the new management of maternal health care by the NHIF. Even most health workers were wondering if maternal health transformation could be more effective when managed by the

NHIF. From the women's perspective, targeting of OBA was not effective as many poor mothers were not reached but the rich and corrupt who knew better the rule of the game accessed OBA. It is also evident in this chapter that the free maternity and OBA were used as Anti-politics machines thus perceived to hide the unequal distribution of resources and services in the community. The chapter also presents the perspectives of health workers who argued that OBA was effective in targeting the poor and their timely reimbursement led to the infrastructural development in both public and private hospital. However, the chapter shows that when free maternity was introduced in the public health facilities, a lot of OBA funds were diverted to private facilities and as a result developed more than public facilities. Thus, many pregnant women preferred private health facilities due to the perceived high quality of care. However, services in the public health facilities deteriorate due to lack of equipment, human resource and late reimbursements from the national government. To express their frustrations with the institutional changes in maternal health, health workers engage in endless strikes which in the long run negated the objectives of social protection through maternal health programs. Both health workers and local people agreed that devolution of health care was good but had been politicized. Moreover, it is also clear in this chapter that the government services will never simply be services to meet people's needs but are camouflage services that serve the interests of governing machinery therefore; anti-politics theory by James Ferguson has been used to describe the hidden political agendas in development discourse. When facing anti-politics while seeking maternal health services, families and the poor women in this study devised other alternatives to finance maternal health as discussed in the next chapter.

CHAPTER FIVE: Alternatives to Financing Maternal Health: An Emic Household and Gendered Perspective

5.0 Introduction

This chapter mainly describes strategies used by families and the economically disadvantaged mothers as alternatives to financing maternal health when they don't have money. In this chapter, I will elucidate the dual social protection mechanisms and other minimax strategies that the women use as a coping strategy when they lack cash to access maternal health care. At least five ideal typologies of emic alternatives to financing health care based on five case studies are also discussed in this chapter which will shed more light on institutionalized gendered strategies, and types of resistance mothers develop to still profit from the maternal health services.

In this chapter, I describe how *Giriama* marginalized women obtain their livelihoods, how they allocated household resources and alternatives the households used to cater for maternal health amidst the availability of social protection programs for pregnant mothers. I will describe how the five purposively selected marginalized women on realizing that free maternity is not free and in the absence of maternal vouchers, use different coping strategies to trying to cope with multiple roles. Such diversifications were meant to get access to additional cash to cater for maternal health and other family needs. Moreover, husband and women's social network relations determined the kind of diversification each woman used to cope with a variety of institutional arrangements which put more pressure on women resulting in exploitations. This chapter will show the rules and power relations between husband and wife. Exploring women's world seemed a bit challenging. In studies of human intentions and social ties like in this case, the quality of data depends mainly on the level of trust between the researcher and the informant (Parker and Harper, 2006). The presence of my research assistants made women in Giriama community, and various households built confidence and trusted²⁹ me. After rapport with the women who we purposively selected for follow-up occasionally, I could visit them alone without research assistants.

²⁹ Sometimes these women could give me money to buy them maize flour which was scarce during the fieldwork period. Some could ask me to buy their children shoes and others just wanted gifts from town. I shared meals, stories and farming activities with various families.

I learnt that the women, who chose to give birth at home even when they had ready access to a health facility, were often those who had many children and had a history of uncomplicated pregnancies. Exemplified case studies of women I present in this chapter are unique because typically they represent different categories of husbands and how they either assist or fail to help pregnant mothers and how this affects maternal health care. These women either had complications, delivered at home and came to health facility later or were using free maternity which seemed expensive in the absence of maternal vouchers.

5.1 Resources Allocation in a Poor Household in Giriama Community

Social protection has been an important component of poverty reduction strategies and efforts to reduce vulnerability to economic, social, natural and other shocks and stresses. A growing body of literature suggests that social protection programmes can play an essential role in strengthening access to and demand for high-quality vital services and social welfare services by the poorest people through childhood and beyond. Moreover, maternal health care utilization is not only related to individual choice or characteristics but also to a large extent depends on the sociocultural arrangements of communities and their social capital (Shaikh Haran and Hatcher, 2008). Therefore, understanding the role of community factors in studies of maternal health care service utilization is important because decisions to seek health care can be related to the characteristics of the community in which a woman lives.

My respondents were the poor of the poorest peasant³⁰ households. Peasant households almost have the same characteristics. A Russian agricultural economist Alexander Vasilevitch Chayanov, for instance, stated that peasants are always balancing the drudgery of work against

³⁰ A broad definition of the term peasant would invoke three important characteristics (Shanin, 1987): peasants are agriculturalists (or possibly engaged in fishing), for whom both production and consumption are oriented to the household, and who are also under some economic and political obligations to outside power-holders.

According to Wolf (1957) peasants are: the agricultural producer in effective control of land that carries on agriculture as a means of livelihood, not as a business for profit.

the return, and they have few desires beyond food and security³¹. This is why a peasant family cultivates enough land to feed its members, but no more. Food produced was consumed within the house, and each wife grew food for her children and her husband. Women were also responsible for farms or gardens owned by their husbands where together with their children and other close relatives could plant, weed, spray and harvest the farm produce. Just like many communities in Kenya, each household had three-stone hearth where women cooked, and it acted as a kitchen.³² The gendered division of labour among the Giriama depicted dynamics of gendered power relations within the households.

Owning livestock is a symbol of wealth³³ and an investment strategy for the Giriama people. Although cattle do not provide security readily for financial emergencies, including the purchase of food and getting treatment when needed. Access to animals was not equal. Older men easily accumulated cattle easily than young people and women who experienced more difficulty in accumulating such. Bride-wealth system gave the majority of cattle to the father of the girl hence more accumulation of cattle by older men. Most of the young men migrated from rural to the main urban centres such as Malindi, Kilifi and Mombasa in search of economic opportunities for feeding their families. During my field stay, some men could work for wages in salt industries while other men were wine tappers, local casual labourers, farmers and fishers. The ability to migrate was hand in hand with the obligation to care for those left behind, and the provision of care constituted an important means of expressing feelings of intimacy over great spatial distances. Some of the men who migrated could come home either carrying maize flour or food

³¹ The poorest households among the Giriama mainly struggled to get food and none had set aside budget for health care or kept some little money for healthcare emergencies. They larger relied on family networks and neighbours for assistance during time of crisis or emergencies. In worse cases, such reliance leads to loss of a life in contexts where assistance was not offered in time.

³² The Giriama community mainly practices endogamy. Polygamy is highly discouraged among the Giriama community but in a home a woman had other co-wives from the husband's brothers. Each household had a three-stone hearth locally known as *masiga* which symbolized woman's membership in the homestead. Each homestead had many hearths and sharing of a cooking fire was very rare because each co-wives had theirs. It is also forbidden for another co-wife to approach another woman's fire while food is being cooked. Once the food is ready, women and their daughters sit together away from men while fathers sit with their sons together but not sharing same bowl of food. Ugali also *sima* is put at the center where each person could get a piece.

³³ Just as Cliggett (2005) puts it, the animals owners are respected within their community, and they have a secure savings account. During my fieldwork there was a long period of drought which resulted to loss of many animals by the Giriama community.

or bring money to the wife to purchase food. Other men resorted to drinking all the money while some avoided coming back leaving women with additional roles to play. In such instances, women had pressure for production and reproduction hence performing men's roles in the homestead. It meant that for families with small children and in the absence of the husband, the adults/women had to work harder to feed them. Due to impossibilities of attaining economic equilibrium through farming or production alone, women were compelled to adapt minimax strategies (diversification of choices made or a means of having a wide range of access to resources, which can minimize the risk of being without resources to buffer risk in production (Lipton, 1988) but not all of them could cope with changes in weather, soil, and other conditions as well as political processes (Sahlins, 1972; Netting, 1993).

Family planning and limiting the number of children and general maternal health issues were an act of responsibility left for women. However, the people in my study expressed that couples could have as many children as they could afford to bring up. A husband in one of the household argued that;

People talk about me having many children, now they are twelve, but I have never sought their assistance in feeding my children. When I am away, my wife takes care of them. So it is God who determines the number of children. My wife will also tell me when she doesn't want to get pregnant anymore (Conversation with Baba Bahari, 48 years old).

This excerpt shows how feminization or genderization of maternal health and cultural conventions regarding family size exerts more responsibilities to women in the absence of the husband³⁴. Almost all women that we followed to the community were illiterate. These women had less decision-making powers, and this negatively affected their utilization of maternal services. Studies have shown that women with little decision-making power especially among the disadvantaged households and when their husbands or the household heads discourages them from using maternal health services are thus unlikely to use those services hence giving birth to many children mainly through home deliveries (Shaikh, Haran and Hatcher, 2008; Ahmed et al.

³⁴ I supposed men could also have taken their children to the health facility. However, I did not witness cases where energetic young men bringing children to the clinic on clinic days, except a few old men. Men were expected to provide for the family, including the provision of health insurance if possible, but the actual visit to the health care providers was women's responsibility.

2010; Hou and Ma, 2012). In the absence of the husband or lack of food, women relied either on kinship and family networks or other social networks such as neighbours, church and other community-based organizations for support³⁵. According to the women, apart from reproduction, they were aware that society expected a lot from them even if they were pregnant. Seen from a distance women were controlled by men, but seen from their (women) point of view they had gained control. With all the pressure they could still manage multiple roles and were also aware that society expected them to do a lot of work. For instance;

Yes, I am a woman I have many roles to play apart from giving birth; I do small-scale farming, have to cook and many more house chores that is when I am not expectant. But still, when I am expectant, there is still multiple works that I do (Personal Communication with Velma 40 years old).

In the following section, I will unbundle the different threads of alternatives to financing maternal health care that households relied on and show how women's perspectives refer to particular narratives of an alternative to care, which are situated in different local contexts. They are very ordinary household stories. I deliberately selected the five cases on the basis of my interest in knowing alternatives to financing maternal health. My main aim in choosing these five cases from my ethnographic research was not to arrive at some representative sample. Instead, I was interested in learning about a variety of experiences of women in relations to their husbands' presence or absence which are:

- a husband who was around and helping,
- a husband who was around but not helping,

³⁵My study participants were Christians while only one woman was a Muslim. Kilifi County is dominated by Pentecostal churches. Women do not attend every church service on Sunday or Saturday. They expressed a feeling that they were going against biblical teachings on relationship between humans and God. Some resorted to remain home one main reason being lack of offerings to give in church. They argued, they rather spend little they have to feed their families than give it to church. However, sometimes church elders visited these families to encourage them to attend congregational meetings on Saturday or Sundays. Some churches also sponsored education of children from poor backgrounds. I learnt that some women sought social support from Pentecostal churches, when facing difficult situations. However, in this study I did not focus on church but informally talked about the roles of church in the Giriama community.

- a husband who was away and not helping (sending none or organizing help)
- a husband who was away and helping,
- Woman is relying on her limited resources to support present but helping husband (woman works alone but has to support her husband).

Therefore, the bulk of ethnographic descriptions in this chapter are drawn from the cases I found interesting in the process of my continued home visits and the relationship with households in Kilifi County.

5.2 Reciprocal Arrangement with Neighbours based on Reliable Migrant Husband (Mama Hussein

I met Mama Hussein in May 2016 during my first phase fieldwork when she came with her newborn baby at Ngoni Health center. At the health center, we agreed to visit her at her home some 15 kilometers from the health facility. I followed her to her house after one week for more discussions. She comes from *Kuhu wa Saidia*, a village in Margarini Sub-County in Kilifi County. The woman got married at the age of 20, and she did not go to school at all. She is now 40 years old with twelve children (4 girls and eight boys). Apart from the firstborn girl who is now 18 years old and in class eight other children of school going age are mainly out of school due to lack of fees, and mostly they go for *madrassa* (Quran classes/religious class). They live in a small house where all her children sleep. The house has no ventilation, poor roofing, mud-walled, poor floor and an old dirty cloth covering the door. They used some wood logs as chairs. The house is partitioned using an old dirty mosquito net (donated by the government to pregnant mothers). There were three old wooden beds, one bed for the parents while the others were for the children. The beds were made of wood and woven using sisal ropes (locally known as *oriri*). However, there are some old worn out mattresses, which from our conversation I learned the husband's employer donated that. Before I left the field after the first phase in July 2016, she had eleven children and gave birth to another boy child in June 2017. Apart from the last born, all other children were born at home. The husband worked as a caretaker in an Indian home in Malindi town and could come home every weekend or sent money and food to the family every end of the month.

This family is caretakers of an Indian man's (husband employer's) over 30-hectare land in *Kuhwa Saidia*. They were allowed to do farming and build their house on the land, which does not yield much. They had seven goats for the husband and some chicken belonging to the wife. In this household, most decisions were made by the husband, and the woman made very minimal decisions. We became good friends with this family, and often they referred to me as *Baraka* a Swahili name meaning blessing. After a long relationship with this family, I was also seen as the eldest son, and this meant some 'hidden-obligations' from my side of which of course I had to play some role. Occasionally, I could carry maize flour which was very scarce during my fieldwork due to maize crisis in the country, and Mama Hussein could prepare *ugali* (one of Kenya's staple food prepared by stirring hot water and maize flour till it becomes solid) which we ate together.

I was with this family for almost nine months and could visit them at least twice a week occasionally with field assistants who acted as my interpreters. During the entire period, I was very keen on knowing the alternatives this household used to cater for health needs. This was based on open formal and informal conversations and in-depth interview I had with the husband and the wife.

At first, I could not figure out how Mama Hassan managed to feed all her children despite the 'hard economic times.' Every time I arrived at the home, the children could run and hug me, take my small bag to their house and bring me a wood-log to sit on. The children were so jovial, and it was very difficult to know whether they were hungry or sick, but from my long-term observation and conversations with the children in this household, it emerged that these children had adapted to difficult living conditions and they knew when food was not there they would sleep hungry and only take water before they sleep. According to Mama Hussein, feeding these children was so hectic, and on a day the family could consume five kilograms of maize flour depending on whether they ate something in the morning or not. When money was not enough to cater for maize flour, they would prepare wheat flour porridge, and sometimes the family could sleep hungry for more than a day as the parents explored alternatives to feed them. During our field stay, one of my field assistants (Purity) trained Mama Hussein and her husband how to make soap shampoo from the locally available raw materials hoping this could reduce financial

burden and pressure in the family. They did it well for the first two months in 2016. Later, neighbours refused to buy the shampoo, and some people wanted to have shampoo on credit which they would not pay afterward or only pay after some pressure and quarrels from the family.

The husband whose workstation was in Malindi sometimes could fail to get his salary in time. However, he had always permitted Mama Hassan to find other alternatives for feeding the family, and he could, later on, sort it out. Therefore, this family relied on some neighbours who were willing to help them in times of difficulties. For instance, when Mama Hassan delivered her second last child at home, she did not have any money to go to the hospital for postnatal care. Their neighbour lent her some money, which she was to refund before end month. However, this did not work as expected. She took so long before repaying the money, and the neighbour threatened to report them (Mama Hassan or Hussein and her husband) to the village elder or take away one goat. The husband's salary was never enough to cater for all basic needs, so he sold two goats to repay their neighbour and use the rest of the money to buy food. From our conversation (delay in debt repayment eroded the trust between this family and their neighbour and 'today' neighbours rarely help them as they used to). For instance, during the in-depth interview she said:

The relationship with neighbours here is not bad, but following the current hard economic times, even if I go to neighbours for a cup of flour, they will tell me they don't have. Sometimes it has been hard until I had to carry my one-week-old child on my back with a sack of charcoal on my head to Ngoni market (6 kilometers away).

To prevent erosion of the trust and being taken to the village elder, my husband had to sell his two goats. It is so shameful to go before elders that you cannot pay a credit which we willingly took from our neighbour.

They also acknowledged that they knew about free maternity but just heard of maternal vouchers. They narrated to me how free maternity works but the mother delivered almost all her children at home. Mama Hassan told me that instead of going to deliver in the health facility where she will be required to pay some money, she delivered her children at home and used the

little money she had to buy newborn other things. Her husband acknowledges that he wished that her children could be delivered in the hospital, but additional costs, which seemed small to the rich or the doctors were just too much for his family. Health workers were on strike when Mama Hassan was expecting the twelfth child. She could not attend any antenatal clinic because health facilities were closed. Moreover, based on her past experiences, she never expected any complication to arise from the pregnancy. One night she felt severe abdominal pain, this time she was seven months pregnant. Her husband was around, and he could not figure out what was wrong with her. He called a neighbour who came on time and suggested they visit any health facility for assistance. That was a very long night for Mama Hussein. She said:

It was a long night full of pain, and I thought I was going to die or lose my baby. My husband did not have money, and we even thought of going to a community health volunteer, but we again thought of asking our neighbour to lend us some cash to go to the hospital. Fortunately, he agreed, and we went to a private health facility in Malindi town.

They got some money for transport to a private health facility in Malindi town. From our conversation, she gave birth prematurely, and the baby had to be taken to a nursery. Being a private health facility the husband was so stressed about the hospital bill because the wife was also admitted. He looked for money left and right from neighbours and relatives, but nobody could give him thirty thousand Kenyan shillings (300 USD). He called his boss who was then outside the country for assistance. His boss responded quickly and paid the money directly to the health facility. Back at home their eldest son, thirteen years old, took care of other children and one of the neighbours could bring them food and water. Mama Hussein was discharged and the neighbour who helped their children sympathized with them thus she did not demand repayment of what she spent on their children's food for the three days they were away. Here it is clear that the informal social networks (neighbours and the husband employer) and informal rules helped this family in negotiating access for maternal health services and the fact that the husband had a job and was serious about paying kept the willingness to pay credits. However, with some people in the network, the family had already used up the potential of help to be given.

My second fieldwork phase was an electioneering period, and there were a lot of political campaigns with a lot of promises. In our discussions, the husband noted that the government

only thinks of the poor when they needed votes and they come with a lot of pledges some of which are not realistic. He for instance said:

I survive without the support from the government now the president preaches free maternity and free secondary education. Surely, these are not realistic anyway they benefit the rich, and once we vote them in, they bring programs that are not realistic to the poor people like us, they take advantage of our situation to get more votes with false promise.

From Mama Hussein's experience, neighbours acted as an important social network which families could rely on. Maintaining such relationships required trust and household could do anything including selling household assets such as livestock to prevent erosion of trust. Selling of livestock however made this family again fall into poverty and this made social protection programs miss its expectations in maternal healthcare hence vulnerability. Moreover, when the husband migrated, his reliability in helping the family to meet basic needs was very important. Therefore, a family could only approach a neighbour when they were sure that the migrating husband was reliable and could do anything possible to maintain trust in the already established social network. This is a case showing that institutional changes in maternal health should be understood as the outcome of the interplay between external factors, which consist of economic and also political factors which lead to change in the relative price of health care. Also, Ensminger (1992) and Haller (2010a) argued that such factors affected groups in terms of institutions, organization, ideology and differences in bargaining power. From Mama Hussein's story, it is also evident how poor women develop tactics for encouraging neighbours and other relatives to come to their assistance in times of need (Also see Cliggett, 2005).

5.3 Multiple Reproduction Roles and Selling own Production with Present Non-helping Husband

Bahati's Case

Nothing is free. If in free primary education parents still pay some money, so you think this maternity is free? No, first clinic visit we pay for laboratory tests and the small mothers book for clinic and of course if there are drugs to be bought I have to buy and like me I come from far so I have to cater for transport, but sometimes I walk if there is no money (In-depth interview Bahati, 38 years old)

This is an excerpt from an in-depth interview with Bahati at the health facility during a postnatal clinic visit. We met her during health talk at MCH. Bahati agreed for a follow up after Maureen (my translator) explained our role and reasons for the visit. Bahati willingly agreed and welcomed us into her home. We visited Bahati, a village elder's wife in Magarini Sub-county, Zhogato village. Bahati lives in a *makuti* thatched (coconut leaves), and mud-walled one bedroomed house separated by some poles to mark the bedroom and sitting room. They have chicken and some goats. From the excerpt, Bahati expressed her fears about how expensive FMS are. However, it helped her deliver safely compared to home deliveries she had previously. Despite paying other monies, Bahati a small-scale farmer and a village elder's wife has different mechanisms of meeting her daily needs and also to cater for healthcare. She has eight children and six are in school. One child is disabled. Therefore, Bahati is mainly indoors or goes with him wherever she goes before other children come from school.

Most of the time, Bahati's husband a village elder was always present at home and depended on small money he got from attending meetings at the chiefs camps or when he resolved local disputes and conflicts. Therefore, Bahati had to look for casual labour to supplement whatever little her husband could give her to feed the family. Occasionally her husband helped, but in most cases, she was the one fending for the family. I witnessed cases where the husband would leave home in the morning and come back in the evening. When he arrived home, they always disagreed with Bahati over some issues which I did not know initially. As I continued visiting this family and spending more time with them, I came to learn from Bahati that she was not happy with her husband's 'I don't care attitude and approach to the family issues.' The quarrels

were mainly based on the husband's refusal to assist Bahati to get a regular casual work in the local chief camp. She also quarreled because he rarely supported the family and the little money he got was mainly spent at what villagers called *mangweni* meaning local palm wine drinking bar. Bahati was not very happy and blamed the local chief for failing to take action against her husband who neglected his duties as the head of the house. This had been their lifestyle, and even neighbours branded Bahati's family as quarrelsome. Bahati told me she was not a quarrelsome woman when things are in the right direction, but when she felt all was not okay, then she had to quarrel.

Bahati mainly relied on *vipande* (casual work- digging and weeding on people's farms) to get money to feed her family. The present but not helping Bahati's husband also demanded his share of food the moment he arrived home this provoked Bahati and sometimes resulted in verbal quarrels. One evening we were around with my research assistant and Bahati had cooked the evening meal very early because the children were starving since they had not eaten any good food for two days³⁶. Coincidentally, before we left the husband arrived, and when he demanded food, Bahati told him that she did not cook any food. They began quarreling. Although I did not yet understand the full content of their words, I realized the emotions behind the words. The husband entered the house and came out with a plate that had a piece of *ugali* (staple meal prepared from hot water and maize flour). The husband said:

You are supposed to cook and keep my share. Remember, I had paid your parents, you should now feed these children and me. I have also built you a house, I have given you children so what do you expect from me? You must now work like other women in this village (March 2017).

This discourse shows what society expects the married women to do. Too much pressure is on women's side, for instance, feeding the children and a lazy or a present but not helping husbands. Lazy husbands also expect women to work hard and should not demand any help from them. Moreover, this case shows how the present and not helping husbands expect their wives to

³⁶ Children were malnourished and sometimes they could go for two days without food. When food was not there they then either took water or porridge at night to at least fill their stomach. Apart from Bahati's family, other families and even some neighbours also lacked food to feed their children.

perform both production and reproduction roles, which in this case Bahati's husband argued that were catered for in the bridewealth payment. Apart from building the house and paying the bridewealth, the excerpt suggests that the additional household chores were meant for the women and Bahati had to look for mechanisms of feeding the husband and the children³⁷.

Bahati sometimes could go with her children for *vipande* for the additional labour force to get more money that would cater for food and other family needs. Therefore, the children could not go to school consistently especially during land cultivation periods since this was when there were many *vipandes*. Bahati also said that through *vipandes* her children could even work for pocket money and sometimes school fees, books, and uniform on their own. I occasionally joined Bahati's children and helped them during *vipandes* for them to get more money. In the case of a child's sickness, Bahati could go to the nearby health facility and leave her national identity card and collect it once she got the money and cleared the hospital bill. Her husband could only assist if the child was critically ill and he was around. Otherwise, sometimes he could go out promising to bring some money home for the treatment of the sick child, only to return home drunk.

For instance, one day the last born 1-year-old was very sick though I was in Kilifi town, Bahati rushed him to the nearest health facility and was admitted for four days. According to Bahati, the bill was too much for the family to bear. Bahati's husband did not have money, and he did not want to borrow money because his neighbours believe he is rich (looking at his goats and three cows) and also being a village elder (volunteer work). He did not even want to sell either his goat or cow. Bahati approached hospital matron in-charge to allow her to go and she would be working as a casual labourer in the health facility until she clears the hospital bill. She was allowed to go on condition that she leaves behind her national identification card. Back at home, she sold all her chicken to reduce the bill, but that was not enough she still had to work in the health facility. Therefore, she ventured in selling firewood, burning charcoal and selling, and also got assistance from her mother and her brothers in Malindi town.

³⁷ I had ethical dilemma whether to arbitrate, ignore, keep quiet or report to the authorities the quarrels in the families. I had to find a way of coping in such scenarios when 'families' had misunderstanding and sometimes resulting to quarrels. I had to excuse myself and take a walk in the village, homestead or play with children around. But later next day try talk to the woman on unforeseen consequences of quarrelling in the presence of their children. By the time I was leaving the field, Bahati had minimized public quarrels with the husband.

Bahati also acknowledges that as a woman she had multiple roles and that she is a mother and needed to take care of his children without bothering her husband. For instance, she said:

You know in my society women are doing a lot of work and men don't consider them very important. For example, I have to look for food in the market and cook, wash, feed children, go to the garden, do everything I can to fees my children and also to ensure that my husband is at peace.

This excerpt shows how care and domestic work have been institutionalized as female roles and are often taken for granted by the husband, thereby devaluating such work and rendering it socially and economically invisible. Moreover, the notion of care and domestic work as a “labour of love” has been criticized for hiding the structural exploitation, however subtle, typically involved in this type of work. From Bahati’s case, it is evident that *vipande*, working as a casual labourer in the health facility and at the chief’s camp, selling firewood, burning charcoal, and assistance from her social networks were some of the coping strategies that helped her with health bills.

5.4 Relying on TBA with Husband not Present and not Helping

Chima

I met Chima during my first phase of fieldwork in a local health center where I had gone to meet another woman who delivered but her child passed on. She happened to be in the same ward where the mother who lost her child was. She had come to see a neighbor though she had a child at home. When I was trying to console the woman, Chima asked me whether I was the husband, a counselor or a doctor but I told her I am a researcher. She got interested in knowing what my research is all about and requested if we could talk more about research later as I came to sympathize with the woman for the death of her child. Then, I met Chima and requested if I could visit her home to see the child and talk more about free maternity and OBA and she agreed. Chima was 38 years old and stays in a village in Mavueni market approximately 20 kilometers from Kilifi town. She went to school up to class five and dropped out after the death of her father who was the breadwinner in their family. At the age of 15 years, she got pregnant

and married a wine tapper (*Mgema*). The husband is mostly away in another village in Jibana sub-county an area mainly known for palm wine production in Kilifi County.

Her first born passed on when he was three years old. She has 12 children and the firstborn- a boy is in class eight. Her husband 53 years old only come home when there was anything urgent to attend to for instance when close kin passes on, or his family member was critically ill. Chima narrated how her husband had abandoned her and their children in this village, and now it was two years since they last met. She attributed her husband's refusal to come home to witchcraft which made him forgot about his responsibilities as a man in the family. However, occasionally when the extended family pressurized him, he remitted some little money home for up-keep, and this was never enough. Issues of health care were just a burden to Chima's family, and in some cases, she relied on traditional herbal medicine to treat her children.

Occasionally, Chima relied on one of the neighbours who was rich to get some little food. She admitted that her husband also used to borrow money from this wealthy neighbour and later work on his farm as a mode of paying back. She delivered ten children at home assisted by a traditional birth attendant (TBA) who she could compensate in installment and without much pressure. She could pay money in bits and sometimes help the TBA attend to the visitors, wash dishes and clean the house. The wealthy neighbour trusted her and occasionally could send her to do shopping in the local market and at least she could get some little money to buy flour for the family. Whenever she borrowed money from this neighbour, she notified her husband to send some money to pay back. Sometimes the husband delayed to send cash or totally failed to respond to her requests and forced Chima to work on the wealthy neighbour's garden, clean the house and wash dishes. One time she had been assisted to get money for the hospital to deliver her current last born, but she did not go to the hospital but resorted to going to a TBA. However, Chima argued that the health facility was far and she could not afford transport expenses and that she was also sure of paying some little money in the health facility because OBA was not there. For instance, she said:

My husband or I do borrow money from my neighbour who is wealthy, and then I refund by working on her farm and also help her do other small chores. This is my home, so she trusts me. She helped me get fare to the hospital and also bought some few items for my new baby. One time I also delivered at home I wasn't able to get OBA and did not have

money to go to the hospital to deliver. Health facility was far and the little money my neighbour gave me I used part of it to compensate TBA and the rest buying my new born few items. Thank God our local TBA helped me, but I compensated her without pressure anyway (In-depth interview, Chima 38).

According to Chima, the mother-in-law could sometimes provide maize gains for her grandchildren to eat. However, that was not enough, lack of support from her husband made her deliver almost all her children under the care of a TBA. According to her, TBA offered the role of companionship and support when she went to deliver. She could go to her for belly massage and also for check-up whether the baby was in good position and also counsels her on issues of life and marriage. Additionally, it was cheap to deliver with a TBA since she accepted any form of payment that Chima had. Despite not being supported by the government of Kenya, delivering at TBAs was a locally crafted institution that played key role in increasing the poor women's bargaining power for delivery.

Chima narrated how her husband has converted her to a 'birth-giving machine' because of his behaviour of staying away from home once the wife got pregnant and this was a recurring behaviour even for previous pregnancies. Chima kept on referring to herself 'a poor widow.' She equated herself to a poor widow who continually struggled to raise her children single-handedly. During my second phase of fieldwork, one day I visited Chima, and on arrival, I found that her lastborn child had been sick for three days. Though Chima had tried treating her with herbal medicine and other over the counter painkillers, the condition worsened. By the time I arrived, Chima had gone to look for money to buy airtime to call her husband. She usually borrowed a mobile phone from her mother-in-law. Chima came back looking worried.

After exchanging greetings in the local language, she looked more worried. I asked what was wrong and she asked me to get in the house. I was shocked to see the child that I left a week ago looking frail, pale skin and had some rashes. She explained to me what she had done including borrowing some money from a friend, and her next action was to call the husband to see what could be done. I gave her my phone to call the husband and when the husband received the phone and heard Chima's voice, he hanged-up. I had to salvage the situation. I called a motorbike rider who usually carry me around to take them to the hospital which was approximately seven kilometers away. I took another motorbike and followed them to the health

facility. Since I knew the matron-in-charge of the out-patient department, I talked to her to have the child attended to quickly, but she immediately referred us to pediatrics ward. On arrival, we found only one health worker who did tests and the child was diagnosed with meningitis. Health worker recommended admission of the child. Chima looked worried, but I assured her that all would be well and she should not be worried about the hospital bill. She called her mother-in-law and told her to look after her children. They were discharged after two days, and I paid the hospital bills because the husband sent the message home that he was not sending any money soon. Chima was grateful for saving her child's life.

Chima's case of absent and not helping husband is just one of many cases representing what other women with such husbands go through in Kilifi County. During FGD with poor mothers, it was commonly mentioned that an absent and not helping husband adds more burden and pressure of additional work to the women and therefore, maternal health care and facility delivery becomes very difficult. Consequently, many poor women who lack support from their husbands end up delivering on the care of TBA. Distance to the health facility, lack of money and family choices and support are some of the other factors which affect skilled birth attendance in Kilifi County. Moreover, socioeconomic status played a significant role in contributing to home deliveries since the poor mothers could pay TBAs anything as per their agreement and without pressure. TBAs are members of the community who could be relied on such that they could avail the care required of pregnant women especially at night. TBAs were also chosen because of their availability and accessibility. This could be attributed to the fact that TBAs are available and could easily be accessed even at night. Other studies have also acknowledged that TBAs were cheap compared to a health facility delivery and this was because payments of TBAs would be paid in kind such as a chicken or installments. In addition, their services are much cheaper compared to health facility charges (Shiferaw et al., 2013; Titaley et al., 2010). According to the economist Douglas North (1990), institutions not only matter for economic activities but that if institutions work properly, they reduce *transaction* costs. These are the costs that arise when two people engage in an economic transaction. Therefore, apart from an increase in bargaining power to get other maternal health services from the TBAs, the poor mothers also preferred delivering at home under the care of TBAs due to flexibilities in modes of payment.

5.5 Relying on Resources from Reliable Migrant Husband

Kiti

*During my first visit, I paid almost 300/= money for tests, and I felt very bad because my children were going to sleep hungry. But all in all other children I delivered at home I used to go to TBA whom I could give, 100/=, 50 /= and sometimes I could help her do other light duties when she had visitors. But this hospital thing is a bit expensive it eats into my little resources, but today it has helped me (**In-depth interview with Kiti**).*

The excerpt above was Kiti's reaction when I said free maternity services were free and OBA only charged Kshs. 100. I met Kiti 27 years old and a mother of four in the maternity ward. She is married, has four children, and she delivered her 5th child a baby girl. Her husband is a fisherman and sometimes a casual labourer. Her husband whom I also met at their home during my first visit is 40 years old. Mostly, he migrates to Mombasa town where he spends most of his time looking for economic opportunities. Kiti got pregnant at the age of 16 years in upper primary school (class) 6. She had to get married to her current husband who did not go to school³⁸. Her children are in lower primary, and they are often on and off school due to lack of school fees. Kiti lived in a small thatched house with her children. Every evening Kiti sells fish in the local market. Kiti's husband remits money home to cater for food and other basic needs. Kiti was happy about this, and she could also supplement with the little she got from her small business.

However, despite getting financial support from the absent and helping husband, Kiti complained about expenses she incurred during antenatal visits in a public health facility. Kiti is one of the women who confirmed that free maternity is never free but a good program because it allowed women to deliver for free in public health facilities. She narrated to me how one time, she almost stopped going to the antenatal clinic because when Kiti first visited the clinic, she was expected to contribute to the cost of healthcare from her pocket a thing she was not ready for. She also felt bad that the money she paid for antenatal clinic could otherwise have been used for food for her

³⁸ In Giriama community, regardless of age, when a man impregnates a girl he is expected to marry her. It is believed that men who refused to marry a girl after impregnating her, calamities befalls them as a result of curse or bad omen from the elders and the ancestors.

children. In this context, payment for health services has been made at a considerable social cost to Kiti's family and represented her "willingness" to pay in the normal sense of the word.

When I met her at the maternity ward, Kiti was pleased that free maternity helped her deliver the baby safely in the hospital. Previously, she delivered her children at home with the help of TBA in their village. It was cheaper for her to deliver at home than at a hospital. She compared what she paid for her first visit to the hospital and what she could have paid TBA. She concluded that delivery through a TBA was much cheaper and had more flexible modalities of payment than a hospital that required money at once. Events that led to delivery at TBAs place were; distance to health facility, lack of money, and mother-in-law also insisted that all her grandchildren had to be delivered at home. Kiti said:

Apart from those hospital expenses, women in Giriama community must obey their mothers-in-law. So when my husband is away, I cannot just go to the hospital to deliver because when I do, then nobody will assist me with household chores. Therefore, our in-laws control us in a way (Informal conversation with Kiti, June 2016).

Giving birth is perceived women's role and mother-in-law in most cases determined where her grandchildren were delivered. Women who went against the in-law's expectations were labeled rebels, and their mothers-in-law rarely assist them after delivery, therefore, apart from other factors hindering access to facility deliveries, Kiti had to obey her mother-in-law. Moreover, relying on her resources and the remittance from the husband made it easier for Kiti to pay the TBA and even attend ANC. However, sometimes it became challenging to get money to feed the children because her husband had no job in Mombasa town. It forced Kiti to borrow money from her sisters. However, the money she borrowed was not enough to cater for health care and food. Kiti's business was also not doing well because she used the fish she was selling to feed her children.

Kiti started attending ANCs because she had severe stomach-aches which forced the local TBA to refer her to the health facility. The TBA informed Kiti's mother-in-law about her condition, she could not resist because this was a recommendation from the TBA. Otherwise, Kiti could not have gone to the health facility. From Kiti's case, it was also evident that women in Giriama

community often had limited control over their own reproductive health decisions. Mothers-in-law had a strong influence on the uptake of ANC in Giriama Community. In Giriama community it is customary for senior women to occupy the top position in a hierarchical family network, exercising authority and power over daughters-in-law. In this patriarchal society, decisions about the management of pregnancy and childbirth usually come within the purview of older women, especially mothers-in-law as do those about perinatal care. I remember talking to one mother-in-law, she admitted that most mothers-in-law believed that as pregnancy is a natural state, there was no need to seek medical care and that ANC was only necessary when complications arose. And that some mothers-in-law could see no benefits in ANC, especially if they had not experienced problems during their pregnancies or deliveries. They mainly relied on traditional medicine for any illness.

In some cases where the mothers-in-law were the main income holder in the homestead, they controlled their savings from the household income and often made daughters-in-law ask for money to go for ANC checks where in some cases they refused to give daughter-in-law money. Interestingly, despite personal history, some mothers-in-law in the Giriama community still supported their daughters-in-law in accessing ANC. However, mothers-in-law have strong decision-making powers during pregnancy and delivery as husbands generally know little about childbirth

5.6 Using own Limited Resources and Help of Present Husband

Halima

Halima, a 39 years old mother of seven children comes from Ganze sub-county in Kilifi County. I met her during the SPIKE project survey in Silala village. I got interested in learning the alternatives her family used to finance maternal health. My interest in Halima's family developed after a short conversation with the husband who did not go to school and had some goats and two cows. After explaining what we were doing during the household survey and my interest to revisit, Halima and her husband agreed that I should always feel at home and visit them. Ganze sub-County was one of the areas in Kenya that were severely affected by drought. I thought Halima's family was a case worth following. Her husband was the only male child in their

family and had the responsibility of taking care of his mother and the homestead. Though he had inherited a big piece of land from his late father, Halima could not cultivate it before seeking permission from the husband or the mother-in-law. Among the Giriama, it is a taboo for women to talk about land issues either in her place of birth or where she is married.

He told me how he valued his livestock than anything else and despite the drought, he could not sell them. Halima's husband perceived his family poor despite having livestock. In Sosoni, wealth ranking varied. Talking to the people in the village and the market centre, in Sosoni village, I learnt that one was considered wealthy if he had many herds of cattle, a permanent house or iron roofed house, had a big piece of land with some investments like rental houses in it, and had piped water or had a water tank in the compound. Halima had ten children; they lived in a small *makuti* thatched-mud walled house. All her children slept in this house. Apart from the firstborn and current last born, other children were born at home with the help of mother-in-law. By the time I met this family, their last-born was one and a half years old baby boy.

Presence of her husband at home brings a sense of security. She said even though they were poor, her children could rarely go hungry even when she was away she believed her children were well fed by their father. Halima narrated how she lost one baby during delivery. Her pregnancy was twins. However, one baby died in the process of giving birth. They had saved money for hospital delivery³⁹, and her husband was ready to take her to the health facility once her date was due. Unfortunately, mother-in-law became sick, and the husband had to use all his savings to treat his mother. So when Halima's labour began at night, the husband had no money. He had to run to close friends and neighbours for help. He succeeded and got a motorbike which took them to the health facility. It was late at night, and there was only one nurse on duty. She was in the first stage of labour, and it reached following morning before she delivered. Halima had to go for cesarean section because she was so tired and her life was in danger. Her husband was worried, and he felt either Halima or the babies would die. He was also concerned about where he would get the money to pay the hospital bills. When the process was completed, it was

³⁹ A majority of poor families in Giriama community did not know how free maternity work. As a result, each family at least struggled to keep some money for hospital fees after delivery. Some ended up delivering at home due to lack of 'delivery fees'.

sad for Halima's husband they lost one child. The nurse explained to them what led to the death of one child one of the main reasons being a delay for cesarean section. Fortunately, they were discharged on free maternity. Halima was sad for the loss of one child but was happy she was discharged for free.

As much as poor women such as Halima benefited from free maternity services, they still had to incur other unforeseen expenses by the family. For instance, at home, Halima had to buy some medicine, and due to lack of money her husband had to struggle to purchase medicine, and it reached a point he had to sell two goats to get money for food and medicine. Here is a case where families still experience out-of-pocket expenditure despite using a free service. Moreover, selling household assets to cater for healthcare further pushed low-income families into poverty.

In a nutshell, this chapter has shown different alternatives for financing maternal health care in a limited resource set up. An excellent working health system is not just about improving health but also about ensuring that people are protected from the financial consequences of illness, and especially the financial consequences of having to obtain medical care. Poor mothers in rural areas still cannot access maternal health care due to external costs, which still exist in free maternity services. Therefore, there exist context-specific strategies used by these women to finance maternal health. Kinship, family networks and other social networks such as the church are mainly relied on to help meet the cost of health services thus, was an informal social protection mechanism that women relied on in Kilifi County. The chapter has also highlighted women's economic dependency on men as a determinant of access to maternal health care services. Access to maternal health care in most cases required a financial outlay (for transportation, medicines and, in some cases, consultation); a woman's ability to pay for these services with her earnings was, therefore, another important determinant of access. If a mother about to deliver is in a situation where her husband is helping and reliable, the likelihood to get credit is much higher than if the husband is not around.

Women's weak bargaining power and position in the household also determined the utilization of social protection schemes in maternal health. The study findings also strongly suggest that

factors other than household economic status, gender inequality were also one of the primary determinants of utilization of social protection schemes in economically disadvantaged families. Therefore, household economic situation, in particular, emerged as an important factor associated with alternatives to financing maternal health care. In cases of migrant husbands, most women used a range of other options to ensure that they feed or get money to sustain their families. However, Neo-Marxist and feminist approaches argued that exploitation of women takes place in the household. Husbands own and control land while women work on the fields of the husband and help reproduction. Meillassoux also used the Neo-Marxist notion of exploitation in smallholder contexts to explain that women are the exploited group, especially in patriarchal societies. Men control property, resources and most agricultural products realized from the land through the workforce of their spouses and children (Meillassoux, 1981). Women are also responsible for the reproduction of labour in other types of production (contract farming, casual labourers or working in informal sectors) this depicts a clear picture of poor women in Giriama community.

Despite decades of experience showing that the feminization of poverty and gender inequality is a primary driver of poverty and that women's empowerment contributes to poverty alleviation. Social protection has been critiqued as gender-blind protection has been critiqued as gender-blind (Newton, 2016). Moreover, other studies noted that gender dynamics, or gender norms and inequalities between women and men in access to economic (e.g., education, jobs), political (e.g., voting, leadership), health (e.g., services), and other resources, influence the lives and shape the health of women, men, and their children (Kraft et al., 2014). Gender inequalities that leave women with control over fewer resources and norms that shape decisions about age at marriage, the number and spacing of children, the division of labor in the family, and men's and women's roles in family decision making contribute to behaviors that influence maternal health (Mosha, Ruben, & Kakoko, 2013; Kraft et al., 2014). Notably, until today, few social protection programmes have sought to address the social risks linked to social discrimination and gender inequality. For women, these include limited intra-household decision making and bargaining power, time poverty due to unpaid work responsibilities and family care, and limited voice within communities, all of which prevent women from claiming their rights and entitlements.

Therefore, such contribute to vulnerability despite all these efforts towards achieving social protection needs through maternal health. This thus renders the achievement of safe motherhood for all in Kenya a challenge.

Additionally, using informal mechanisms are not enough for households to protect day-to-day expenditures against the risk of catastrophic health expenditure. Nevertheless, households can mitigate some of the short-term effects of health shocks by borrowing, using savings, depleting assets and relying on transfers. The implications of these actions for welfare in the long term are likely to vary by coping strategy. For instance, the depletion of productive assets and borrowing impose costs that run well beyond the current period can drive families into poverty

The findings from this study, therefore, give us a primary conclusion that those women who manage to get broader community support and the support not just of their husbands but their kin and even in a more extensive social network found it easier to meet the costs and thus was able to go to the health center. Therefore, it might be better to be honest regarding the costs for the delivery and to see this as not just a personal family based duty but also the one of a larger community. Rotating credit associations or locally defined insurance schemes helped some women in this endeavor. Women who were integrated into self-help groups were better prepared to cover all the costs than those who are not. However, for the very poor there is a need for primary assets otherwise they will also be excluded from the participation in such options. Community-based measures, therefore, might as well discuss how people want to include even their poorer members in the network of local security systems.

From the study findings, it would be important if the government would think of introducing appropriate financing systems that will ensure access to health services by the poorest segments of the population. Programs to empower women economically and socially and help them secure livelihoods as this could increase their decision making power and improve the demand for maternal health services in Kenya.

CHAPTER SIX: Contesting and Shopping Institutional Options on the Utilization of Maternal Healthcare

6.0 Introduction

In this chapter, I will examine how institutional change affects how poor mothers negotiate continued access to maternal healthcare. The chapter discusses how gender roles and the institutions of the allocation of household resources impact on the utilization of maternal health care services. It also describes how women choose maternal health programs that are advantageous to them based on their knowledge and power to re-negotiate for access to such services. The chapter also describes the gendered specific division of labour in the peasant setting and whether such give women an advantage for proper maternal health care.

In the post-2015 Sustainable Development Goals (SDGs), the successors of the Millennium Development Goals (MDGs), social protection is proposed as a powerful instrument both for achieving poverty eradication (SDG 1) and for the reduction in inequality (SDGs 5 and 10). The new global mandate accorded to social protection reflects its remarkable contribution to poverty reduction across the Global South (UN, 2015). The literature on social protection, inequality, and poverty suggest that social protection programs are the policy tool for the eradication of poverty and inequality. The exact targeting of beneficiaries is the essential pillar behind the success of every social protection schemes.

6.1 Gender Lens and Social Protection

Social protection has risen rapidly up the policy agenda in international development circles over the last decade as a key mechanism to address poverty and vulnerability. Social protection may be high on the policy agenda in international development circles, but the way it plays out in practice at national and local level is deeply political, especially so when viewed through a gender lens (Jones and Holmes, 2011).

According to Newton (2016), a gender lens is not an optional add-on, but an integral part of social protection policy and programming if it is to achieve long-term sustainable change. Therefore, with a gender lens, social protection programs such as maternal health programs have

the potential to transform different socio-economic conditions at different levels systematically. Such ‘transformative social protection programs’ must account for the different risks experienced by men and women across their life from the design phase onwards. Without a gender lens, social protection programs can reinforce traditional gender stereotypes, increase the time poverty of women and even result in gender-based violence. Although cited as one of the great success stories of development reaching large groups of the poor, social protection has been critiqued as gender-blind (Elson, 1995; Kabeer, 2010; Jones and Holmes, 2011; Newton, 2016). This is despite decades of experience showing that the feminization of poverty and gender inequality is a major driver of poverty and that women’s empowerment contributes to poverty alleviation. As a result, gender remains one of the most pervasive categories of social inequality, an asymmetry almost universal with enormous local and cultural variations (Elson, 1995; Kabeer, 2015).

Gender refers to “women’s and men’s roles and responsibilities that are socially determined” (WHO, 2008). Gender differences in health, therefore, are caused by society’s institutional responses to secondary sex characteristics that distinguish males from females. However, there is increasing consensus among gender scholars that gender is not primarily an identity or role that is taught in childhood and enacted in family relations. Instead, gender is an institutionalized system of social practices for constituting people as two significantly different categories, men and women, and organizing social relations of inequality by that difference (Ferree, Lorber, and Hess 1999; Lorber 1994; Glenn, 1999; Ridgeway 1997; Ridgeway and Smith-Lovin 1999). The allocation of resources at the household level is mainly male dominated among the Giriama, and this has left many women isolated and vulnerable, but equally made them maneuver and strategically re-define their position within the society. While gender roles and responsibilities vary across cultures, they are rarely equally balanced. For instance, women and men do not have equal access to money, information, power, and influence. In Giriama just like in other African societies, what is perceived to be masculine is more highly valued than what is seen to be feminine, and families and communities treat women, men, girls, and boys differently. Gender roles and relations, therefore, involve the exercise of power.

According to Maillassoux (1981) despite women's crucial roles in reproduction, they are never recognized as the path of the social organization. Women's labour is hidden behind the 'male-figures' in the society, and Maillassoux linked this to the historical exploitation of women's reproductive functions. Women's subordination makes them susceptible to two different kinds of exploitations. First, the exploitation of their labour, in that they lose their claim to their produce, which is handed over to their husbands who take control of it or pass it on to the elder and is never returned to them in its entirety. Secondly, the exploitation of women's reproductive capacities, mostly since filiation (that is rights over the progeny) is always established through men. Direct exploitation of women in the domestic community is often alleviated by the fact that they are given allotments or gardens, all or part of whose produce is theirs. The degree of a women's exploitation, however, cannot be measured only by the amount of time she works, without recompense, for the community (Meillasoux, 1981; Ridgeway, 2014). It is also to be measured by the labour energy she receives back from her children, in other words, by the amount of time given by her children to supply her needs. It happens in domestic societies that women benefit from some of the agricultural labour of their unmarried sons and that their influence depends on the number and position of their children. However, being deprived of real rights over their progeny, the relations women maintain with their children do not involve obligation, as do those between children and their fathers. This is the domestic mode of production that Maillassoux (1981) referred to as the gendered-exploitative relations where men own the means of production and control the relations of production.

Therefore, for social protection programs to have a transformative impact at a more systemic level that begins to address the structures of inequality, it needs to be supported by interventions that improve women's access and control over resources in relation to men; enhance their voice, capabilities, productive roles beyond traditional ideas of 'appropriate work', decision-making and agency (e.g. through education and building their entrepreneurial skills, voice and confidence); and support them to move beyond their normative roles as mothers and caretakers. In the following section, I will now explain how the institutions of gender roles and allocation of resources impact on utilization of maternal healthcare services by poor households in Kilifi County.

6.2 The Impacts of Gender Roles on the Utilization of Maternal Health Care Services

Even though the key roles of unpaid care work and social institutions has been neglected in the analysis of gender gaps in social protection, it is critical to understand gender inequalities. Women typically bear the bulk of caring responsibilities spending disproportionately more time on unpaid care work than men. This is in addition to their paid activities, thus creating the ‘double burden’ of work for women. Evidently, on account of gendered social norms that view unpaid care work as a female prerogative, women across different regions, socio-economic classes, and cultures spend an important part of their day on meeting the expectations of their domestic and reproductive roles and this puts a lot of pressure on women who want to benefit from social protection interventions.

The unequal distribution of unpaid care work between women and men represents a brake on women’s economic empowerment and influences gender gaps in social protection programmes outcomes. Discriminatory social norms can also explain gender inequalities in unpaid care work and thus in social protection intervention outcomes. Some of these gender disparities in time-use may be explained by socio-demographic and economic factors, such as levels of education and wealth, but discriminatory social attitudes are also to blame. By defining which behaviours are deemed acceptable or unacceptable in a society, social institutions influence gender roles: in most societies, working for pay is considered a masculine task, while unpaid care work is seen as women’s domain. Gender norms and gender stereotypes ‘feminize’ caregiving, and prevent men from assuming equal caring responsibilities (Ferrant and Nowacka, 2015).

Among the Giriama community, productive work is done by both men and women but seen as women’s work just like in most communities in Kenya. Though women produced goods and services and often earned money from the local markets, men usually had preferential access to such productive resources as capital, land, tools, and other jobs and could earn higher wages. On the other hand, reproductive work was mainly done by women. Women could work fewer hours in “productive work” due to their “reproductive” work. “Community management” roles were often sex-segregated. Men were more involved in decision-making about the use of community resources, while women were more likely to be involved in the day-to-day

management of the resources⁴⁰. In the Giriama community, women filled parts of all three roles, while men were involved in one or two. This tendency led to what I refer to as “triple burden”⁴¹ borne by women. Unequal burdens of work and responsibility, for the care of young and old, often meant that women were expected to sacrifice their rest, leisure, and health; women themselves internalized these values, which often marked who is seen to be a ‘good’ woman. Women often have less bargaining power than men to act and to protect their interests or those of their children in the case of a conflict, including the ability to make decisions, command resources and, at times, influence the behaviour of others. This is partly because of gender norms that recognize men as decision-makers, but also because the poor mothers are often in a poorer negotiating position because of their more significant social and economic vulnerability if their relationships broke down.

Most women argued that despite being excluded from participating in decision-making in the family, men were supposed to show their care and attention by not letting basic needs lack at home. However, this was almost an impossible task in Giriama community where unemployment and poverty were widespread. In this study, women also noted that a man was valued when he returned home from work every evening or night with a bag of food and walked directly home. Indeed, women appreciated their husbands when they could assist them to feed the family, and such husbands helped reduce pressure on women. As shown in the discourses below regarding who a good man is, he should be assisting with food and not just with money, coming home straight and earlier (meaning no drinking or spending time with other women or extravagantly spending cash or use the money for himself). For instance;-

We value men who can care for their children and wives but not one whose work is to sire children and fails to provide food and other necessary things (FGD participant aged 41 years).

⁴⁰ Women managed their husband’s farms but the husbands made decisions on how to use the farm produce. In some household, husbands could sell part of farm produce while others could distribute the produce to other extended family members without even consulting the woman.

⁴¹ Triple burden here refers to women bearing the responsibility of production, reproduction, and community management roles.

In another FGD

At home women do a lot of work so then he is important only if he can help me and always come home straight after 'work'. At least he will bring children some food if at all he gets or brings money home so that we buy food (FGD participant aged 37 years).

Despite the presence of a good husband when maternal vouchers were still being issued, most poor women preferred OBA to free maternity. However, when the vouchers were no longer there, and the free maternity took over, many mothers devised other means for meeting the costs of maternal health care. Some women avoided attending antenatal clinics due to transportation and additional expenses and resorted to seek services from TBAs and only go to the hospital to deliver. Such mothers sometimes had complications during delivery, which led to the death of the infants or the mother. Other women also entirely avoided utilizing free maternity and resorted to delivering their babies at TBAs home where modalities of payments were more flexible and cheaper. Men rarely got engaged in women's arrangements on maternal health care services; some men would provide transport to the health facility if the woman expected first born.

From participant observation, most men in the Giriama community had difficulties fulfilling their culturally ascribed roles as providers. I could observe men trickling in the local markets from the villages and they would idle, smoke cigarettes, chew khat (*miraa*), play draft, gamble, take palm wine, and also engage in discussions about local politics. To me, this was a clear sign of laziness and irresponsibility by men. A majority of poor women in this study complained about men drinking too much, gambling, having sexual affairs with other women, and thereby spending their meagre income on amusement outside the home. They would return home late, hang their dirty clothes on the clothesline for the woman to wash, and demand sex and food just to leave the following morning again. If the man stayed away all night, no longer wanted sex, or if the provision for the house diminished, the woman could be sure that he had another woman to care for. Women had to be on guard, always watching for small signs of infidelity. To cope up with burden and pressure from multiple roles, some women I spoke to secretly joined local rotating credit associations (*chama*) where they could borrow money for health care and other family use and emergencies without bothering their husbands. Therefore, poor women in such

associations, which were mostly a secret kept away from their husbands who could otherwise force the women to give them all the money were in better position to negotiate for access to health care since they had an alternative for borrowing money from the associations.

For example:

Mama Velma

I first met the 39 years old Mama Velma at Ganze sub-county hospital when she came for the postnatal clinic. Her child was very sick and weak. Mama Velma was from Jila village in Ganze Sub-county. Jila is one of the villages in Ganze that was severely affected by the prolonged drought in the country. Mama Velma schooled up to class three and got married at the age of 17 years. Currently, she has ten children, and her firstborn is in class six while other children of school going age stays at home due to lack of school fees. Out of ten children, only three were born in the hospital while the rest were home deliveries with the assistance of a local traditional birth attendant. Mama Velma's family has approximately twenty hectares of land, and due to the prolonged drought in Ganze, the land had not been productive. They also relied on milk from their two cows and one goat. Mama Velema milks the cows and the goat in the morning and sometimes in the evening and keep the money for her husband who during my field stay was always away from home. Every morning and sometimes in the evening the neighbours come to collect milk where some pay daily and other pay at the end of the month. Milk production was meager due to the extended drought in the area. Therefore; money got from selling milk was never enough to feed ten children. Her husband is a matatu driver assistant (manamba) at Bamba center, and mainly comes home in the evening. She told us that her husband is caring when sober but drinks too much alcohol and palm wine that is when he becomes so hostile, and he was also sometimes harsh when he returned home without money from his job and this primarily contributed to the inability of other children to go to school due to lack of school fees.

Mama Velma was introduced to local rotating credit associations (chama) by a health worker who was a friend to her mother. According to her this was a secret and had helped her cater for facility deliveries and other emergencies in her family. She could

easily borrow money from 'chama' then payback later or get deducted from her dividends at the end of every year. Therefore, for Mama Velma, she could easily deliver her last born child at a private health facility when the health workers were on strike.

Sometimes when the husband is not willing to meet the costs of healthcare, the more impoverished women had to meet the expenditures of healthcare since the gender division of labour and household duties fell under the sphere of care work. Women also relied on the kinship and other social networks to help them cater for the costs of healthcare. Cases where the kinship or the husband was able and willing to cover the costs, women did not have to meet the costs but if they were poor and the husband and his family did not want or could not contribute, then important household assets or property especially women's assets such as livestock, chicken and even land had to be sold to meet other financial obligations before and after delivery of the mothers. Later on, this could lead to lack of money for meeting the daily livelihoods at the household level. Meaning that in the quest for meeting the costs of health, the poor households were still economically subjected to competition in the allocation of the scarce household resources, which in most cases led to more economic vulnerability and low resilience. From the day to day struggle by women to meet other living expenses, it is clear that delivery was in the economic sphere of women who also had to take care of the costs of healthcare. Thus, women who manage to get wider community support and the supports not just of their husbands but their kin and even in a broader social network found it easier to meet the costs and thus, were able to go to the health center. Moreover, the woman also uses her assets and having access to the community members made them survive and get the cash needed. To illustrate this I describe here a case of Hadija;

Hadija

By the time I met her, Hadija was 33 years old. We met at a maternity ward in Malindi county hospital. She was from Kijijini village in Malindi. She had six children and her husband the only son in the homestead is a fisherman and also relied also on casual jobs to supplement fishing. Hadija had seven chicken and one goat for her husband when I first visited her, but by the time I was leaving the field, she had no chicken left. The

chicken were sold and the money used for food and other basic needs. Hadija's house was near the sea. Most of her children spent time at the beach picking shells, which she used for making necklaces and bracelets for selling. During my visits, I could see her mother-in-law bring some grains and even maize flour for Hadija to cook for her grandchildren. According to Hadija, this assistance was good but never adequate.

Initially, she delivered her children at home due to lack of money to go to the hospital. It was cheaper for her to pay the traditional birth attendant than paying health workers. She could also give the traditional attendant a chicken or pay her in installment. She delivered in the hospital, but she did not have money to buy cotton, cloths, sanitary towels, and other medicines. Her husband sold some of her chicken and remained only seven. Money was used to buy things she required in the hospital. After cesarean delivery, Hadija was supposed to get immunization of anti-D since she was Rhesus negative and gave birth to a Rhesus positive infant. The money was not enough, and her sister-in-law and her brother had to bring some money to buy some medicine (Anti-D immunoglobulin) which was urgently needed by the doctors. According to Hadijah, free maternity was very expensive than home deliveries, and she wondered what could have happened if her relatives were not around to help her. She did not regret having her chicken sold to help her.

From my field notes, poor mothers were aware that issues of pregnancies were “women’s business.” Some women also blame their husbands for neglecting them during pregnancy and only to re-surface when the child was born. For example:

Scenario A

In this community just like other women, I know my roles. Sometimes we do a lot of work some of which are meant for men, but all these are to keep our families intact. As a woman I know I have many roles for instance; reproduction, farming and taking care of home when he is not there. I only wonder why sometimes I see husbands selling let's say farm produce, which is never adequate or chicken or even a goat belonging to his wife to

get money for paying debts. I tell you it is inequality, but it is culturally acceptable. Most women here have a low education, so when somebody talks about gender equity, then it might be challenging to achieve. But, for sure maternal health and issues of pregnancies are mainly for women and this includes being ready to meet some costs (field notes June 2016).

Scenario B

Why should he make me pregnant and leave only to re-surface when the child is born? Some men are very careless. They don't provide food, they only make you pregnant and leave. Women are exploited, and I think culture plays a very critical role in this. When I got pregnant, I started saving little money because I knew he would only come after I deliver and the small savings enabled me to pay the local traditional birth attendant. I did not go for the antenatal clinics. The hospital is far, and they also need money on every visit. In short, I am saying pregnancy is a woman's business in this community (Field notes, personal conversation with Mama Kiponda. March 2017).

Examples from these two scenarios showed that when men were not willing to help their women who had multiple roles which piled pressure on the poor women, therefore, women had to look for ways of negotiating access to health care which was less costly to them. Exploitation of women at the household level is also evident in the excerpts above. Women work on husband's farms, but consumption and use of farm produce were determined by the husband who rarely consulted their wives. This, therefore, led to gender inequity, which made poor women more vulnerable to poverty hence negating social protection goals in maternal health. However, despite the embedment of the institution of allocation of resources in the culture, poor women still find a way of negotiating access to maternal health care. Since maternal voucher was no longer in supply and in the discourse of free maternity, which was not free, and in the midst of meager resources or no resources allocated for maternal health care or healthcare emergencies, poor women had to prepare in advance before delivery. Mostly, such preparations were never adequate, and mothers thus deliver at home under the care of a traditional birth attendant. However, the government argues that social protection in maternal health programs meets the

demands of all women, but from the study findings this was not the case. Home deliveries, which were cheaper for poor women are still high among the poor mothers.

Therefore, due to hidden costs for the utilization of maternal health services, the women had to negotiate for access and utilization of the available maternal health programs. Thus, the women choose maternal health program they deemed most advantageous according to their knowledge and power in different situations⁴². Sometimes the health systems as social institutions systematically created barriers to the utilization of maternal health care thereby excluding particular sub-groups of the population, but the poor mothers still negotiate to overcome such exclusion. If all options failed then, the mothers opted to deliver at home under the care of traditional birth attendant hence low utilization of facility-based maternal health care. This, therefore, means that there could be a likelihood of a rise in maternal mortality thus making social protection fail to achieve its goals through maternal health.

Redistribution and reduction in poverty are at the center of social protection policies. However, most women preferred OBA since it reduced catastrophic expenses. From the perspectives of the poor households in this study, the OBA programme was more comprehensive as it covered the antenatal care, delivery, post-natal care, and family planning thus cost-effective relative to FMS. On the other hand, free maternity services across the purposively selected six public health facilities were catering only for delivery services, which proved to be expensive for the vulnerable household which it intended to protect. OBA paid for all services incurred in the facilities, while FMS only catered for delivery. This implied that families had to bear the extra costs of antenatal care and post-natal care this combined with transport costs, drugs and supplies might have as well made the families with expectant mothers incur catastrophic health expenditure.

Men had different reactions to gender roles and choice of maternal health services. For instance:

*There is what my society expects me to do so I stick to my lane. Let her also do her roles
(Field notes, June 2016).*

⁴² This is the basic argument of “institutional shopping” that is in a situation, an individual chooses the most advantageous services, or good or institutional frameworks based on their knowledge and power.

No those are women's roles I cannot accompany her for birth, what I know she knows where to deliver once she starts feeling labour pains (Personal Informal conversation in the village, June 2016).

The above excerpts stem from a personal, informal conversation with men in the market. Mainly at the motorbike shades locally known as 'base.' Our discussions were about politics and other social issues; however, at some point, I could informally introduce topics on reproductive health and tactfully divert conversations on free maternity and maternal health. Informal discussions are rich anthropological methods of gathering data. For instance;

I accompany her for delivery because we are a family and one thing. Though, in this society issues of giving birth are left for women alone (May 2016).

Hey! If you go against society's expectations, you will be labeled by your friends or your family members a 'woman' (February 2017).

No. If I help her, I will be labelled a 'weakling' or a 'woman' by my relatives. So I avoid it because she knows that is her role too (April 2017).

From the excerpts, it is possible to deduce that institutionalization of gender roles and expectations also determined the utilization of maternal health care services. From participatory observation, a few men could occasionally accompany their spouses to clinics for check-ups or deliveries. For those men whom I met in the villages and did not accompany their wives to the hospitals or deliveries said that those were roles for women and indeed, elderly women or other women accompanied pregnant mother to the maternity for delivery. In the evenings I could spend time with men in the market at their resting bays and was interested to know more about how they perceive traditional gender role expectations and utilization of maternal health care. Majority of men told me that, in helping their wives, men received a lot of uncomplimentary comments from family members especially their mothers and colleagues. If they persisted in performing such "women's tasks" they would lose respect from friends, family and the community at large. A few men revealed that men who were cooking, washing and sweeping were not given a listening ear in community meetings and were not allowed to make decisions because other meeting participants considered that their contributions were coming from their

wives. Some men expressed that they would want to offer help to their wives, especially during the pregnancy period and childbirth, but the social and cultural structures in the communities were not conducive to them performing such tasks. This concurs with a recent study in rural Ghana on male involvement in maternal health through community-based health planning and services where gender role expectations restricted men's involvement in maternity care because the society had no space for men in such "feminine roles" (Bougangué and Ling, 2017). Therefore, it is evident for men that they refer to the gendered role related to birth as a way of avoiding additional responsibilities to cater for maternal health. Women, on the other hand, try to refer to the more so-called modern roles of men as caring and the duty to be reliable. Both sexes try in the change of gender institutions to see what is best for them in the context of individuation and lack of older institutional wider cognatic and agnatic kin, especially the female lines which provided security.

Gender roles play an essential role in the utilization of maternal health services because such roles give either women or men decision-making powers, which have a direct or indirect influence on the outcome of the maternal health care. Despite multiple gender roles, which put pressure on poor mothers, from informal conversations with women in the village, it emerged that those in their first-time pregnancies were most likely to seek various maternal health services. Such women endeavored to overcome financial, physical and social barriers such as dictatorship from the mother-in-law to seek maternal health services. By permission from their husbands, some women could go and stay with their elder sisters, an aunt, or their biological mothers until they deliver their first child. This meant that women often had a more extensive social network for assisting them and the husbands' kin group. I would thus argue that while the institution of assistance has been reduced, women now face the combination of remaining gender norms (delivery is women's issue) while facing increasing individuation (giving birth is your private issue). However, women who experienced child's death declined to use any maternal health services citing negligence from the health providers, and some attributed such deaths to anger from the gods or ancestors⁴³. Evidently, power dynamics within the household

⁴³ Some elderly women in this community believed that death of a first born child in a family was anger from gods or ancestors as a result of spilling the blood of their lineage in strange land. The umbilical cord had to be buried in the child's home soil rather than hospital which they labeled as a 'strange land'. Therefore, newly married women

made women unable to take control over their reproductive health, and this put them at an increased risk of maternal death due to decisions for the utilization of maternal health services were also determined by the mother-in-law and sometimes in the absence of the husband, the pregnant women always had to get permission from their mother-in-laws. There is also the issue that women often had a larger social network of women assisting in her and the husbands' kin group. I would argue that while the institution of assistance has been reduced, women now face the combination of remaining gender norms (delivery is women's issue) while facing increasing individuation (giving birth is your private issue). For instance;-

I stayed with my elder sister when I was about to deliver. However, I asked for permission from my mother-in-law because my husband was away (in-depth interview, Bahati, April 2017).

If you go ahead and deliver where she doesn't recommend then, the mother-in-law can label you tough headed, and I need her after delivery, so I have to obey her (Personal conversation with Riziki, May 2016)

Indeed, the absence of OBA and introduction of free maternity services has not solved the challenges faced by poor mothers to access and utilize maternal health services, and therefore, the poor women adapt minimax strategies to get maternal health services. If the social protection programs recognize that often there exist unequal bargaining position of women in the household then using arguments from a new institutionalism perspective, institution of gender and proper allocation of meager resources could help in the reduction of maternal health care costs and also help the women to coordinate and secured valued benefits of either health facility deliveries or home delivery (North, 1990; Haller 2010a, 2010b). Locally, poor women struggled to fulfill the multiple roles and households also strive to meet healthcare needs which turns that women had more roles to play due to the undermined institution of gender by the social protection

were expected to deliver in the village assisted by either the mother-in-law or the TBA. Those who delivered their first born in the health facilities were branded 'tough headed' and the repercussions were either the death of the child or not being assisted after birth by mother-in-law. However, women preferred delivering their first born in the health facility therefore some assisted by their husbands could save little money to cater for deliveries. Unfortunately, those whose children passed on 'regretted' and attributed such deaths to either negligence of the health workers or punishment from the ancestors or gods of the land.

programmes. I argue that women who can control capital and who can hide this capital from men and his relatives had more bargaining power to select the institutions which suit them best, while more vulnerable women had lesser institutional options to choose.

Newton (2016) also argues that for social protection programs to achieve its transformative potential and address inequality, it has to take into account all forms of discrimination and how they intersect with other social dimensions, apart from gender, which prevents women from achieving the same level of socioeconomic rights as men across their lifecycle. For instance, women's role in the unpaid care and domestic work is well acknowledged as an obstacle to their ability to enjoy rights to work, rest, leisure, education and health and evidence from the study shows this too. Therefore, in conclusion, this chapter shows that as recipients of the social protection programmes in maternal health, not all women could control how income was distributed within the household as this was also anchored in the institution of gender. Unequal power relations at the household level were also determined by gendered norms which in the long run defined whether men could help pregnant women do some household chores or not. These norms affected the risk and vulnerability, health-seeking behaviour and health outcomes as well as health sector responses of the poor women in this study.

Consequently, gender inequality was, therefore, a cross-cutting determinant of health that operated in conjunction with other forms of discriminations which were institutionalized and has been ignored by many social protection programs targeting the poor women. Gender norms that allow superior value and power to men increase women's risk of gender-based violence, which could contribute to poor maternal health. Maternal health is rarely examined through the institution of gender lens and allocation of resources resulting in strategies and interventions that do not improve access as the environment in which the decisions are being made remain unchanged. Therefore, gender and development advocates have challenged simplistic assumptions that are merely targeting women equates to empowerment as it ignores the complex bargaining contexts and process within the household (Molyneux, 2009; Holmes and Jones, 2013). Findings from this chapter that men use so-called 'cultural' gender norms legitimated by the ideology of masculinity to exploit women concur with Biketti et al. (2016) who study in Kenya also showed that women were expected to spend their earnings on household

expenditures, which were hitherto responsibilities of men, thereby contributing to the feminization of responsibilities.

From the findings, it is clear that households are not homogeneous units but are sites of ‘bargaining,’ in which women and men have different abilities to decide and control how the transfers are pooled back into the household. Moreover, it is evident that men continue to hold the primary authority and control over most resources and benefits, with women being relegated to subordinate production. Male control reinforces male ‘authority’ within rural households. Therefore, understanding gender as ‘relational’ will be key, as women and men negotiate how social protection resources are used for consumption, production, and investment. From the study findings, I, therefore, argue that for social protection programmes through maternal health to achieve the objectives, attention must be paid to gender roles and relations between women and men, in particular, how they affect intra-household decision making and bargaining power, time poverty, and women’s reproductive unpaid care work.

As a result, building institutions from the bottom-up in a process termed “constitutionality” (Haller et al. 2016)⁴⁴ would be appropriate because such a process will take into account local institutions such as cultural values and beliefs and integrate them with social protection policies through cross-cultural participatory planning and the creation of local management committees for resource governance (Preuss and Dixon, 2012). Moreover, the development policies and interventions need to be based on an understanding of men and women’s differential access and control over resources and the institutions underpinning men and women’s bargaining power to adopt more effective measures to reduce gender inequalities.

⁴⁴ Roles of constitutionality are discussed in chapter eight.

CHAPTER SEVEN: The Socio-Cultural Conceptualization of Birthing: Reflections from the Field

7.0 Introduction

This chapter is based on reflections on discussions with the local rural communities in Kilifi County about the socio-cultural meaning of giving birth and practices related to giving birth. I know that this aspect could be stand-alone anthropological research, but since this PhD research was based on maternal health and social protection, then it would be of value to briefly describe experiences and practices on giving birth and what this meant based on the local people's culture. Moreover, I also reflect on encounters during fieldwork and informal conversations with traditional birth attendants and the health workers. Therefore, this section will address the participants' perspectives on cultural practices and beliefs related to giving birth and whether such practices could hinder the objectives of social protection.

Birth is a universal human experience that takes place in a specific cultural context. Cultural perceptions of what symptoms are considered normal and abnormal during pregnancy influence health-seeking behaviours, which, in turn, ultimately affect maternal mortality. All cultures have some traditional practices which were developed and passed from one generation to the next, as a reflection of the society's ideas about life (Shamaki and Buang, 2014; Walton, Maria, and Schbley, 2013). Pregnancy brings joy to the family. In the African culture, children are regarded as equaling wealth, especially male children. Therefore, a woman falling pregnant constitutes an achievement. The woman considers herself as someone who has reached one of the milestones expected of the family and by society at large. The woman is awarded respect, power, and status in the community. In Giriama, the woman's name changes immediately after the birth of her first child and the mother is then referred to as the mother of her daughter or son. For example, if the name of the child is 'Karisa,' she will be called 'Mother of Karisa' (Mama Karisa). However, irrespective of where they live, whether in an urban or rural area, cultural and traditional norms of ethnic origin influenced women, which, in turn, affected their adaptation to the pregnancy period and their attitude towards postpartum maternal and newborn care (Reed et al. 2017).

Despite the global outcry to address the problem of maternal mortality, unskilled delivery remains an issue in many African countries. Pregnancy and childbirth are almost universally associated with culturally based ceremonies and rituals. Mead and Newton (1967) reviewed the literature on 222 cultures and found that all had beliefs about appropriate behaviour during pregnancy, labour, and the postpartum period. Foods to eat, activities to avoid, and care and behaviour during delivery and the postpartum period are all culturally prescribed.

According to Jordan (1982), childbirth is a private and complex transaction whose topic is physiological and whose language is culture. This implies that the cultural context in which birth occurs provides norms that influence attitudes, values, and interpretations of personal and interpersonal experiences. Therefore, while childbirth is a biological event, the pregnancy and birth experiences surrounding it are mainly socially shaped by cultural perceptions and practices (Rice 2000; Kaphle et al., 2013). Other scholars have also argued that the medical view of pregnancy and birth often fail to appreciate the influence that traditional beliefs and practices have on maternal healthcare service utilization (Benoit et al., 2010; Haines et al., 2011; Sawyer et al., 2011; Teman, 2011). Such failures also hinder the goals of social protection schemes in maternal healthcare. For one, beliefs surrounding a routine, uncomplicated pregnancy may paint a different picture than that commonly shared within Westernized institutional medical practices. Medical risks or problems during pregnancy may, therefore, go undiagnosed for longer, the different viewpoint delaying women from seeking care at institutional practices while favoring more familiar informal healthcare practitioners (White et al., 2012; Morrison et al., 2014). Therefore, in this study, it is worth describing women's reflections on the socio-cultural practices and beliefs during pregnancy, birth, and post-delivery. Next section contains information on social and cultural practices and beliefs on birthing based on thoughts and experiences from women some of whom delivered in a health facility and some at home or assisted by TBAs.

7.1 Socio-Cultural Practices and Beliefs on Birthing

During my field stay in Kilifi County, I had informal conversations with four TBAs and two local community health workers who told me that despite the existing skilled maternal health care, among the Giriama communities, pregnancy was an unknown journey whose successful destination was also embedded on adherence to set cultural practices and beliefs. Cultural beliefs

and practices were mainly there to caution pregnant women against engaging in considered taboo. TBAs and community health workers revealed that it was considered a taboo for pregnant women to prepare for birth anywhere because it was believed that this could result in misfortunes including stillbirth. The preparations mentioned during our conversation included: buying clothes, purchase of birthing supplies like a razor blade, setting aside money for delivery and deciding on where to deliver. Also, it was considered harmful to guess the sex of the baby or give a name or a gift to the unborn baby. Indeed, these beliefs discouraged women from making individual birthing plans as expected during the antenatal clinics, including delivery at a health facility. This means that such cultural beliefs do not cushion women against depleting all their resources hence become vulnerable while giving birth.

As I mentioned in chapter two, health workers strike led to more maternal deaths and most pregnant women had to deliver by the assistance of a TBA locally known as *Mkunga* also *Wakunga* (plural) despite other factors, such deliveries were also embedded in cultural beliefs as discussed here.

7.1.1 Pregnancy as a Journey Embedded on Cultural Beliefs

'Pregnancy is a delicate journey whose destination is not easy to determine unless you follow the right path' (Giriama say; Informal conversation with a TBA, February 2018).

The Giriama say above implied that a pregnant woman is considered vulnerable both physically and socially and there are norms and practices which are intended to offer protection to both the woman and the unborn baby only if she adheres to cultural beliefs. Therefore, it means that certain beliefs exist surrounding what facilitates a good pregnancy and its outcome, as well as negative sanctions and all these, emanate from society's socio-cultural beliefs. Moreover, the Giriama say also meant that pregnancy represented a highly constructed social world that had been designed for women to adhere to. Thus, pregnant mother and the family are expected to follow the society's accepted beliefs for successful delivery, and in case of premature deliveries then the society had a way of explaining such misfortunes. The poor women in this study expressed to me their experiences and feelings during pregnancy. Majority of women I talked to also attributed pregnancy to a delicate journey whose destination is determined by adherence to

some rules from the community, health facility and family level. Most women I talked to had between five to twelve children. They argued that they gave birth to many children because they adhered to cultural beliefs which strongly advocated for patriarchal domination hence locking out women in the decision-making a sphere. However, in this study, it was also evident that due to the burden of taking care of children amidst other multiple roles, some women were willing to either stop giving birth or use other long-term family planning methods. However, it was not possible for women to decide on their own due to unequal positions in the family.

In the Giriama community, pregnancy, childbirth, and postpartum practices are culturally prescribed and form a journey that every woman would go through. There are many norms that the women are expected to observe to prevent them from drifting away from this social and culturally acceptable journey.

One such norm is abstinence from sex when they are pregnant. The pregnant women are warned that if they have sex, the baby will be born covered with 'white dirt' that is believed to be the semen from the man. Such a woman faces social stigma even in the health facilities because she is perceived as having no sexual control, which is the reason she had sex when she was pregnant. However, in other communities, sex during pregnancy is not entirely prohibited. Among the Akamba community of southern Kenya, sex is permitted in the early stages of pregnancy because semen is believed to nourish the mother and the baby (Maithya, 2009).

Among the Giriama, it is a taboo for a pregnant woman to view the body of a dead person. Breaking this taboo may have fatal or undesirable consequences. It is believed that if she sees a dead body, the baby will die in the uterus. A non-fatal but undesirable outcome is that the baby will be born with congenital abnormalities. While this taboo may not present immediate physical danger to the baby, it may have health implications. It discourages pregnant women from emotionally draining circumstances like grieving, which may trigger premature labour resulting in preterm delivery hence endangering the survival of the new baby. More broadly, these notions are informed by aetiologic concepts of illnesses and misfortunes in this community, just like in other African communities.

It is considered inconvenient to deliver in the main house because it is used by the husband, other family members, and visitors. Delivery by a man is culturally offensive therefore women traditionally delivered with the assistance of an elderly woman or mother-in-law. Not only are men not supposed to conduct deliveries, in Giriama culture men and children are also not supposed to occupy the same physical space as the mother. Traditionally, during his wife's pregnancy, a man should provide for her financially, and that is the end of his involvement. However, just as it is evident in chapter five and six of this thesis mothers with their children engage in multiple roles to meet basic needs while their husbands fail to meet their culturally expected obligations and only lazy around in the markets. Girls and childless women are also discouraged from attending births because they do not know the issues of giving birth.

Diet is also paid attention to. For instance, eating meat from a dead animal was prohibited. This was because it was believed that eating a dead animal may harm the mother and the baby in the uterus and leads to death. This socio-cultural practice is consistent with the scientific knowledge that meat from a dead animal could potentially spread infection. I argue that this is a norm to guard against eating meat from infected animals that are dangerous to mother's health and that of her unborn baby. Beliefs regulating what a pregnant woman eats were also observed among the Giriama women who believe that eating excessive fatty food can make the baby too big leading to difficult labour. Nutrition-related practices during pregnancy are based on a belief that 'hot' foods are harmful and 'cold' foods are beneficial. Because pregnancy is believed to generate a hot state, pregnant women were advised to maintain a balance by eating cold foods and avoiding hot foods. Cold foods were recommended in early pregnancy to prevent miscarriage. Hot foods were encouraged during the last stages of pregnancy to facilitate labour.

Similar food restrictions exist in other communities in Kenya, for instance, the Akamba. Traditionally, pregnant women are discouraged from eating certain foods such as eggs, fatty meat, and honey to avoid the baby becoming too big because that would cause problems during delivery, which may result in the death of the mother, the baby or both. An overlarge baby would require delivery procedures that were traditionally unavailable. Just like in the contemporary Giriama community, in Kamba and among the Luo of Western Kenya, women are still advised to avoid such foods in the advanced stages of pregnancy (Ominde, 1970; Maithya, 2009). Such

restrictions serve to maintain or foster good health in an environment of limited healthcare resources.

Before giving birth, in the second and third trimester, expectant women are expected to visit a *Mkunga* to check the position of the baby and woman is expected to take certain herbs. The community believes that these herbs make the woman strong so that she will have the energy to push the baby for a normal delivery at birth. The herbs are also believed to build and boost blood levels because blood loss is anticipated at birth. This is also thought to prevent anemia. The herbs are also believed to strengthen the pregnancy to avoid the malformation of the fetus and a miscarriage, which could be inflicted by jealous people or evil eyes. Sometimes *Mkunga* happens to the mother-in-law. However, during FGD with mothers who had delivered, the question was posed as the motivations behind visiting TBAs, women continuously pointed flexible modalities of compensating (*See description in sections 5.3 and 6.2*).

Additionally, the *wakunga's* traditional knowledge and healing abilities, mainly regarding massage was also another motivating factor. Pre and the post-natal massage was the most commonly cited practice by women. Even women who had given birth in health facilities confessed to hiring a *mkunga* for massage to aid in the delivery process and to relieve pains. Women described how massage is done for instance:

We visit them because of their long-term experience in massage which is very important. Moreover, sometimes if it is mother-in-law, then it is automatic that you must be massaged and you cannot refuse (Nzame female FGD Participant, May 2017).

Okay, the massage process is a bit involving. To begin, coconut oil is smoothed over the mother's abdomen. The area of the womb is kneaded and massaged in circular motions, feeling for the head of the baby and "the way" of the birth canal. Mkunga knows, and if the baby is felt to be in the wrong position, (for example breach or feet first), they can correct its placement through massage. For premature labour pains or backaches, massage is also the recommended treatment in our culture. Then after birth, massage is also done to "remove the waste" coupled with other practices such as tying kanga around the mother's stomach (Binti female FGD Participant, May 2017).

Health professionals though claimed that massage is harmful to both the mother and child. This is because abdominal massage of mothers leads to ruptured placentas or placental separation from the uterine wall connected with massage, which could sometimes result in massive blood loss or the necessary removal of the entire uterus.

When they get massaged the result is either a ruptured placenta or heavy bleeding during or before delivery (Informal conversation with a health worker; Field notes, 22/06/2016).

When the baby is born, the *Mkunga* uses a razor blade to cut the umbilical cord, and then waits for the placenta to expel, which she disposes off while observing a culturally defined ritual. During discussions with women in the health facilities and villages, the majority noted that they preferred delivering their first born babies at home to bury their placenta in the ancestral soil. Two women who lost their first born babies during delivery in the health facility attributed such deaths to anger from gods of the land. The gods were hungry with them for not burying the placenta in the ancestral soil. One, for instance, resorted to delivering all other children at home and none of them passed on. Therefore, culturally the destination of the placenta also mattered in the Giriama community.

Firstborn died in the hospital. I think it was a punishment from the gods because I did not bury his placenta in our land. I guess it was thrown for dogs and cats to eat. I stopped going to the hospital, and all the other children I delivered at home are now fine. (Field notes May 2016).

In Giriama where the community believed that placenta must be buried in a certain manner for women to continue bearing children, pushes the women away from the hospital where the placenta is burned by incinerator and likelihood of more home deliveries and more maternal mortalities (evident during long-term health workers strike).

Homebirth is considered a cultural practice in its own right. One *Mkunga* spoke of days when no one talked about hospital birth, and women's affairs were left up to women. Just as customs of language, cultivation, and food preparation were passed from generation to generation so too was the tradition of homebirth. When a child is born, it is considered a blessing and received with jubilation. However, twins or multiple births are considered a blessing. However, elaborate

rituals are performed for such babies. For instance, special herbs are mixed with the cud of a sheep or goat and spilled on the babies; this is to avoid diseases or death of the twins. The twins are also served special soup from different pots to bar any misfortune from pursuing them in life. Culturally, families that give birth to twins are considered fertile in, and people with a desire to have multiple children rush to marry them. As part of an elaborate ritual, the skin from a goat's head is made into wrist bangles (rings) “*viroko*” for the mother and her twins to ‘protect’ them. The wrist bangles are locally known as *chinga*. During the naming of the babies which is usually done by the husband or an elderly family member, these skin bangles are dressed on the wrist of the twins. If they are a male and female the bangles are worn on the right and left wrists respectively.

In summary, this chapter describes the socio-cultural conceptualization of giving birth in the Giriama community. The practices and beliefs outlined in this chapter play an important role in determining the likelihood that women will use formal services or not. Based on the practices and beliefs outlined in this chapter then it is often simplistic to blame the women and their family members for their poor utilization of medical services during pregnancy and childbirth. However, there is a need to acknowledge that when services are culturally competent, women and their families are likely to express higher levels of satisfaction and have higher rates of utilization. Therefore, to achieve the SDG target, policymakers and health care providers must find ways to encourage women from groups with traditionally low rates of maternal health care utilization to access these services. By recognizing and appreciating prevailing local beliefs, maternal healthcare providers can be better positioned to provide culturally competent care to women and their families, thereby improving maternal and infant health outcomes when possible.

CHAPTER EIGHT: An outlook: How to Make Maternal Healthcare More Participatory in Kenya

Based on the recommendations from the women's and practitioner's perception of maternal health care initiative and its contradictions, this chapter describes how maternal health care programs as social protection schemes can be made more accessible for the poor. This chapter draws examples from other studies to explain why a more participatory approach could be used to develop a new institutional arrangement and how such will incorporate local needs and decisions hence making social protection achieve its objectives.

This chapter discusses the conclusions from the main empirical chapters and theoretical issues addressed in the entire thesis.

8.1 Introduction

Kenya is committed to reforming its health system by providing affordable and equitable, access by the population to essential health services thereby putting the country on the path to achieving universal health coverage. As a result, Kenya recorded an increase in the proportion of facility-based deliveries from 44% in 2008 to 61% in 2014 (Kenya National Bureau of Statistics (KNBS) and ICF International, 2015). This increase has been partly attributed to the free maternal care policy introduced in June 2013 (Republic of Kenya, 2015). However, as described in the previous chapters, free maternity is not free.

Participation has a longer and more varied genealogy in development thinking and practice than is usually acknowledged, and has been periodically regenerated around new schools of thought, institutional agendas and changing political circumstances. Participatory approaches during policies development conventionally emerged out of the recognition of the shortcomings of top-down policy approaches. Therefore, the ostensible aim of participatory approaches to policy formulation was then to make 'people' central to development by encouraging beneficiary involvement in interventions that affect them and over which they previously had limited control or influence (Cooke and Kothari, 2001). Thus, the broad aim of participatory policy approach is to increase the involvement of socially and economically marginalized people in decision-making over their own lives (Guijt, 1998). Moreover, even the stakeholder's influence and share

control over development policies, decisions, and resources that affect their lives. This implies that since local knowledge reflects local power then, participatory approaches to development policies are then justified in terms of sustainability, relevance, and empowerment.

Thus, the mechanism through which theorists believe that efficiency and equity should increase is by public decisions being brought closer and made more open and accountable to local populations (Oyogi, 2000; Smoke, 2000). For this to happen, several authors argue that some form of downwardly accountable local representation is necessary (Agrawal and Ribot, 1999; Ribot, 1995; Smoke, 2000). Ostrom (1990) argues that through broad-based local input and influence, decentralization brings local knowledge into the decision-making process, which should result in better-targeted policies and reduced information and transaction costs. Moreover, local participation in decision-making makes people more likely to have a sense of ‘ownership’ of those decisions such as rules for resource use (Haller et al. 2016; Haller et al. 2018; Haller and Merten, 2018). Because of this ‘ownership’ presumably, they will provide better information and be more engaged in implementing, monitoring and enforcing such rules. Also, marginalized groups could have a more significant influence on local policies because of the open nature of decision-making, thus increasing equity (Smoke, 2000; Margulis, 1999; Ostrom, 1990).

The global dialogue around policies for health today places much discussion on specifically those living in poverty. Participation is not only promoted in the context of provision and utilization of health services. Notably, participation of community members in healthcare is not new. An apparent example is the participation of community people in the provision of care to family and community in their own cultural settings. In addition, community lay people have been involved in the delivery of allopathic health services for the last one and a half centuries. Despite the apparent consensus about the value of participation, there is no single agreed concept of what participation is or should be (Martin, 2008), and programmes often develop without an explicit definition.

The Alma Ata declaration emphasized the importance of community participation in the planning, organization, operation and control of primary health care services (WHO, 1978). Community participation and empowerment can improve access to health services and health

service outcomes (WHO, 2015), however the literature also shows significant variations regarding the interventions implemented, the nature of the communities involved and inputs provided and how participation is defined (George, Mehra, Scott and Sriram, 2015), with implications for effectiveness (Rifkin, 2014). When community participation is minimal and focused only on raising awareness of health issues, this may not necessarily improve access to skilled care services (Marston et al. 2013). Factors that can facilitate increased community participation include pre-existing intrinsic motivation among individuals in the community, community-level trust, strong external linkages, and supportive institutional processes such as decentralization reforms and engagement with social movements (Gerge et al. 2015). Conversely, community participation can be hindered by a lack of political goodwill, training, interest, and information, along with weak financial sustainability and low community accountability (George et al. 2015). Rassekh and Segeran (2009) found that the most successful community engagement strategies were those that provide feedback through sharing results with communities; foster local adaptive learning; harness community resources and promote equity. These processes and factors when brought together strengthen community capability⁴⁵.

If the community is actively involved in health policies, then this promotes people's involvement and encourages them to take an interest in, to contribute to and take some responsibility for the provision of services to improve health. However, to-date, health policies in Kenya mainly adopt a top-bottom approach in the formulation and implementation phases. Evidence, from the study findings, shows that there has been resistance to such 'beneficiaries-insensitive approaches.' Therefore, this calls for a need for adopting new participatory strategies, which are people-oriented. Participation approaches can be understood in terms of two broad categories. The first is utilitarian (Morgan, 2001), where participation is a discrete, short-term intervention and might involve, for instance, using community resources (land, labour, and money) to offset the costs of providing services (Morgan, 2001). This approach has been criticized for treating participation as an add-on or input to healthcare programmes (Kahssay, Oakley and World Health Organization,

⁴⁵ A set of dynamic community resources, traits, and associational patterns that can be brought to bear for community building and community health improvement.

1999), and for ignoring the underlying context and processes contributing to communities' health inequalities (Draper, Hewitt, and Rifkin, 2010).

The second approach aims to effect wider social and political transformation through social processes, e.g. dialogue that develops over time (Morgan, 2001; Guareschi and Jovchelovitch, 2004; Campbell and Cornish, 2012). It focuses on lack of resources and social injustice as causes of poor health (Rifkin, 2014) and sees community participation as a way to distribute power more evenly within and between communities, healthcare professionals, and the state, while also developing individuals' and groups' own abilities to participate in the process of change improving their own health directly, or via community development activities (De Vos et al. 2009). In other words, if community participation is viewed as a process of empowerment and a social practice, it must necessarily be configured according to the social and political context, and change as the context changes. Even the process of participation itself may affect health by developing community networks which in turn can provide social support, one effect of which might be to encourage healthy behaviours (Campbell and Murray, 2004).

From the study findings, it is evident that making maternal health policies were not just political and social processes they also missed an emic bit. Social Anthropology, therefore, plays a role to show connections between policies, politics, social processes and culture. The rules, intentions, and aims of policy are always ideological that is they are more systemic formulations of the way people assume that society works and should work and how consistent actions within institutions will maintain or bring desirable situation has been lacking in policy-oriented studies. Therefore, creating local institutions as a solution to issues of trust and malfeasance in economic life and assisting in matters of presentation and transparency, calls for a discussion with locals (Haller et al. 2016). This means that there is a need for participatory approaches during policies formulation and implementation as advocated for by the sustainable development goals which emphasize on the need for inclusiveness of all institutions in the societies for sustainable development and providing access to justice for all and building efficient, accountable and inclusive systems at all levels.

Based on this background I, therefore, present a new theoretical perspective introduced by Haller, Acciaioli, and Rist in 2016. The basic tenets of this anthropological theory encourage the bottom-up institution building processes of constructing laws, rules norms, linking the collective actions and personal views with the motivation of these actors to trust the social and political dynamics of crafting these institutions. Such participatory approaches in institution building might level the bargaining power of heterogeneous actors and reduce mistrust and enhance transparency and accountability of the maternal healthcare services in Kenya.

8.3 Constitutionality

Following the work of Ostrom, which showed the principles for well-functioning institutions, and Ensminger, who emphasized the role of the bargaining power and ideology in the process for institution building, there are still very few examples of anthropological research on the emic perceptions of stakeholders who were involved in such processes in reconsideration. Thus, Haller, Acciaioli, and Rist (2016) introduced a new theoretical perspective called constitutionality, which refers to successful process of institution building for resource management, emphasizing the local perspectives on their will to participate and the ways feeling of trust “and the development of a sense of ownership in the institution-building process” as the approach seeks to “focus upon local agency and creativity in the construction of novel institutions to deal with environmental issues” (ibid:1). Constitutionality was derived from the New Institutionalism (Ostrom, 1990; Ensminger, 1992; Haller, 2010), the theory moves beyond the framework of New Institutionalism to examine the strategic dimensions of how grass-root participation in institution building was actually accomplished, negotiated, legitimized (by reference to ideologies), and established, involving compromises that take into account power issues (Ensminger 1992; Haller 2010). The matters of bargaining power are essential because of the heterogeneity of local communities regarding internal power distribution and often characterized by a relative lack of control in dealing with outside actors such as the state. However, constitutionality shows how conflicts over resource management can lead to institutional solutions formalized as compromises with a collective benefit for most or even all actors (Knight, 1992). However, Haller et al (2016) argues that constitutionality as an approach considers unevenness in power relations, across multiple levels of interaction that is; local,

regional, national, and global in its handling of the effects of ideologies and discourses, as well as the contextualization of narratives (histories) of local actors.

In this thesis, therefore, I have described how local actors amidst challenges and frustrations, in the provision of maternal health services, use different strategies to deal with those problems and negotiate their roles and statuses with other players and also claim that they are not restricted in their actions. Thus, constitutionality shows various possibilities used by local actors to deal with their problems, negotiating their roles and statuses with other players, and claims that they are not restricted in their actions.

Using evidence from the fieldwork, I will now discuss the local perceptions of the institution-building process that might make maternal health services more participatory and likely to restore ‘trust’ in Kenya’s health care sector.

Consultation is a crucial thing when coming up with anything. Consultation does not stop only at the county level, even the community members need to be consulted. That is why we have community strategies. As much as politics and policy go together, we need to be sober and look at sustainability. That is why if it could have been consulted widely then the next president may not see FMS as the current president’s affair but people’s agenda (Roundtable discussion, county health team officials).

Neglecting people’s needs and expectations may make healthcare services less relevant to the communities they serve (Informal conversation with a village elder May 2017).

If we say we are benefiting from free maternity, then we might lie because other women suffer like us and this free maternity is very active during political campaigns. I feel that if women and the local leaders are included in policymaking, then free maternity might have a substantial positive impact on maternal health even for the future generations. I feel the policy is detached from some of our cultural beliefs (Anzi a female FGD participant, May 2017).

The excerpts above stems from a roundtable discussion with the county health team who were the key decision makers in policy implementation in the health facility, informal conversation with the village elder and focus group discussion with women in the village. From these three

excerpts, the main concern was lack of consultation and including local knowledge with the local actors' during policy formulations, free maternity policy perceived as the president's thing and seen negatively and the issue of lying which violated: trust, fairness in distribution and accountability. According to the study respondents, therefore, policymaking and discussions should incorporate people's most felt needs which correspond to their norms and values since this would lead to 'locally sense of ownership' of policies by the locals and as a result, this could be passed on to the next generations.

Indeed, the lack of local participation was recognized as one of the leading errors in the reform processes in maternal healthcare and confused the obligations of each stakeholder in the health system. In addition, maternal healthcare reforms in Kenya have been affected (or dominated) by political preferences of governments-in-charge. As a result, therefore, the health system experiences financial and technical instability, inefficiency, and inequality of access and health services quality. Thus, resulted in inconsistent positive health-seeking behaviour and low awareness of priorities and objectives of the health system among professionals and citizens and this had negative consequences both in the functioning of the health system and public opinion.

Form the excerpts, I, therefore, argue that the inclusion of citizens or the local actors may help increase transparency and accountability in political decision making with regards to healthcare, as it provides civil society with information on the health system and health policies that can be used to monitor government practices. Citizens can then raise concerns or challenge their local authorities and health authorities. For instance, in Colombia, citizen involvement in the monitoring of funds allocated to vital public sectors helped prevent as much as US\$ 5.4 million from being lost to corruption (Kohler, 2011). In India, as another example, citizen participation helped expose that physicians were demanding bribes from mothers seeking treatment for their babies in maternity wards (Sayedoff, 2007). The examples from Colombia and India above are a clear indicator of local transparency and implications for monitoring policies. From the study findings, the aspect of transparency lacked and local people also felt excluded from policy formulation processes, therefore, lack of a sense of ownership. The Kenyan government, thus, can also emulate transparency and policies monitoring and look for possible ways for the inclusion of local people during the formulation and implementation of health policies. As a

result, therefore, the findings reflect that there is a need for a bottom-up approach when crafting health policies. This would make the locals express their feelings and their thoughts about possible ways forward which could also make maternal health policies better.

Empowering the local people through continuous health talks geared towards behaviour change in the villages and also having a community representative could lead to change in community's attitude towards facility delivery and also participate in the institution-building process based on their perspectives. As the village elder indicated neglecting the people's needs and expectations makes health policies 'irrelevant' when such policies conflict with the norms and values of the community. Through participation, the local community members will, therefore, craft rules that will govern memberships and belong to the maternal health care programmes for social protection, and also develop regulations that will coordinate the system of resource management.

Ostrom (2008) argued in the process of institution building then, 'trust' is essential and that if any group of local people thinks they "share a common future (for instance, benefiting from the social protection schemes in maternal health) and their actions are known to others, and that cooperative actions do lead to increased utilization of the services", then they will probably adopt a stable relationship based on trust and reciprocity. Her suggestion is to let the local stakeholders build self-organized resource governance systems (what she called "polycentric system"). This will give them the possibility to achieve the needed utilizing of local knowledge and to gain from the creative learning process of trial-and-error during the crafting of such institutions.

Following the work done by Ostrom (1990, 2005), who showed the principles for well-functioning institutions, and Ensminger (1992), who emphasized the role of the bargaining power and ideology in the institution-building process, there are still very few examples of anthropological research on the emic perceptions of local stakeholders who were involved in such processes in retrospect. With this being said, constitutionality tries to show the extensive possibilities used by local actors to deal with their problems, negotiating their roles and statuses with other players and claims that they are not restricted in their actions. Constitutionality as a theoretical argument is based on four case studies done in Mali, Zambia, Bolivia, and Indonesia.

The four case studies showed the potential to create such new institutions when the local actors are given the “freedom” and space to empower themselves based on their perspectives, and that the state is providing such opportunity for them (bylaws, policies or political circumstances). In these cases, NGOs and state representatives can help the local process by providing a neutral platform for their debates, and by doing this, they were reducing the transactions costs of the organization and the possible social learning process (Haller et al. 2016; Haller and Merten, 2018).

To make maternal healthcare in Kenya more participatory, therefore constitutionality can be potential for long-term sustainable health policies. The constitutionality approach indicates in practical situations of high power asymmetries that identifying interest groups and giving them a platform to discuss among themselves first before helping to bring the different ideas together is crucial for a sense of ownership. This could be achieved only if, the local actors are empowered to engage in the institution-building process based on their perspectives, which can be analyzed emically. The state recognizes these solutions due to the existence of laws, regulations, and policies that accommodate local actions; by forming interest groups, heterogeneous actors in these contexts can discuss what kinds of institutions, both “traditional” and innovative, they feel to be of importance before negotiating overall regulations; and non-governmental organizations (NGOs) and state actors, despite never being neutral in the institution-building process, find it appropriate to create a relatively open platform for local debates, thereby reducing transaction costs for organizations and catalyzing communicative action for enhancing social learning processes.

The constitutionality approach, emphasizing bottom-up processes and communicative-strategic action, will incorporate local actors’ agency into the processes of negotiating and constituting maternal health policies. However, highlighting local agency also requires understanding the views of local actors and their bargaining power constellations upon institution-building regarding fairness, including gender equity, as well as a sense of ownership from an emic perspective. These are central dimensions underlying actors’ motivations and strategies for crafting and enacting local institutions despite power asymmetries that fluctuate with regard to

different issues at different historical moments (Haller et al. 2016). Therefore, various departments of health in the government and agents should engage with local actors in various ways of negotiating resource governance arrangements related to differences in bargaining power.

For instance, hospital matrons noted that the moment devolution started, many committees were restructured. Health committees in the counties were equally affected. For example, in Kilifi County, the hospital health committee had been dissolved, and the county office took charge and the roles of the previous committee. This meant that the doors for close consultation with the community members had been closed as much as the communities were represented in the County by the elected politicians such as the Members of County Assembly wards (MCAs), women representatives and Members of Parliament it emerged that some of these politicians were mainly concerned with their political interests. However, the participatory approach advocated for by the policy implementers in this study has been used as a ‘Trojan Horse’ (see Blaikie, 2006) by the politicians and other powerful actors. Moreover, local people have been restricted to “participatory” roles in collective choice and operational choice, while such powerful actors as state agents have primarily monopolized the operations of the constitutional option. The excerpts also reveal that the erosion of local institutions to manage the maternal health and other health policies emerged from political, economic, and significant institutional changes in the devolved system of governance. Therefore it is evident that restructuring or doing away with health committees is a narrative which means that participation has decreased since devolution and decentralization. For instance:

Since devolution, most committees have been restructured or done away with. We used to have local community representatives in during budgeting for health care services. The local community representatives could summon the entire hospital committee to question how money had been spent. But today we have MCAs who mainly present their political wills. So consultation will still be necessary to make health care policies participatory (Key informant interview, Hospital Matron, March 2016).

Unless we involve the locals in the policies drafting processes, then I tell you we will still have challenges in health care policies and even other policies. Each community has their customs and values thus we cannot say a policy passed by the parliament will work in every culture. I think even the politicians are also keen on policies that will benefit the people but not necessarily that every policy addresses the local needs (Key Informant, Hospital Matron, February 2017).

However, as much as I propose constitutionality as a way of including the locals in the policy-making processes, considerable challenges remain regarding such issues as ensuring inclusiveness and long-term adherence to the crafted policies and this are purely based on the issue of trust. Cautiously, if this trust is eroded, as we see now in this study, it is extremely difficult to get the whole process restarted; thus constitutionality needs also to be studied under situations of eroded trust. However, I believe that the approach is suited to overcome these difficulties if people feel that they are involved in the process and if there is fair play with external neutral actors involved. Of course, neutrality is always a tricky thing, but perhaps in the process, people can agree on who this (external neutral actor) might be. One way to sustain commitment will be therefore to allow different categories of community members such as the people with special needs, the elderly, the young parents and adolescent to devise their own ideas for local rules and regulations before bringing these for discussion in intergroup fora, thus allowing a sense of ownership to emerge for all the interest groups.

After that, it is crucial to bring these different ideas together in a more or less neutral and open setting, a platform involving all participating groups that can be identified by external agents or political movements. According to Haller et al. (2016), such a setting provides a structured context for making the new regulations that have been crafted with the participation of all actors binding for all (locals and outsiders, the disempowered and the more powerful). Of course, such locally owned institutions, are possible where such policies as decentralization of various sorts facilitate official recognition not only of the regulations locally crafted but of the local knowledge that has formed the basis for such crafting. According to Haller et al., preconditions for such processes are “(a) emic perception of need of new institutions, (b) participatory

processes addressing power asymmetries, (c) pre-existing institutions, (d) outside catalysing agents (fair platform), (e) recognition of local knowledge, and (f) higher-level state recognition” (Haller et al. 2016). If these conditions are met, conflicts over management of maternal health can lead to institution building in which all affected actors participate and negotiate the constitutional rules for healthcare management. This does not necessarily lead to an equal integration of all actors or a win-win constellation, but to compromises that take into account power issues, local perceptions of social protection schemes in maternal health and senses of ownership, as well as a local agency with specific notions of equity and fairness.

The process of constitutionality cannot just follow pre-existing rules because it involves new socio-organizational experiences. Therefore, it requires the provision of platforms perceived (emically) by all groups as relatively unbiased and fair and inspiring ‘trust’ where ‘trust’ in state-imposed frameworks has been lacking. Perhaps, it can be checked from an emic perspective what could have been good maternal health rules in this perspective in the past as this will inform the crafting of new rules. However, fulfilling this enabling condition for the emergence of new forms of maternal health care policies might require some interventions by outside actors, whether NGOs, researchers, state agencies, or political leaders, who can articulate the process of constitutionality with the larger political and economic context and facilitate the social inscription of new institutions in by-laws, conventions, codes, and other regulations (Haller et al., 2016). I, however, argue in line with Haller et al. (2016) that these actors can only catalyze local institution building process if their interests do not become dominant and if local actors regard their presence as legitimate, as providing a fair platform in a context of different bargaining power constellations (ibid.). Notably, just as Haller et al. (2016) argues, the role of state actors in the process of constitutionality remains crucial to realize a balance between devolved governance in Kenya and an encompassing state framework that accommodates such institutional decision making and crafting at local levels, in accord with such principles as devolution, legal pluralism, and subsidiarity.

This chapter has therefore focused on the local views regarding their will for participation, and by this to examine how a new “sense of ownership in the institution-building process” is being

created. As constitutionality emphasizes, during the crafting of new policies, the stakeholders do not simply follow the rules of participation which were presented to them in the form of “take it or leave it”, but take different active formulations to negotiate and empower their roles and needs, leading to new constitutional rules for resource governance. However, when the effectiveness of informal institutions is threatened, social actors try to invoke the external-enforcement mechanism of the state to establish institutional constraints that give them a distributional advantage. From the previous chapters, the local people lacked trust in the government on her provision of free maternity health care as they labeled it political and not being free as the government put it and did not feel that relying on government would enable them to utilize maternal health services. Therefore, the county government needs to shift the emphasis of healthcare to the people themselves and their needs, reinforcing and strengthening their capacity to shape their lives.

8.4 Ways Forward

Social protection embedded in the seventeen Sustainable Development Goals (SDGs)⁴⁶ is moving up the development agenda in Africa. However, social protection in health care is specifically closely embedded in SDGs number 1-5, 8,10,12,16 and 17. Social protection is recognized as both an economic and social necessity, capable of promoting inclusive, people-driven and sustainable economic growth, eradicating poverty, reducing inequality and generating

⁴⁶ The SDGs include;- 1. End poverty in all its forms everywhere; 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture; 3. Ensure healthy lives and promote well-being for all at all ages; 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; 5. Achieve gender equality and empower all women and girls; 6. Ensure availability and sustainable management of water and sanitation for all; 7. Ensure access to affordable, reliable, sustainable and modern energy for all; 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all; 9. Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation; 10. Reduce inequality within and among countries; 11. Make cities and human settlements inclusive, safe, resilient and sustainable; 12. Ensure sustainable consumption and production patterns; 13. Take urgent action to combat climate change and its impacts; 14. Conserve and sustainably use the oceans, seas and marine resources for sustainable development; 15. Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss; 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels; 17. Strengthen the means of implementation and revitalize the global partnership for sustainable development.

resilience to future shocks. Moreover, the (SDGs) embody a systems-oriented approach to understanding the connections between human health, poverty, economic development, and the environment.

Every society seeking to improve access to health care has debated, who should be eligible and on what basis whether all residents, citizens, or just working populations. They have contested what services should be guaranteed whether inpatient or outpatient care, high-cost or low-cost treatments. They have also struggled over what share of health-care costs should be financed through public levies, private contributions, or payments at the time of service. Universal health coverage can be achieved in many different ways. There is no single recipe, and advocacy on the issue in the past decade has explicitly recognized this fact. Whether or not a country has achieved universal health coverage, therefore, depends on three related factors: who is covered, for which services are they covered, and with what level of financial contribution?

From this thesis, it is evident that despite championing universal health care, most service beneficiaries in Kenya's healthcare system lost 'trust' in the system. Therefore, to restore 'trust' in Kenya's healthcare system then, the government needs to adopt a conscious process of initiating institution building from below which does not suffer from the drawbacks of top-down imposed processes of democratization, devolution, and participation, which are often subject to processes of elite capture. Haller et al (2016) refer to such process as constitutionality which refers to the institutional design and multi-leveled processes, involving perceptions, attitudes, strategies and other dimensions, based on the principle of real, though differential incorporation of all actors' positions so that most feel a sense of ownership of the process, resulting in a sustainable institutional setting and, finally, an underlying constitutional result. Only by this process can constitutionality be realized which means that all actors feel, however differently, that they are part of the constitutional set-up. If these institutions are negotiated and agreed upon, they are more likely to become embodied as part of the subjectivity of the participants and to be deployed for strategic reasons, leading to more sustainable maternal health policies other than so-called "participatory" processes. However, the role of the government will remain crucial in the process of constitutionality: It is the balance of the principle of subsidiarity that is at stake: where

does the state interfere, where shall it not interfere in the process. Cautiously, the problem is that state administrators are not always interested in such formalization because this might put them out of control of specific resources. I also argue that we must go beyond the local to explore both historical process and the broad range of contemporary context of maternal health care.

Through such bottom-up initiative, the likelihood of a social accountability as a participatory approach might be possible. I use social accountability to refer to a citizen-centered approach to accountability in government services and schemes. It can play important roles in reducing error, fraud and corruption; ensuring that cash is delivered to recipients regularly, reliably and accessibly; improving policy design; and strengthening state-society relations. Social accountability refers to the steps that governments can take to enhance the participation of recipients and broader civil society in accountability initiatives, and the steps that recipients and broader civil society can take to hold governments to account for the delivery of social protection.

Improving access to skilled care during pregnancy, childbirth, and postpartum remains a priority strategy for improving maternal health and is key to achieving one of the many indicators specified in sustainable development goal (SDG) 3, reducing the global maternal mortality ratio. Despite the availability of other social protection schemes, home deliveries through traditional birth attendants (TBAs) are still high in Kilifi County. Due to social and cultural acceptability locally of the TBAs, I recommend that the roles of the TBAs should be modified from ‘unrecognized village TBAs’ to ‘village maternal health workers (VMHWs)’ whose responsibilities would mainly be to promote perinatal care and institution-based delivery of pregnant women. The VMHWs ought to function at the grassroots level of the rural health service delivery system where they can mobilize the pregnant women for institutional delivery, assisting with home visit for basic care and escorting pregnant women to the hospital for childbirth. The local health institutions should be responsible for providing routine supervision and management and economic compensation for VMHWs. However for successful transformation such institution building requires engaging the local people, both the national and

county government and other actors, training TBAs for their new role, and providing incentives and sanctions for human resources management.

Additionally, I would recommend that the national and Kilifi government to re-consider training the community health volunteers (CHVs) because they also play a critical role in saving lives, especially at the community level where people lack access to the formal health system. CHVs are highly appreciated in the community and seen as important contributors to maternal and newborn health at the grassroots level. Despite playing a critical role in saving lives, presently CHVs are neither paid nor maybe remunerated. The county governments who currently have authority for decision making, adapting the policy to their local context, finance, implementation, and management consider allocating a remuneration budget for CHVs. Moreover, the national or the county government can get CHVs paid and formally integrated into our health system.

Additionally, having gender aware programs that identify and addresses the different practical needs and strategic interests of women compared to men can support the design of a gender transformative social protection that tackles strategic gender interests from the very beginning. For instance (Newton, 2016) proposed that social protection can include training initiatives for women that challenge stereotypical ideas of ‘traditional forms’ of work. Therefore, the broadening of social protection agenda towards transformative and distributional goals translates as a shift away from short-term solutions towards long-term approaches that tackle the structural barriers underpinning poverty. This, therefore, acknowledges that an emphasis on equality and rights, in addition to financial protection, is required to lift households out of poverty. Rather than ‘only’ increasing consumption and basic welfare outcomes for the poorest, transformative social protection tackles the dynamics of their marginalization and exclusion underlying the power imbalances (see Newton, 2016).

A particular challenge that many African countries still face today Kenya included is that of ensuring coherence between national policies, strategies, programmes, and activities in the promotion of social protection. Gender inequality may still prevent women from obtaining access to healthcare services. Therefore, efforts to improve maternal health care utilization and outcomes must also find ways to empower women and overcome the effects of gender

inequality. Therefore, attention must be paid to gender roles and relations between women and men, in particular, how they affect intra-household decision making and bargaining, time poverty, and women's reproductive unpaid care work. Attention must be paid to the structures (e.g., norms, values and institutions) underpinning the imbalance of power between men and women must be recognized and taken into account. For social protection to address the strategic interests of men and women as citizens, it is crucial to frame social protection as a socio-economic right. Therefore, promoting institutional linkages between social protection and a broader package of social and health policy objectives to support women's practical gender needs and transformative potential to change gender relations among men, women, boys, and girls more broadly at the household and community levels. Strong linkages are needed, for example, across health and reproductive health services; social development and rights awareness training; credit access and employment training; school allowances and elderly benefits. Moreover, maximizing the potential of the interface between communities and programme implementers to initiate community dialogue on ways to address gender inequalities such as gender-based violence and gendered forms of social stigmatization. At the same time, raising community awareness and capacity of the community can enhance understanding of and demand for gender-related social protection programme provisions.

Therefore, I furthermore recommend that health workers should be motivated to implement the policy of free maternity services in Kenya. The National Ministry of Health should seek the views of health workers on various implementation issues since the implementers are better placed to understand the challenges and offer solutions. This can be done through the various stakeholder forums. In addition, feedback channels can be created to obtain feedback from health workers (implementers) regarding implementation progress and challenges. This will ensure that implementation challenges are minimized and the policy is implemented successfully.

CHAPTER NINE: Conclusions

This chapter discusses the conclusions from the main empirical chapters and theoretical issues addressed in the entire thesis. It shows how the empirical data collected in the study contribute to our understanding of social protection in maternal health. The chapter also shows how the application of constitutionality as a recent anthropological theory can be used to restore ‘trust’ in the health sector in Kenya.

9.1 Summary of the Empirical Chapters

This thesis has described women’s and practitioners’ perceptions of social protection scheme initiatives in maternal healthcare and the contradictions in Coastal Kenya. The central theme that emerged from this study was ‘how free are free maternal health services in Kenya?’ The present thesis has been organized in a way that it systematically describes the emerging themes in the entire study. The study has utilized new institutionalism theory by Douglas North (1990) and Ensminger (1992). This theory helps, understand how the institutions as the formal and informal rules of the game shapes how households get access to maternal healthcare services and how such ‘rules of the game’ were shaped by differences in bargaining power of actors in this case for instance, the pregnant women versus husbands and the wealthy mothers versus the poorest mothers and how relative price shape choices of the institutional setting, which was in favor of them. Favourable institutional setting motivated women to seek healthcare while unfavourable institutional environment forced women to look for alternatives of access to care. Peasant economic theory by Chayanov (1989) explains how production and consumption decisions in the household economy are interrelated, and the minimax strategies adopted by women amidst multiple gender roles to access and cater for maternal health services. Neo-Marxist theories helped in understanding how women are exploited at household level due to multiple roles which exert pressure on them hence vulnerable. These theories helped in exploring how gender relations at the household level give the poor women economic advantages and disadvantages and power to get access to the not so free maternal healthcare. Lastly, constitutionality by Haller, Acciaioli, and Rist (2016) helps in proposing how a more participatory approach can be achieved through a new institutional arrangement by incorporating local (poor mothers and health

providers) needs and decisions and how the government can recognize such local perspectives in line with existing laws, regulations and other policies that accommodate local actions.

A central discussion in chapter two is the responses from the poor mothers and the health workers. It was evident that their responses merged on the central recurring theme in this thesis that free maternity was free in theory but not free in practice. Non-medical expenses such as transportation cost for pregnant mothers and persons accompanying them, laboratory tests, antenatal profile, and medicine were for example not covered by free maternity services package. Therefore, mothers had to meet these expenses before getting the services, which meant: without payment no “free service” or in other words: “No payment - no access.” The health workers who were the primary implementers of free maternity policy also felt that free maternity was expensive for the health facility. This was due to inadequate staffing, inadequate equipment, delays in reimbursement of funds from the county and national government, inadequate infrastructure, and supplies. This led to incredible frustrations among the health workers. Even the policymakers in the County also noted that fee exemption policies that appear comprehensive on paper led to catastrophic out-of-pocket health expenditures by the poor households. The central discussion is supported by Ferguson (1994) anti-politics machine arguments on government policies.

Chapter three shows changes in approaches to financing maternal health care since the implementation of free maternity health care in Kenya. For instance, in October 2016 the National Government unveiled an expanded Free Maternity Care Programme at the cost of Sh5.4 billion. The expanded programme dubbed "*Linda Mama, Boresha Jamii*" extends its services beyond normal delivery to include ante-natal care, delivery through caesarean section and post-natal care free of charge. The programme is meant to reduce maternal morbidity and mortality rates in the country. However, the maternal vouchers (OBA) are no longer in supply (see chapter three). From the perspectives of the local people, despite changes in policy approaches in maternal health care, the services are still not accessible to economically disadvantaged households. Among other factors, inaccessibility to OBA made some poor mothers deliver at home this was after realizing that free maternity was too expensive for them than delivering at home. However, the rich could easily get OBA and also utilize free maternity services because

they crafted the so-called 'rule of the game' which guaranteed them higher bargaining power than the poor mothers hence easily access the services in either public or private health facilities. Furthermore, the increase in the value of healthcare services that one gets for free attracted the more powerful actors to secure the service by using their informal networks and kinship rules as an institutional setting to gain access to a service, which was restricted. Thus, they used rules (institutional shopping) within their networks on reciprocity and mutual help to justify their demands and get access, and such are some of the basic arguments of new institutionalism theory.

Chapter three also shows that women without strong social networks to increase their bargaining power were not able to get access to the facilities, and this was the major problem of the OBA. When OBA discontinued offering services, the poorest still strongly preferred the free maternity services scheme, or, if there were hidden costs, they resorted to giving birth at home by the assistance of mother-in-law, an elderly woman or TBAs. Moreover, OBA money was not mainly directed to the public health services but rather to the private clinics, which could capitalize on the services paid while the public sectors only had little money and did not get it in time. Free maternity started operations in 2013 in all public health facilities in Kenya. As a result, the public health facilities were swamped and entirely overloaded, creating resistance by the health workers hence weapons of the weak in the administration.

Chapter four shows how free maternity has been used as anti-political machinery by the national government. For instance, perspectives of the local people and the health workers were that the President used the norm of the free distribution of things not out for betterment but mainly for the reason to buy votes, without paying attention to the sustainability of these programs regarding how they will be financed in the future. However, in this view, this does not seem to be the case as the strategy was to become voted and promising distribution in this domain seemed to have delivered success. Therefore, the discourse prevails that despite free maternity services being a good social protection program, public health facilities were still overwhelmed with a large number of mothers who delivered, and there was no enough space to accommodate them. The narrative of the political instigation of the free maternity policy emerged across all the health facilities. The health workers felt that while the free maternity policy had increased access

to supervised skilled deliveries and had benefited the poor, they, however, noted that it was used as a political resource to gain votes and not long-term oriented.

Still in chapter four, the narrative prevailing from the actors in the health service and the local women was that free maternity was “the president’s thing” with a clear political orientation, which really acted as an Anti-Politics Machine in a double sense: first it shrouded the political interests, second it added to the burden of women because one could not just deliver without paying for all the other services and medication before and after birth . For women, the ideology that free does not mean free, the narrative that it was a political project and the discourse that it involved burden rather than help was also evident in this study.

On realizing that free was not free and in the absence of OBA, the households, therefore, used various strategies to cater for the cost of maternal health care in Kilifi County. Using peasant economic theoretical lens, chapter five gives a thick description of the alternatives households use to finance maternal health care. The peasant economic theory has shown how women balanced the household needs and the drudgery of work to meet the daily basic needs. Hence, for this study, the theoretical ranking of husbands was important to find out whether such ‘exploitations of women’ occur at the household level or not. Through such ranking, four categories of husbands were identified. They included; Husband present and helping; Husband present and not helping but causing costs; Husband who was away and helping, and Husband who was away and not helping. It emerged that women with a present and not helping a husband and absent and not helping husband categories were more exploited. There were production and reproduction roles leading to increasing own labour exploitation and selling women’s production with too much economic pressure on a woman at present and not helping the husband. Formal and the informal social networks such as the kinship, the church, and neighbours also acted as alternatives for financing maternal health care. However, such social capital had rules of the games for creating and activating them, and such social capital was not free since there were expectations by the social networks. Women who could not afford facility delivery also resorted to giving birth at home under the supervision of the traditional birth attendants due to flexible modalities of payments.

Chapter six of this thesis describes how gender roles and the institution of allocation of household resources impacted on the utilization of maternal health care. It also presents how poor households choose the most advantageous services or good or institutional frameworks based on their knowledge and power to get maternal health services. In this chapter, gender inequality and exploitations were evident at the household level. Indeed, it emerged that households were not homogeneous units but were sites of ‘bargaining’, where women and men had a varying degree of abilities to decide and control how the resources were pooled back into the household. The chapter summarizes that attention should be paid on gender roles and relations between women and men, in particular, how they affect intra-household decision making and bargaining power, time poverty and women’s reproductive unpaid care work and how these affect the utilization of maternal health care services.

Chapter seven has described the socio-cultural conceptualization of giving birth in the Giriama community. It emerged that there exist various cultural practices and beliefs playing an important role in pregnancy. Moreover, cultural practices are also linked to the likelihood that women will use formal services or not. The chapter, therefore, shows that there is a need to acknowledge that when healthcare services are culturally competent, women and their families are likely to express higher levels of satisfaction and have higher rates of utilization. Thus, policymakers and health workers must find ways to encourage women from groups with traditionally low rates of maternal healthcare utilization to access these services. By recognizing and appreciating prevailing local beliefs, maternal healthcare providers can be better positioned to provide culturally competent care to women and their families, thereby improving maternal and infant health outcomes when possible.

Chapter eight presents the overall outlook of the local perceptions on how to make maternal healthcare more participatory as a way to make social protection scheme achieve its objectives. The chapter shows how Kenya and other countries introduced community health workers in response to the Alma Ata declaration of 1978 on community participation as one of the key components of Primary Health. It also acknowledges that involvement of community members in healthcare is not new and that community members’ participation in the provision of care to family and community in their cultural settings existed since time immemorial. However, for a

long time, Kenya has adopted a top-bottom approach in health policy making and implementation. In this chapter, I introduce constitutionality, a recent anthropological theory advocating for bottom-up processes and communicative-strategic action, will incorporate local actors' agency into the processes of negotiating and constituting maternal health policies. The chapter shows that to restore 'trust' in Kenya's healthcare system then, the government needs to adopt a conscious process of initiating institution building from below which does not suffer from the drawbacks of top-down imposed processes of democratization, devolution, and participation, which are often subject to processes of 'elite capture.' However, despite the bottom-up institution building process, the role of state actors remains crucial to realize a balance between devolved governance in Kenya and an encompassing state framework that accommodates such institutional decision making and crafting at local levels, in accord with such principles as devolution, legal pluralism, and subsidiarity.

Overall, this work can be seen as a proposition for broader social protection programs in maternal health. This work should be seen as a proposal for a much broader perspective on social protection through maternal health care; it takes into account people's views on how social protection programs are essential and how such plans can be made beneficial to the targeted populations. Moreover, the findings are relevant to current health systems debates locally and globally particularly regarding the design and implementation of free maternity care and user fee removal policies. Indeed, studies that focus on people's perceptions are necessary for realizing how larger scale institutional changes crosscut and are appropriate in local and moral worlds. It is, therefore, my hope that the perspective I have put in this work on local perceptions of social protection schemes in maternal health will be helpful for those working to understand and support efforts to improve social protection and maternal health in Kenya. It is through understanding the centrality of a gender lens to social protection and engaging ourselves in understanding what matters to others in their local moral worlds, what resources and competencies these require, then we can appreciate what we have in common and respect the diversity in our various quests for a good life. More specifically, despite proposing a bottom-up participatory institution-building process in health care, based on evidence from previous studies on this approach, the key to success of such new institutions that have constitutionality is that local diverse groups can develop a shared notion or a problem and can develop an

accommodating institutional design. Because the groups are heterogeneous, the health care design must start from the respective groups themselves so that their respective interests on health care can be articulated separately without the involvement of other often more powerful groups. This will, therefore, mean that all actors feel that they are part of the constitutional set-up.

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Figure 2. 4 Key political pledges of the ruling government in 2017 campaigns



**UHURUTO
2017**

We will expand free maternity care to include government funded NHIF cover for every expectant mother for one year.

Figure 1. 4 Coconut Palm Trees and Other Crops

