MINISTRY OF HEALTH

STATUS OF IMPLEMENTATION OF FREE MATERNITY SERVICES (FMS) PROGRAM IN THE DEVOLVED HEALTH SYSTEM IN KENYA

A COMPREHENSIVE ASSESSMENT REPORT

January, 2015

FOREWORD

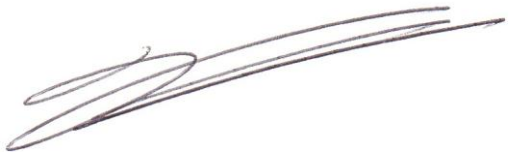
Maternal and Child Health has remained a high priority for the Government of Kenya and in particular the Ministry of Health (MoH). Over the years, the Government has come up with various programmes to address the various aspects facing the health sector in general as well as reproductive health. One key Government intervention was the introduction of the Free Maternity Services by H.E The President of the Republic of Kenya in his declaration of the free maternity services on 1st June 2013. The overall objective of this programme was to increase access to skilled delivery services and hence the reduction of the maternal and infant mortality.

After over one year of implementation of the program, my Ministry commissioned a study to monitor the implementation of the Free Maternity Services program in order to document areas that require policy and operational re-orientation both at National and County levels for maximum benefits of the programme. The key focus areas for the assessment included; establishing the trends of deliveries at facility level, assessment of the status of maternal health and wellbeing, assessment of availability of services, equity, quality of care and sustainability on health service provision. This study placed emphasis on the holistic and comprehensive monitoring system that adequately takes cognizance of the complexity of Universal Health Care and the need to involve all the stakeholders in the monitoring process especially through gathering their views on the program at all levels.

The study found out that Free Martenity Services Programme was a timely, noble idea with a nation wide acceptance by all health sector players including the beneficiaries of this service. Over the past one year of implentation the Ministry has recorded key milestones that included increased number of deliveries, increased uptake of antenatal care services with more mothers attending the required antenatal visits and increased favourable pregnancy outcomes.

Despite these achievements there is need for concerted efforts in addressing challenges such as inadequate amenities, inadequate equipment, inadequate human resource for health among other challenges in order to realise even more benefits of the free maternity services program.

It is my sincere hope that implementaion of the assessment recommendations will rejuvenise the programme objectives and thereby lead to improved health status of women and children in this country.



Mr. James W. Macharia
Cabinet Secretary,
Ministry of Health.

ACKNOWLEDGEMENTS

This report on the Monitoring of the Implementation of the Free Maternity Service (FMS) programme in the devolved health systems was undertaken and prepared by a team of dedicated personnel both from the Ministry of Health, WHO and the Consultants. My sincere acknowledgement goes to WHO-Kenya office for the continued support and its valuable guidance, technical and financial support that it has provided for this study. My acknowledgement goes to Dr. Jane Ong'ang'o the principal lead Consultant and Mr. Alex Mwaniki assistant consultant for their resourcefulness that ensured all processes of the study were conducted well, providing a valuable assessment of the programme.

I wish to express my appreciation to each and every one who contributed through various forms in the success of this report. My acknowledgements go to Dr. Custodia Mandlhate, the WHO/Kenya representative, together with Dr. Humphrey Cyprian Karamagi and Hillary Kipruto the WHO team for their technical inputs into the process. The Ministry of Health technical teams led by the Director of Medical Services Dr. Nicholas Muraguri, together with the Dr. Jackson Kioko, Dr. Bartilol Kigen, Dr. Isabella Maina, Dr Charles Kandie, Ms Rose Kuria and Ms Tecla Kogo for oversight and guidance into the evaluation process.

The study information and data was gathered through the support and commitment from a large team of sampled County Senior Staff, Facility Administrative teams, field supervisors, enumerators, key informants (national and at the county levels), the communities and data entry clerks. This survey could not have been undertaken without the willingness, enthusiasm and commitment of the participants to respond to the questionnaire. Gratitude is extended to all, especially those healthcare personnel, who despite their busy schedules accorded our team adequate time.

Dr. Khadijah Kassachoon,
Principal Secretary,
Ministry of Health.

PREFACE

The report on the Monitoring of the Free Maternity Services Programme has presented crucial insights for improving maternal and neonatal health outcomes. The various recommendations have given the health sector and its players a new focus to improve this worthwhile programme. There is need to adopt regular assessments and monitoring and evaluation not only of this initiative but for other similar programs in the Ministry to avert unnecessary and unforeseen challenges.

The report is structured into four chapters namely; introduction, methodology, report findings and discussions, and conclusion and recommendation.

Chapter One [1]; presents the background information highlighting the maternal and neonatal health statistics and the national bench-marking goals. It also enumerates the various Government and Ministry efforts to address the maternal and Neonatal health challenges and constraints. The rationale, goal and the report objectives have been justified within this chapter.

In Chapter Two [2]; the report gives an account of the detailed methodological approach adopted. These included the sampling frame, sampling procedures, justification of the sample size, data collection tools and the processes, data management, analysis and report writing. It also describes the study limitations and how this can be mitigated in future work.

Chapter Three [3]; presents the report findings in line with the objectives. It compares the maternal and Neonatal health trends before and during the programme implementation. A detailed analysis of the facility readiness was undertaken by facility levels and by County. The chapter further describes the client perception of the program as reported by those who had benefited from the service.

Chapter Four [4]; summaries the main conclusions in line with the report objectives and it lists a number of recommendations to be considered for a successful implementation of the programme.

Dr. Nicholas Muraguri,
Director of Medical Services
Ministry of Health

ACRONYMS

AIE	Authority to Incur Expenditure
AMTS	Active management of the third stage of labour
ANC	Antenatal Care
APH	Ante partum Haemorrhage
ARH	Adolescent Reproductive Health
ARVS	Antiretroviral therapy
BP	Blood Pressure
BTL	Bilateral Tubal Ligation
CECs	County Chief Executive officer
CS	Caesarean Section
DHIS	Division of Health Information System
DMS	Director of Medical Services,
EMONC	Emergency-Obstetric-and-Newborn-Care
FDGs	Focused Discussion Groups
FMS	Free Maternity Services
FP	Family Planning
Hb	Haemoglobin
HCW	Health Community Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Preventive Treatment
IUCD	Intra Uterine Contraceptive Device
KEMSA	Kenya Medical Supply Association
KHSSP	Kenya Health Sector Strategic Plan
LLITNs	Long Lasting Insecticide-Treated Nets
MDGs	Millennium Development Goals
$MgSO_4$	Magnesium Sulphate
MOH	Ministry of Health
MS	Microsoft
NHIF	National Hospital Insurance Fund
OBA	output based approaches
PAC	Post-Abortion Care
PMTCT	preventing-mother-child-transmission
PNC	Post-Natal Care
PPH	Post-Partum Haemorrhage
PS	Principal Secretary
SD	Standard Deviation
SPSS	Statistical Package for Social Scientists
UHC	Universal Health Coverage
WHO	World Health Organization

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CHAPTER 1: INTRODUCTION

1.0 Introduction and Background

Maternal and child health has remained a high priority for the Government at large and for the Ministry of Health (MoH) in particular. A significant determinant of maternal health is attendance of Antenatal Care (ANC) and skilled birth attendance. Births assisted by skilled providers have averaged at 44 percent in the past few years according to Ministry of Health reports. The benefits of utilizing the community trained birth attendants cannot be gain said. The increase in the use of skilled birth attendants has the potential to significantly reduce maternal and infant deaths which are key Millennium Development Goal (MDGs) deliverables.

H.E The President of the Republic of Kenya declared maternity services free in all public health facilities on 1st June 2013 with the overall objective of increasing access to skilled delivery services thus reducing maternal and infant mortality which in effect will help Kenya in moving towards achieving the Millennium Development Goal (MDG) 4 & 5. Moreover, social health protection through Universal Health Coverage (UHC) is one of the flagship projects as per the Kenya Health Sector Strategic Plan (KHSSP) 2014-2018 and Free Maternity Services (FMS) is a major stride on the road to UHC.

1.1 Maternal Health in Kenya

Kenya has long suffered from high maternal morbidity and mortality rates. The most recent estimates set the maternal mortality rate at 488 deaths per 100,000 live births (KDHS 20009), well above the MDG target of 147 per 100,000 by 2015. For every woman who dies at childbirth in Kenya, it is estimated that another 20-30 women suffer serious injury or disability due to complications arising during pregnancy or delivery. These high rates have persisted despite improvements in other health indicators over the past decades. The problem is driven, at least in part, by lack of access to quality maternal health services, including ante-natal, delivery, and post-natal services. Although health sector infrastructure has grown over the past decade, many women still live at a considerable distance from health facilities, cannot afford to pay fees for maternal services, and/or face other barriers to accessing quality care. Access to skilled delivery has therefore been a particular challenge. Overall, only 44% of births in Kenya are delivered under the supervision of a skilled birth attendant, well below the target of 90% of deliveries by 2015. Traditional birth attendants continue to assist with 28% of births, relatives and friends with 21%, and in 7% of births, mothers receive no assistance at all.

1.2 The Rationale

There has been an observed increase in the total and proportional number of deliveries since the inception of the free maternity services program. In addition to total number of deliveries and monies disbursed, it is crucial to assess the impact free maternity services program on maternal health and wellbeing as well as accessibility of services, availability of services, equity; quality of care and sustainability on health service provision. In this regard, there is need to set up a clear, holistic and comprehensive monitoring system that adequately takes cognizance of the complexity of UHC.

The efficiency and effectiveness of the programme at all levels depends on among other things, the involvement of stakeholders in health. The stakeholders include clients/ end users of the product i.e mothers, the service providers (facility based health care workers), the health management teams; the governance teams, the national government and the community at large. Hence the need to involve all the stakeholders in the monitoring process especially through gathering their views on the program.

1.3 Goal

To assess the implementation of Free Maternity Services program and its effects on the health services delivery.

Specifically the study aimed to:-

1. To monitor the overall effects of the policy change on the health sector.
2. To establish the changes in the maternity services utilization patterns.
3. To assess the change in the quality of care being received in facilities.
4. Provide inputs for the development of the FMS policy.
5. To provide recommendations for effective and efficient implementation of the FMS programme.

CHAPTER TWO: METHODOLOGY

2.1 Study Design and Scope

The study used a mixed research method to collect information from the key informants. This included qualitative and quantitative research methods. The information was collected at both levels of the Government decision making organs; The National level and the County Governments. At the National level the team sought qualitative interviews with 9 departments within the MOH and a representative of a health development partner. At the County, the key informants included County Chief Executive officer (CECs) for Health, County Health Directors and Maternity-in-charges. Questionnaires were administered to Clients (mothers) to understand their perceptions of FMS and focus group discussions (FGDs) were conducted for community members.

2.2 Data collection

The Research assistants and data clerks received a one day intensive training to understand the purpose of the survey and to familiarize with the data collection tools that they used to collect the data. A total of 10 teams were used to collect data in the sampled regions. The entire data collection took two weeks in the month of September 2014. To ensure quality control, each team had a team leader who supervised the collection of the data and ensured all the information required was gathered and documented accurately with regional backstopping provided by the Ministry of Health National level team. The data was collected using structured questionnaires, guided personal interviews and focused group discussion (FGDs) guidelines.

2.3 Sampling Procedures and Sample Size

The study used stratified random sampling in the selection of the facilities to be interviewed, the selection of the key informants and the selection of patients. To supplement the quantitative aspects 9 Focus Group Discussions (FGDs) were held in Coast, Eastern, Central, Rift Valley and in Nyanza regions. A total of 24 Counties were selected with weights as the number of facilities *(Annex 1)*.

Out of the 24 Counties 360 health facilities were sampled for the assessment of facility readiness for offering the FMS. For the same facilities a tool for assessing the quantitative indicators for monitoring the FMS was administered. A total of 603 mothers who had received FMS were sampled to be interviewed on their perception of the FMS program *(Annex 2)*.

2.4 Data Analysis

Upon the completion of the data collection exercise, a team was constituted to undertake data cleaning that included coding of the open ended statements. Two days data entry training was undertaken for the data clerks. The data was double entered into MS Access database and later exported to Statistical Package for Social Scientist (SPSS) version 22.0 and STATA version 12 for analysis. The study used descriptive analysis to answer the study objectives.

The qualitative data from the FGDs and key informant interviews was recorded on audio recorders and this was typed into scripts. There was familiarization with these scripts so as to get details of the information before breaking it into parts. During this process the major themes emerged. The themes were in the form of short phrases, ideas, or concepts arising from the texts. Quotes from the original context were arranged appropriately under the developed themes. This formed categorized data from which interpretations were made using various expressions such as; guided words, context, internal consistency, frequency and extensiveness of comments, specificity of comments, intensity of comments and big ideas.

2.5 Limitations

The study experienced the following setbacks:

- absolute non-response from the sampled facilities for trend indicator patterns (Some facilities did not respond to the data collection sheet on the trends analysis tool that resulted to the use of the Health Management Information System (HMIS) datasets from DHIS-2).
- Some indicators data sets are not available from DHIS-2. The DHIS data which was used to make analysis of these trends could not provide more profile on the various ANC visits (1st, 2nd, 3rd and 4th). This could have informed on attendance by number of visit. The data did not also have indicators to define the causes of maternal death, neonatal death and the proportions of live still births and macerated still births. If these specifics were clearly indicated, the quality of care would also be defined from this data. Causes of PPH also needed to be identified in this data so that targeted strategies would be designed to prevent PPH, the most common maternal complication
- The assessment was not able to compare some service situations with the previous pre-FMS years. For example the presence and functionality of referral systems in the facilities for previous years compared to the FMS year.

CHAPTER THREE: STUDY FINDINGS AND DISCUSSION

3.0 Introduction

This section provides the analysis of the three parts of the study that include:

3.1 The maternal services which entailed trend analysis of antenatal care attendance, PMTCT maternity services, types of delivery, maternal complications and family planning services.

3.2 Service availability for free maternity services. This entailed review of all the services that are available within the free maternity services framework.

3.3 Facility readiness to provide the free maternity services. This entailed review of level of facility readiness of to provide facility readiness across the different services which are available in the facilities.

Data that is regularly received in DHIS (MOH) on maternal services was used to analysis the trends over 3 Financial Years (FY) (2011/12 – 2013/14). Using an evaluation questionnaire, 283 health facilities (across different levels) were assessed for readiness of FMS. A total of 386 mothers who had benefitted from the FMS services were interviewed to establish their perceptions and their opinion on the quality of FMS service received.

3.1 Maternal Services Trend Analysis

3.1.1 ANC Attendance

There was increased utilization of ANC service in the year of initiating FMS especially among ANC re-visits (13%). Pregnant mothers attending 4th ANC visits recorded 11% increase. Other services related to ANC that recorded increased utilization included; ANC clients HIV testing (6%) and ANC partner HIV testing (33%).

Table 1: Trends in ANC attendance by year

ANC Event	2013/14	2012/13	2011/12	Average Change % (From yr 2012/13 to 2013/14)	Average Change % (From yr 2011/12 to 2012/13)
New ANC clients	1,234,997	1,169,586	1,144,314	5.59	7.92
Re-Visit ANC Clients	2,212,930	1,956,974	1,936,589	13.08	14.27
Clients with Hb <7g/dl	23,596	23,819	31,351	(0.94)	(24.74)

ANC Event	2013/14	2012/13	2011/12	Average Change % (From yr 2012/13 to 2013/14)	Average Change % (From yr 2011/12 to 2012/13)
Clients given IPT 1st Dose	354,821	358,843	390,382	(1.12)	(9.11)
Clients given IPT 2nd Dose	325,237	324,019	349,903	0.38	(7.05)
Pregnant women attending four ANC visits	558,526	502,673	495,466	11.11	12.73
LLITNs distributed to ANC clients	749,952	691,140	657,751	8.51	14.02
ANC clients counselled	1,284,723	1,213,404	1,221,996	5.88	5.13
ANC clients Tested HIV	1,180,372	1,114,052	1,120,321	5.95	5.36
ANC clients HIV^{+ve}	38,789	42,594	52,081	(8.93)	(25.52)
ANC clients tested for syphilis	846,295	817,012	773,024	3.58	9.48
ANC clients Syphilis +ve	10,723	10,827	10,796	(0.96)	(0.68)
ANC clients issued with preventive ARVs	41,766	42,841	46,200	(2.51)	(9.60)
Infants tested for HIV at 6 weeks	25,930	25,074	28,107	3.41	(7.75)
Infants tested for HIV after 3 months	13,705	15,383	17,877	(10.91)	(23.34)
Mothers HIV^{+ve} referred for follow up	23,553	24,984	31,965	(5.73)	(26.32)
Partners HIV^{+ve} referred for follow up	3,553	3,431	6,461	3.56	(45.01)
Infants issued with preventive ARVS	37,773	40,423	45,488	(6.56)	(16.96)
Mother counselled on infant feeding options	299,756	307,328	336,200	(2.46)	(10.84)
ANC Partners Counselled	71,103	53,388	57,880	33.18	22.85
ANC Partners Tested	64,775	48,713	51,584	32.97	25.57
ANC Partners HIV^{+ve}	2,803	2,792	4,075	0.39	(31.21)

Source: DHIS

3.1.2 Maternity PMTCT

Mothers in the maternity counselled and tested for HIV increased by 12% and 11% respectively. Deliveries of HIV positive mothers increased by 10%, while infants initiated on cotrimoxazole increased by 5%.

Table 2: Trends in PMTCT services offered by year

PMTCT Service	2013/14	2012/13	2011/12	Average Change % (From 2012/13 to 2013/14)	Average Change % (From 2011/12 to 2012/13)
Maternity Women Counselled	265,232	236,245	231,419	12.3	14.6
Maternity Women Tested for HIV	231,977	209,023	203,926	11.0	13.8
Maternity Women found HIV+ve	6,461	9,507	12,415	(32.0)	(48.0)
Maternity Women issued with preventive ARVs	10,250	13,261	16,554	(22.7)	(38.1)
Maternity Infants administered with preventive ARVs	16,711	18,903	21,928	(11.6)	(23.8)
Deliveries from HIV+ve Women	27,658	25,168	26,166	9.9	5.7
Maternity Women Initiated with Cotrimoxazole	7,199	8,484	10,984	(15.1)	(34.5)

Infants initiated with Cotrimoxazole	4,551	4,351	5,590	4.6	(18.6)

Source: DHIS

3.1.3 Type of delivery

There was an increase in the normal deliveries and in the caesarean section deliveries at 22% and 17% respectively with live births increasing by 21% in the year FMS was introduced compared to the previous year. Neonatal deaths and maternal deaths registered increases of 27% and 10% respectively. These increments are based on absolute numbers that utilized the services. The proportion of normal deliveries between the first year of implementing FMS and the previous year remained the same (85%) and similarly the proportions of caesarean section in these years more or less remained the same at 12.3% (2013/14) and 12.7% (2012/13). Institutional maternal mortality rate changed over the years from 215/100,000 live births (2011/12) to 124/100,000 live births (2013/14).

Table 3: Trends in type of delivery, by year

Maternal Event	2013/14	2012/13	2011/12	Average Change % (From 2012/13 to 2013/14)	Average Change % (From 2011/12 to 2012/13)
Normal Deliveries	724,154	594,673	273,698	21.8	164.6
% of ND among total deliveries	85%	85%	83.3%	-	-
Caesarean Sections	104,564	89,154	41,505	17.3	151.9
% of CS among total deliveries	12.3%	12.7%	12.6%	-	-
Breech Delivery	8,618	7,794	4,354	10.6	97.9
Assisted vaginal delivery	9,768	9,865	9,116	(1.0)	7.2
Live birth	812,486	671,524	308,073	21.0	163.7
Still birth	34,013	30,587	24,010	11.2	41.7
Underweight babies <2500gms	41,012	33,867	18,221	21.1	125.1
Pre-term babies	23,625	18,389	11,092	28.5	113.0
% of preterm babies among live births	*2.8%*	*2.62%*	*3.34%*		
Babies discharge Alive	769,876	633,882	283,029	21.5	172.0
Maternity Referrals	52,908	43,723	28,120	21.0	88.2
Neonatal deaths	9,969	7,866	4,553	26.7	119.0
Maternal Deaths	1,006	913	663	10.2	51.7
Institutional Maternal Mortality Rate/100,000 Live Births	124	136	215		

Source: DHIS

3.1.4 Maternal Complications

Over the years the most common complication among the deliveries was obstructed labour. There was a decline in its incidence between the years 2011/12 to 2012/13 from 3.2% to 1.6% and this decline continued into the year 2013/14 though at a slower rate to 1.3%. Among the complications reported there was a notable decline between 2011/12 and 2012/13 and thereafter there seemed to be no difference between the year of first implementing FMS and the previous year.

Table 4: Trends in Maternal complications, by year

Complications	2013/14	2012/13	2011/12
Total number deliveries	**847,104**	**701,486**	**328,673**
APH (Ante partum Haemorrhage)	5,646	5,353	5,908
% of APH among total deliveries	*0.7%*	*0.7%*	*1.8%*
PPH (Post-Partum Haemorrhage)	8,875	7,798	7,438
% of PPH among total deliveries	*1%*	*1%*	*2.3%*
Eclampsia	4,316	4,168	4,069
Ruptured Uterus	837	826	863
Obstructed Labour	10,740	10,961	10,599
% of Obstructed labour among total deliveries	*1.3%*	*1.56%*	*3.2%*
Sepsis	1,700	1,529	1,636
Total	*32,114*	*30,635*	*30,513*
% of all complications among total deliveries	*3.8%*	*4.36%*	*9.3%*

Source: DHIS-2

3.1.5 Family Planning (FP)

There was a minimal (1.5%) increase of clients enrolling for use of the various FP methods over the 3 years. Between 2012/13 and 2013/14, there was a 9% increase of clients enrolling for FP use. Implants insertion method recorded the highest increase of 53% over the 3 years.

Table 5: Trends in use of family planning methods, by year

Year	2013/14	2012/13	2011/12	Average Change % (From 2012/13 to 2013/14)	Average Change % (From 2011/12 to 2012/13)
Type of FP Methods					
Pills Microlut	73181	95,931	114,468	(23.71)	(36)
Pills Microgynon	178145	181,119	182,778	(1.64)	(2.53)
FP Injections	679331	587,860	619,065	15.56	9.74

IUCD insertion	72697	56,977	59,904	27.59	21.36
Implants insertion	258267	211,272	168,877	22.24	52.93
Sterilization BTL	6943	9,588	18,994	(27.59)	(63.45)
Sterilization Vasectomy	614	724	2,948	(15.19)	(79.17)
Client receiving condoms	684304	648,503	748,321	5.52	(8.55)
Natural Family Planning	10281	10,953	12,321	(6.14)	(16.56)
All others FP	42628	37,028	49,548	15	(13.97)
Total	**2,006,391**	**1,839,955**	**1,977,224**	**9.05**	**1.48**

Source: DHIS-2

3.2 Service Availability for Free Maternal Services

The survey received responses from a total of 283 facilities from the 24 Counties sampled randomly, of these 3 (1.1%) facilities were private and the rest were public from levels 6 - 2. Level 6 were 2(0.7%), level 5 were 12 (4.2%), level 4 were 68 (24%), level 3 were 142 (50.2%) and level 2 were 56 (19.8). Findings from 16 key informants are also included in this analysis and discussion.

Table 6: Services Provided by County Facilities

County	Child Health	ANC	Maternity	Clinical Lab	Operative	Other Services
Bomet	88.9	88.9	55.6	88.9	22.2	0.0
Embu	100.0	100.0	100.0	100.0	44.4	0.0
Garissa	100.0	100.0	100.0	93.8	18.8	12.5
Isiolo	87.5	87.5	100.0	75.0	37.5	0.0
Kajiado	100.0	100.0	91.7	91.7	16.7	100.0
Kakamega	100.0	100.0	100.0	95.8	20.8	91.7
Kiambu*	100.0	100.0	100.0	100.0	100.0	0.0
Kilifi	93.3	93.3	93.3	80.0	13.3	26.7
Kirinyaga	100.0	100.0	100.0	100.0	9.1	9.1
Kisii	100.0	100.0	100.0	94.1	35.3	17.6
Kisumu	94.1	94.1	94.1	82.4	35.3	41.2
Machakos	95.0	95.0	95.0	95.0	15.0	25.0
Meru*	100.0	100.0	100.0	100.0	100.0	0.0
Mombasa	92.3	92.3	84.6	53.8	38.5	23.1
Murang'a	100.0	100.0	100.0	100.0	20.0	0.0
Nairobi	95.7	100.0	100.0	95.7	39.1	78.3
Nakuru	100.0	100.0	70.0	100.0	20.0	0.0
Nandi**	100.0	100.0	100.0	100.0	100.0	100.0
Narok	100.0	100.0	100.0	66.7	11.1	0.0
Nyeri	100.0	100.0	100.0	100.0	20.0	10.0
Trans Nzoia	100.0	100.0	100.0	100.0	11.1	0.0
Uasin Gishu	100.0	100.0	100.0	90.0	10.0	0.0
Vihiga	100.0	100.0	100.0	90.0	10.0	80.0
West Pokot	100.0	100.0	100.0	55.6	11.1	11.1
National Service Provision	**97.8**	**98.0**	**95.2**	**89.5**	**31.6**	**26.1**

** = Sampling was for only level 5 health facility in the county, **=only level 4 health facilities were visited*

A majority of the facilities visited in the counties provided child health, ANC, Maternity and clinical laboratory services in the following proportions respectively 97.8%, 98%, 95.2% and 89.5%. About 31.6% of the facilities offered operative services, as expected most of the operative services were at the higher facility levels of 4, 5 and 6. Generally maternity services were available at all levels except in some level 2 and 3 facilities.

Table 7: Services Provided by Level Facility

Facility Level	Child Health	ANC	Maternity	Clinical Lab	Operative	Other Services
VI	100.0	100.0	100.0	100.0	100.0	0.0
V	100.0	100.0	100.0	100.0	93.3	20.0
IV	100.0	100.0	100.0	100.0	47.1	29.4
III	97.9	98.6	96.5	94.4	9.2	35.9
II	92.9	92.9	85.7	60.7	14.3	25.0

Source: Field work

All facilities visited that had maternities offered basic obstetric care and of these 24% offered comprehensive obstetric care. All level 5 and 6 facilities offered comprehensive obstetric care, while basic obstetric care was mainly offered at the lower levels.

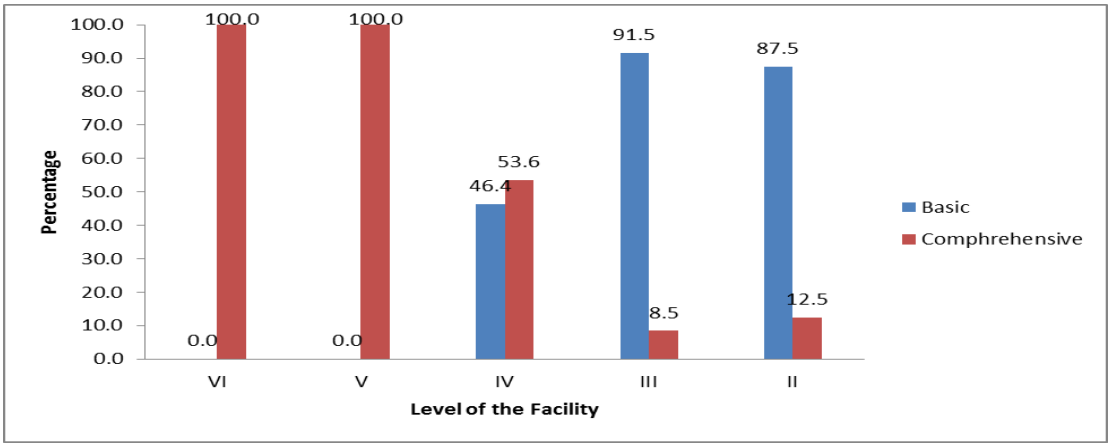


Figure 1: Essential Obstetric Care provided by the facilities; *Source: Fieldwork*

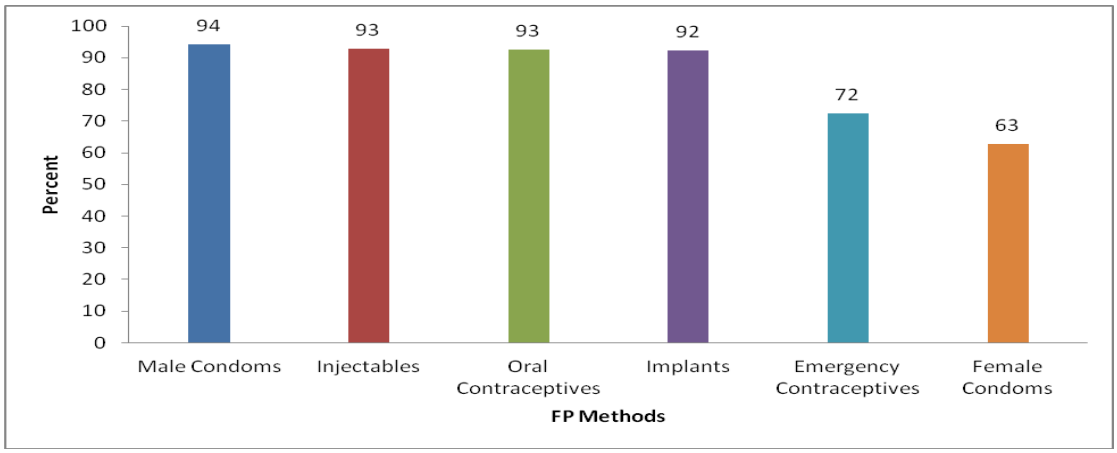


Figure 2: Family planning methods offered; ***Source: Fieldwork Field work***

The various family planning methods were available in most facilities

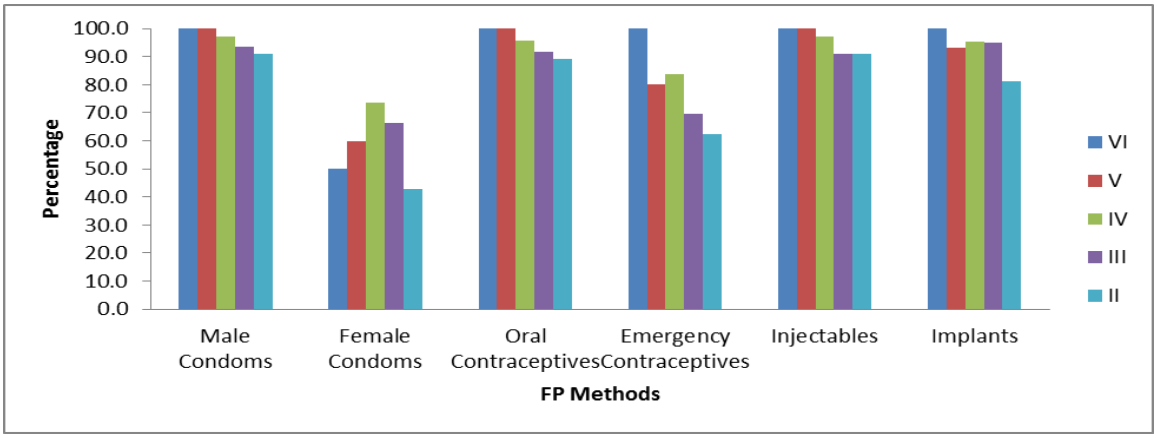


Figure 3: Family planning methods offered by facility level; *Source: Field work*

Table 8: Reproductive Health Services Provided by the Facilities

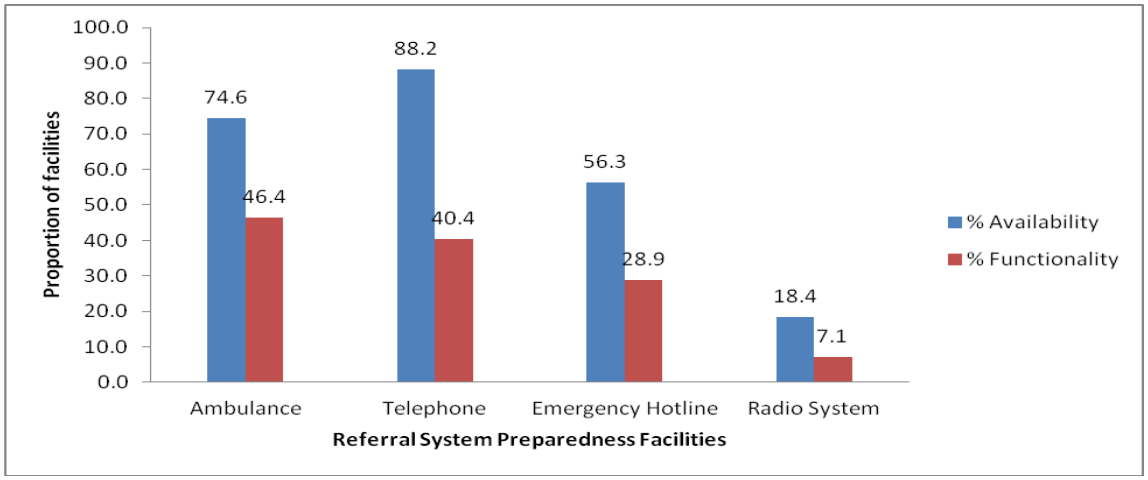
Reproductive Health	Percent
Post Abortive Care	69
Breast Cancer Screening	83
Cervical Cancer Screening	57
Youth Friendly Service	25

Source: Fieldwork, 2014

The least offered reproductive service was the youth friendly service at 25%

3.3 Service Readiness and Quality for FMS

Figure 4: Readiness to provide referral services



Source: Fieldwork, 2014

Overall, 60% of the sampled facilities had referral systems in place though only a third (31%) of these systems were functional. More specifically, majority of the facilities (75%) had ambulances and

telephones (88%) for use in cases of referral, but unfortunately not more than half of either were functional.

There was reported inadequate staff in the health facilities with specialized cadres (gynaecologist, paediatricians) being the most affected, followed by the medical doctors and mid-level cadres (clinical officers, nurses) as expressed by some of the health facility key informants. A majority of staff were tasked to work in multiple departments whenever on duty especially in the lower level facilities (levels 2-4).

Table 9: Personnel trained in reproductive health

Area of Training	Proportion Trained	Average Number per Facility
EMONC	67.5	3.0
PMTCT	92.4	8.2
PAC	65.7	2.2
FP	81.3	3.2
ARH	47.3	2.2
FANC	82.6	5.2
IMCI	80.9	2.6
VIA/VILI	83.1	2.8
Nationally, Trained	**75.1**	**3.7**

EMONC (Emergency Obstetric and New born Care), PMTCT (Prevention of Mother to Child Transmission)
PAC (Post Abortion Care), FP (Family Planning), ARH (Adolescent Reproductive Health), FANC (Focused Antenatal Care),
IMCI (Integrated Management of Childhood Illness), VIA/VILI (Visual Inspection Acid/visual inspection with lugol's iodine)

Source: Fieldwork, 2014

Majority (75%) of the health facility HCWs had received some form of reproductive health training, with an average of 4 HCWs trained per facility. Among the various reproductive health trainings offered to the health workers, PMTCT was the most commonly received by the HCWs with an average of 8.2 HCWs trained on PMTCT in each facility visited (table 4.2). About 60% of the facilities had CMEs, with 55% conducting them weekly and 35% monthly. This finding is similar to sentiments made by a key informant who indicated that *"….most of our workers are qualified, we are updated with current practice, have job aids and we do receive support supervision from our partners. Professional CMEs are held every Thursday…".*

Table 10: Personnel Trained in Reproductive Health by Facility Level

Facility Level	EMONC	PMTCT	PAC	FP	ARH	FANC	IMCI	VIA/VILI
VI	100.0	100.0	100.0	100.0	100.0	100.0	50.0	100.0
V	86.7	100.0	80.0	93.3	53.3	93.3	66.7	100.0
IV	75.0	94.1	76.5	63.2	61.8	67.6	55.9	91.9

III	49.3	93.5	66.2	64.8	45.8	65.5	59.2	87.3
II	42.9	84.6	46.4	55.4	30.4	64.3	39.3	48.7

Source: Fieldwork, 2014

The proportion of HCWs trained in the various aspects of reproductive health was higher in the higher level health facilities compared to the lower level facilities.

3.3.1 ANC IEC and Reference Materials

Most ANC clinics had the basic reference materials for care (FANC guidelines; 76%); (FP guidelines; 81%).

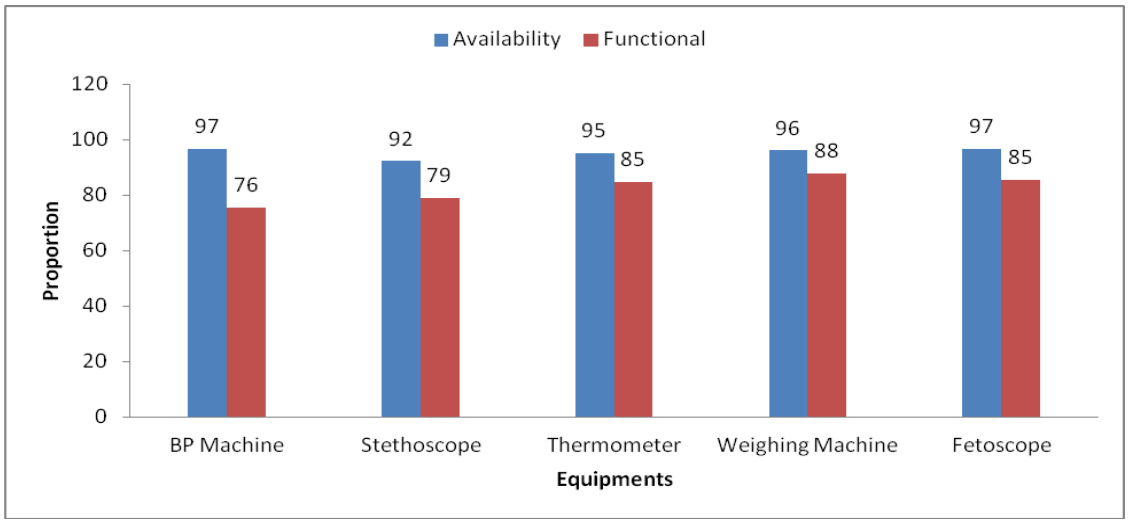
Table 11: Waiting Time

Waiting Time (in Minutes)	Mean	Minimum	Maximum	Range
First Client	22.7	4.0	127.0	123.0
Second Client	20.5	5.0	180.0	175.0
Third Client	23.0	5.0	180.0	175.0
Average Waiting Time	**22.1**	**4.7**	**162.3**	**157.7**

Source: Fieldwork, 2014

The time between arrival of mothers at the ANC clinic to when they were attended to by the HCWs was observed. Observation was done based on a sample of three clients per facility. On average 22 minutes of waiting was observed among the facilities visited (table 3.11). Of concern is waiting time of 2 hours (180 minutes). The long waiting time may be attributed to increased number of mothers attending the ANC and/or inadequate number of staff to serve the mothers. One Key informant observed that with introduction of FMS there had been an increase in utilization of services by up to 26% increase in deliveries, 22% increase in caesarean section and 50% increase in ANC visits, indicating a drastic increase of workload in that respective health facility.

Figure 5: Availability and functionality of bsic equipment for ANC



Source: Fieldwork, 2014

Most facilities had the basic equipment's for ANC clinic available and functional. Non-functioning equipment was more commonly found at the lower level health facilities.

Table 12: Availability and functionality of basic equipment for ANC by facility level

Facility Level	BP Machine		Stethoscope		Thermometer		Weighing Machine		Fetoscope	
	Availability	Functionality	Availability	Functionality	Availability	Functionality	Availability	Functionality	Availability	Functionality
VI	100	100	100	100	100	100	100	100	100	100
V	100	80	93	100	100	100	100	100	93	100
IV	100	79	94	94	96	95	99	97	100	100
III	97	78	94	100	95	98	96	98	97	97
II	91	58	86	97	93	95	91	100	93	95

Source: Fieldwork, 2014

Table 13: Availability of Essential Commodities for ANC

Essential Commodities	Availability	Stock-Out	Average Days-out of Stock
Iron/Foliate Supplements	93	11	23
Vitamins Supplements	89	9	26
Malaria Prophylaxis	46	9	31
Tetanus Toxoid	99	2	3
HIV Rapid Test Kits	96	3	16
National Average	**84.6**	**7**	**19.8**

Source: Fieldwork, 2014

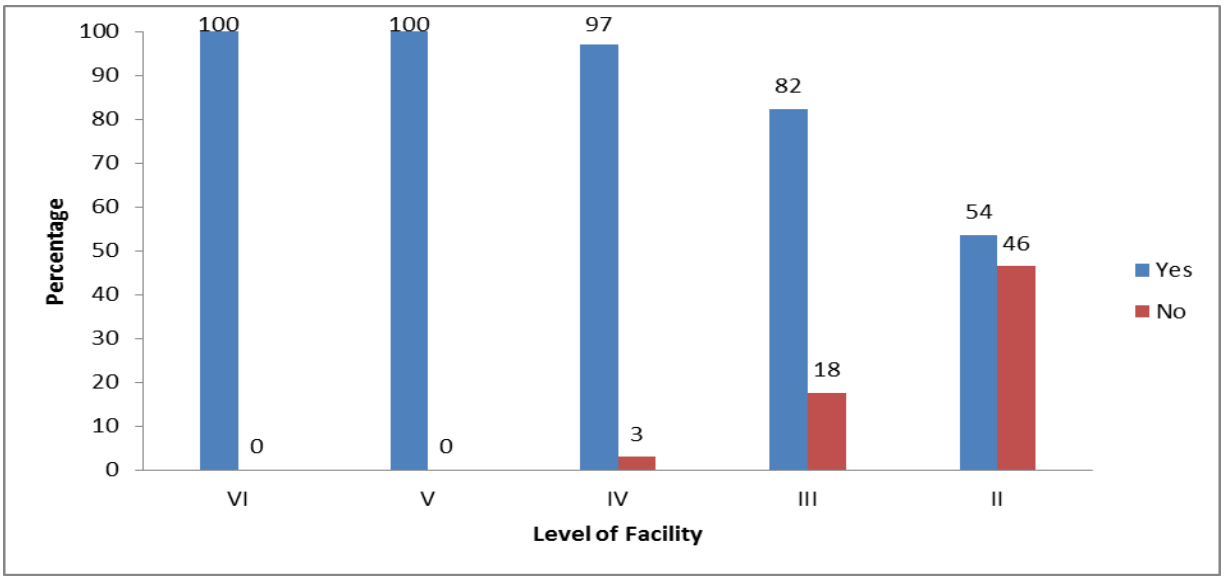
Most essential commodities for ANC were available except malaria prophylaxis drugs only being available in 46% of the facilities at the time of visit. N/b Stock outs of the malaria prophylaxis drugs were mainly

reported, in some malaria non-endemic counties e.g. Nairobi, Kajiado, Machakos. Key informants reported that generally the essential commodities for the ANC were available and that they easily receive them from KEMSA on request.

3.3.2 Maternity Care

Twenty four (24) hours Maternity in-patient services were offered by 82% of the facilities. As would be expected most of the facilities that did not offer 24 hour maternity in patient services were level 2 facilities.

Figure 6: Service provision for 24 hours



Source: Fieldwork, 2014

Delivery guidelines and job aids for reference were available within the maternity units that were visited as demonstrated in table 14 below.

Table 14: Delivery Guidelines and Job Aids available in the Maternity units.

Delivery Service Guidelines	Percent
EMONC	56.5
FANC	67.5
FP	64.3
Community mid-wifery	27.9
IMCI	54.8
IPC	53.0
Job Aids	
New born Resuscitation	62.2

Immediate newborn care	61.8
Warm Chain Chart	46.6
AMTSL	68.9
Kangaroo Mother Care	49.8
Vacuum Delivery	34.3
MgSO4 Administration	65.7

Source: Fieldwork, 2014

3.3.3 Essential Amenities

Essential amenities for the mothers in the facilities were assessed. It was established that toilets were available in 87% of the total facilities; bathrooms were found in 79% and evidence of running water found in 64%. Of these 69% of the toilets and 62% of bathrooms were functional.

Availability of beds in the maternity ward was reported by 89% of the facilities. Incidences of mothers sharing beds within the maternity wards were evident in 18% of the facilities and key informants provided the same information. Baby cots were available in 54% of the facilities.

A maternity in-charge said *"space is inadequate, when women share beds, there is no privacy. The linen may be adequate but it could be better, we have only one resuscitator yet so many babies are born every day. Sometimes examination lights are not functioning. There is no ventilator in the maternity so very sick patients are sent to ICU"*

These sentiments revealed compromised functionality and inadequacy of essential amenities and equipment's in some maternities.

Table 15: New Born Essential Commodities

Essential New Born Commodities	Percent
Firm Surface for New-born Resuscitation	63
Incubator	47
Other Functional Heat Source	68
Working bags valve	71
Working Suction Equipment	72
Disposable cord tie/clamp	75
Towels/Blanket to wrap the baby	31
High flow of Oxygen source	63

Source: Fieldwork, 2014

Only 22% of the facilities had new born units. At least 63% of the facilities had firm surface for new born resuscitation while 72% had functional suction equipment and 63% had high flow oxygen source.

Table 16: Delivery Essentials

Delivery Essentials	Percent
Delivery Pack	90
Episiotomy Set	77
Vacuum Extractor	40
Manual Vacuum Aspiration	58
Surgical Sutures	78

Source: Fieldwork, 2014

A majority (90%) of the facilities had delivery packs, 77% had episiotomy sets and 78% had surgical sutures and the essentials became less available at the lower facility levels as capacity of function also decreases.

Table 17: Delivery Essentials by Facility Level

Facility Level	Delivery Pack	Episiotomy Set	Vacuum Extractor	Manual Vacuum Aspiration	Surgical Sutures
VI	100.0	100.0	100.0	100.0	100.0
V	100.0	92.9	80.0	86.7	100.0
IV	95.6	78.3	55.9	77.9	83.8
III	93.7	75.6	35.2	57.7	76.8
II	71.4	72.5	17.9	26.8	66.1

Source: Fieldwork, 2014

Of the facilities visited 77% had a room (space) that was defined as an operating theatre. The table below gives a profile of the available theatres.

Table 18: Profile of the available operating theatres

Delivery Apparatus	Availability, (%)	Functionality, (%)
Operating Table	28	81
Operating Light	26	72
Anaesthesia giving set	28	69
Scrub Area Adjacent to or in operating room	26	74
Tray/Drum/package with sterilized instruments	25	-
Halothane or Ketamine	15	-
Presence of HCW who can perform C/S or on call 24 hrs/day	21	-
Presence of Anaesthetist or on call 24 hrs/day	14	-

Source: Fieldwork, 2014

Availability of privacy in the maternity units was reported in 67% of the facilities and 84% at least had a delivery bed.

3.3. 4 Partographs

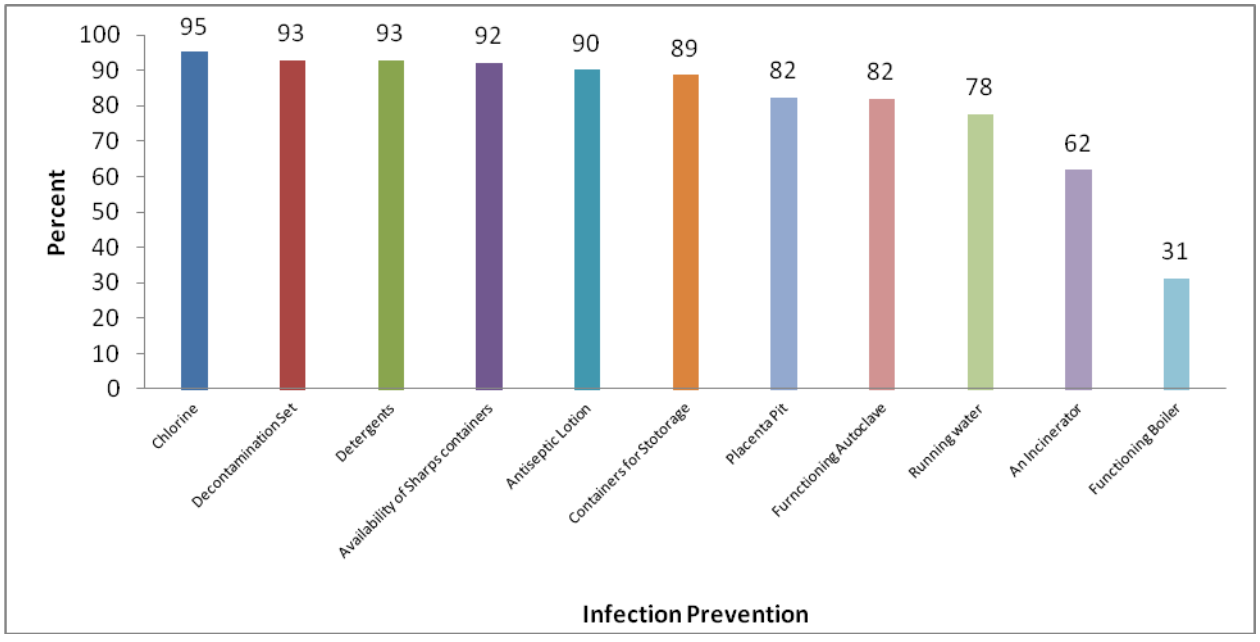
Among the facilities visited 73% reported availability of partographs with 82% utilizing them for monitoring labour.

Table 19: Documentation of Partographs and Post natal Information

Information	Percent
Partograph	
Mother's Biodata	48
Fetal Condition	44
Progress of Labor	42
Maternal Condition	39
Birth Information	43
Post natal ward records	
Baby Examination	34
Postnatal Mother examination	36

The study evaluated the extent to which documentation was done by sampling 3 patient files from the labour ward and another 3 from the post natal ward. It was noted that patient information was not adequately documented with post natal records being the most affected.

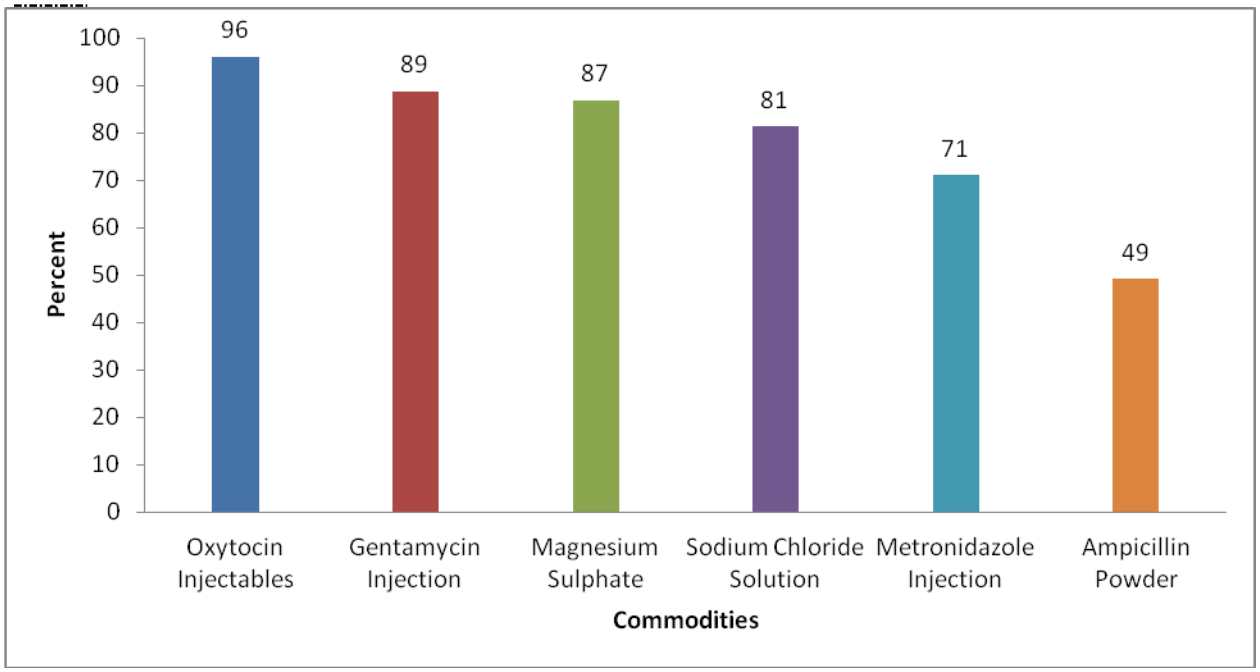
Figure 7: Availability of Infection Prevention Materials / equipment



Source: Fieldwork, 2014

Materials and equipment for infection control were generally available in most facilities. However this survey did not determine the extent of infection control practice.

Figure 8: Availability of essential commodities in the maternity



Source: Fieldwork, 2014

A majority (96%) of the facilities, 89% of facilities and 87% of facilities visited had Oxytocin injection, Gentamycin injection and Magnesium sulphate available respectively. The commodity most affected with stock outs was Ampicillin with 11% of facilities reporting it's out of stock in the one month preceding the survey.

Table 20: Maternal deaths and audits in the last 12 months, by county

County	Total No. of Maternal Deaths	Total No. of Maternal Audits
Machakos	34	20
Kakamega	32	0
Kisii	30	8
Kisumu	26	7
Nairobi	26	7
Garissa	24	16
Kajiado	22	0
Embu	20	8
Kilifi	19	8
Isiolo	14	2
Vihiga	14	2

County	Total No. of Maternal Deaths	Total No. of Maternal Audits
Mombasa	11	3
Trans Nzoia	8	6
Bomet	4	4
Murang'a	4	4
Nakuru	3	3
West Pokot	3	1
Kirinyaga	2	2
Uasin Gishu	2	20*
Kiambu	1	11*
Nandi	1	0
Narok	1	0
Meru	0	0
Nyeri	0	0
National	**301**	**132**

**= cumulative back log of maternal audits*

Source: Fieldwork, 2014

There were a total of 301 maternal deaths that occurred in the 12 months preceding the survey in the county health facilities that were visited. Over the past 1 year a total of 132 maternal audits were undertaken. Some counties however did not have evidence of maternal death audit e.g. Kakamega, Kajiado) despite having recorded some maternal deaths.

Table 21: Availability of registers in the facilities

Register	Percent
ANC Register	89
Maternity Register	88
PNC Register	91

Source: Fieldwork, 2014

Among the health facilities visited the basic registers for recording and reporting were available as demonstrated. Monthly summary reports were available in 89% of facilities.

3.3.5 Supervision

Eighty seven percent (87%) of the facilities reported that they had received support supervision in the 3 months preceding the survey. Most of the facilities (79%) reported being supervised by the County Government, while supervision by the National Government was reported by only 2% of the facilities. National key informants said that with devolution, conducting supervision in counties had become challenging, one said *"we have had only one single supervision session after devolution. Supervision should be at least quarterly and should not be seen as policing but as engaging. This is fundamental".*

3.4 Key Informants'Perceptions of FMS Programme

In-depth interviews were conducted among key informants both at the National and County levels. At the National level discussions were held with key informants from various departments within the MOH, including the office of Director of Medical Services, the 4 Directorates (Policy Planning and Health Care Finance, Standards and Regulatory Services, Preventive and Promotive health services and Clinical services), the Health care Financing Unit, Reproductive Health Unit, Intergovernmental Liaison Unit, Division of Health Information System unit. One representative of a health development partners was also interviewed. In total 9 key informant discussions were held at national level. The scope of discussion at the national levels covered various themes including, the role of the various departments in the FMS initiative including its inception, implementation and monitoring, the scope of the initiative, reimbursement, the quality of care, the coordinating mechanism of the programme, challenges and possible solutions.

At the County level, the key informants included County Chief Executive officer (CECs) for Health, County Health Directors and Maternity-in-charges. In addition to the themes discussed at the national level, there was a focus of discussion on service availability, readiness for FMS and the quality of care at this level. A total of 16 key informants participated in discussions at county level.

(a). Noble Idea

There were a number of key informants especially from the National level who were involved in the inception planning of the FMS programme idea. The FMS idea was initiated before the 2 Ministries (Public Health and Sanitation and that of Medical Services) were merged with the purpose of being *"a strategy to enhance maternal service access to the poor"* a key informant provided these sentiments. A majority of the informants both from the national and county levels felt that the FMS program was a noble idea, with some giving various expressions *"This is a worthwhile program. We need to strengthen the coordination mechanism. It requires continuous monitoring of service delivery to maintain quality"*, *"this is a good idea, it increases access to mothers"*, *"FMS is a noble idea. It is an opportunity to give our mothers quality care".* Comments from the community on the idea included *"for mothers who could not afford, this is really a benefit"*, *"the government should continue with this offer"*, *"we are thankful to the government"*, *"this is a saving to many families".* The sentiments indicate that the idea of FMS is generally acceptable and well appreciated by the community.

(b). Scope of FMS

The survey sought to find out who is involved in the coordination of the FMS program, key informants felt its' implementation is mainly overseen by the Ministry of Health (MOH) alone. One informant said " *On initiating FMS implementation, the (MOH) put together a team under the DMS (Director Medical Services) to oversee the FMS programme, basically a MOH team was purposed to have technical and finance experts"* and another said *"FMS was designed at the technical level at the MOH and RH unit and did not involve the Reproductive Health Inter-country coordinating Committee (RHICC) which could improve function of the program, the FMS policy development is ongoing right now and is more inclusive".*

There was communication from the MOH as per the circular dated 1st April 2014, that FMS programme covers the following services; ANC, Deliveries, PNC and complications of delivery including; ICU care, renal dialysis, and complicated medical diseases in pregnancy. The communication also informed that facilities would be reimbursed Kshs 2,500 and Kshs 5,000 for health centres/dispensaries and hospitals respectively based on performance (number of deliveries conducted). Despite the availability of this circular which was circulated long after start of FMS implementation, sentiments from key informants indicated that they were not clear as to what these funds cater for, one said *" it is not clear what these funds cover, is it only delivery? What about ANC and PNC".* Key informants raised concern over the scope of FMS in terms of the conditions it takes care of. One said *"Conditions related to pregnancy including; ectopic pregnancy, early pregnancy bleeding and issues related to new born care need to be considered in this programme for better maternal and child outcomes"* and another said *" preterm babies have increased, nobody takes care of this"*

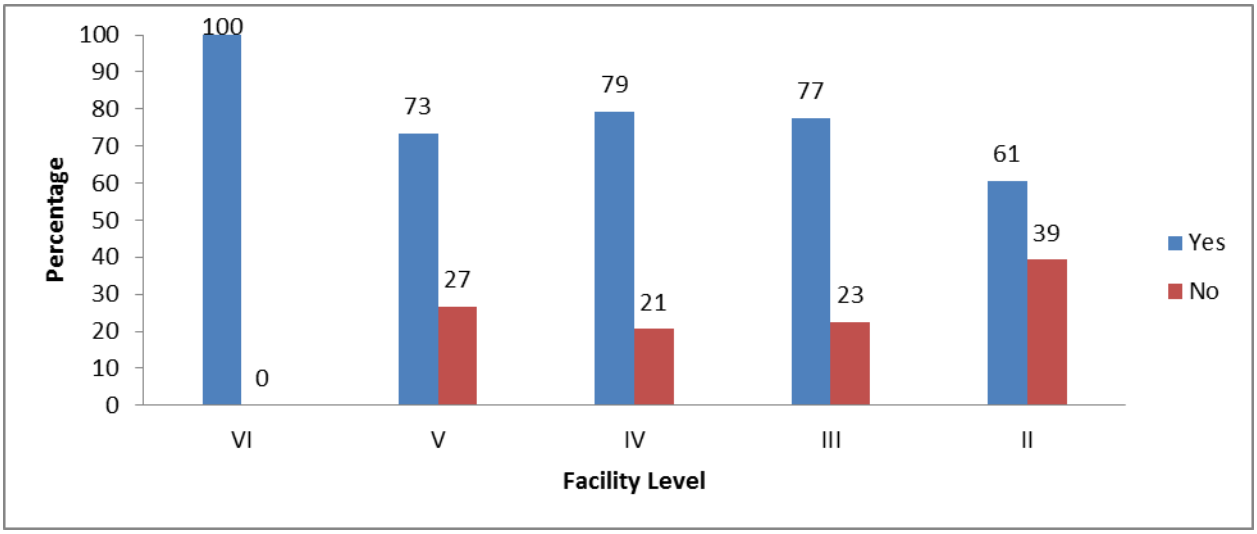
(c). Reimbursement of Funds

Various key informants reported on some of the factors that were considered in costing reimbursement for each delivery which included sentiments such as *" it was assumed that an estimate of 15% of deliveries become complicated, that at health centre/dispensary level there would be no complications thus a reimbursement of Kshs 2500 for a delivery and not Kshs 5000 as in the higher level facilities, that women spend not more than 24 hours at the facility on delivery and that the costing is mainly based on delivery charges without including ANC and PNC".*

The MOH decided to use the existing health financing schemes Health Sector Service Fund (HSSF) for health centres/dispensaries and the Hospital Management Service Fund (HMSF) for hospitals to reimburse

facilities providing FMS. Key informants reported that, after devolution some health facilities closed the HSSF accounts, and hence the FMS funds were channeled through central county revenue accounts. This had made facilities to have no control of the FMS funds and some facilities were not informed at all on their reimbursements. In otherwise situations where the funds were received directly into facility accounts, key informants informed of the benefits with these expressions *"a facility usually proposes on how to use the funds for maternal services and if acceptable this is approved by the AIE holder", " facilities receiving HSSF are better off, because they can plan for this money".*

Figure 9: FMS reimbursement status by facility level



Source: Fieldwork, 2014

At the time of the survey 74% of the facilities reported that they had received reimbursement from the FMS programme within the 6 months of January to June 2014. All of the referral hospitals had received their reimbursements. Twenty five percent (25%) of facilities reported having missed reimbursements. Reasons for no reimbursement included: no feedback 8%, reimbursement reports not prepared, inaccurate reports, inactive health facility bank accounts and other administrative issues. A key informant said *"monthly reports for reimbursement have been provided regularly to the national office, but we have not received reimbursement for the last 4-5 months. The last reimbursement was in April 2014".*

Despite the provided reimbursement, key informants in the implementing institutions had complaints on the reimbursement; *"we have incurred financial loss of millions of shillings (>100 million)"* a referral hospital that had to cope with the increased number of referrals and complications reported. These facilities felt that they are under compensated and they had complained about this to the MOH. Workload had increased because of increased utilization of the service; for example a National referral

hospital reported a 26% increase of deliveries, 22% increase of Caesarean section and 50% increase of ANC attendance yet staffing was inadequate (1 nurse taking care of 15 patients). An approval by MOH to provide staffing had never been implemented, they reported. The hospital relied on post graduate doctors who were not compensated to do the work and in addition, part time nurses were hired to mitigate the overwhelming work. Two referral hospitals reported that maternal mortality had increased because there was a tendency to focus more time on the complicated referral cases, *"jeopardizing the care for the booked uncomplicated patients"* a key informant reported. This is because of delay in providing care to the booked patients.

Key informants had suggestions on the use of the FMS funds disbursed; *"facilities should be able to invest the monies earned from this service to maintain quality and standards"*, *"FMS funds should be directly used to improve the quality of care in the ANC and maternity"*

Issues related to financial sustainability were mentioned by key informants and some suggested the consideration of using other existing health financing mechanisms e.g. National Hospital Insurance Fund (NHIF), Output Based Approaches (OBA). They also expressed a need for an audit of the whole programme to evaluate the cost effectiveness.

3.5 Clients' Perception on FMS

3.5.1 Introduction

A total of 386 post-partum mothers who had delivered at the health care facilities visited were interviewed to seek their opinion on quality of service of the FMS programme.

Table 22: Characteristics of the Clients and time taken to reach health facilities

Client Characteristic	Freq.	% (N =386)	Mean (Range)
Age			
15 - 19	58	15.0	
20 - 24	126	32.6	
25 - 29	108	28.0	
30 - 34	63	16.3	
35 - 39	27	7.0	
40 - 44	4	1.0	
Parity			
Zero	8	2.1	
1 – 3	308	79.8	
4 – 6	70	18.1	
7+	0	0.0	
Education			
No Formal Education	44	11.4	
Primary Level	163	42.2	
Secondary Level	142	36.8	
Tertiary	37	9.6	
Time on Foot (Minutes)			48.7 (2 to 360)
Time taken by Vehicle (Minutes)			37.3 (3 - 180)

The mean age of the mothers interviewed was 25 years (SD 6). The age category 20-24 made up the highest proportion (32.6%) compared to the rest of the age categories. A majority (80%) of the mothers were of parity 1-3. About 42% had primary level as their highest level of education while 37% had secondary level education. The mothers reported that the average time taken from home to the health facility on foot was 49 minutes while the average time by vehicle was 37 minutes.

3.5.2 Client Perceptions on FMS

Mothers who had benefitted from FMS were interviewed in the post-natal wards to assess their perception on the quality of care they had received in the maternity through the FMS program. Various dimensions of health facility, health care delivery and Interpersonal aspects of health staff were assessed to determine the opinion of the mothers as indicated in the table 2. For each item in the questionnaire, respondents would respond to one of the three options: agreeable (+1), Don't Know (0), or Disagreeable (−1).

Table 23: Rating of Different Aspects of Service by the Clients

FMS	Ranking of the FMS	
	Mean	STD
Health Facility		
Adequate Staff	0.09	0.99
Well Suited to treat Women	0.88	0.46
Adequacy of Rooms	0.12	0.99
Adequate clean water	0.53	0.83
Hand washing facility Adequate	0.62	0.77
Bath Facility	0.34	0.91
Toilets	0.38	0.92
Overall, Environment very Clean	0.72	0.67
Well Equipped	0.57	0.78
Distance to Facility	(0.23)	0.96
Average Sub-Score	**0.40**	**0.83**
Health Care Delivery		
Health Officers in the Health facility examine pregnant women well	0.87	0.46
Staff Very Capable	0.72	0.58
Good supplied Drugs	0.68	0.60
Obtain drugs Easily	0.62	0.69
Provision of very much privacy	0.51	0.85
Unnecessary and humiliating procedures	(0.17)	0.97
Adequate information of danger signs of delivery and postpartum provided	0.62	0.75
Average Sub-Score	**0.55**	**0.70**
Interpersonal Aspects		
Very open Staff	0.84	0.52
Compassionate Staff	0.80	0.56
Respectful Facility Staff	0.85	0.50
Adequate Time devoted to Clients	0.69	0.70
Honest staff	0.82	0.52
Average Sub-Score	**0.80**	**0.56**
Overall, Rating	**0.58**	**0.70**

Source: Fieldwork, 2014

Table 24: Descriptive statistics and Total Perceived Quality Score

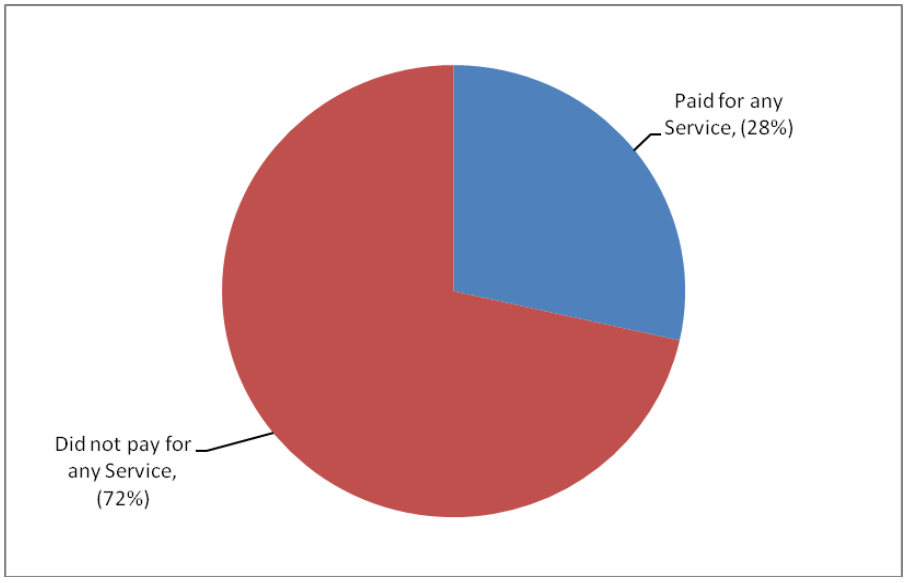
	Health Facility	Health Care Delivery	Interpersonal Aspects of Health Staff	Total Score
Number of Items	10	8	5	23
Possible range of Score	-10 to +10	-8 to +8	- 5 to +5	-23 to +23
Mean	0.40	0.55	0.80	0.58
SD	0.83	0.70	0.56	0.73

Source: Fieldwork, 2014

The overall rating of the FMS services by the clients who had benefitted was 0.58 out of a possible score of 1, with the lowest rating of 0.40 for health facility aspects and 0.55 for health care delivery. The best services rated were the interpersonal skills of the health staff (0.80). The least satisfaction levels were found in the number of staff (0.09), adequacy of rooms (0.12) and distance to facility (-0.23). As much as assessment of quality of care by clients is subjective, it can still provide useful input to help the provider understand and establish acceptable standards of services. These findings should contribute to the improvement of the FMS program.

Although FMS services were free, a third (28%) of the clients reported to have paid some fee for various services that ranged from laboratory tests, drugs, ANC booklet and registration, x-ray services and delivery charges.

Figure 10: Clients reporting having made any payment for expected maternity services



Source: Fieldwork, 2014

3.5.3 Community Perceptions of FMS

There were various Focus Group Discussions (FGDs) conducted among community members within the catchment areas of the sampled facilities. Some of the views derived from the discussions were guided by the following themes.

(a). Understanding of FMS

Most of the community members were aware of the FMS programme which they had heard of from the media and also from mothers who had benefitted. A majority of the community members understood the FMS program as *"no fee for delivery"* others said *"clinic, medication and delivery are free"*, *"I am not sure if you have a caesarean section whether it will be free"*. All these sentiments indicate that it may not be very clear within the community what the scope of FMS is, there is need to reinforce on specific messaging to the community on the scope and benefit of FMS program.

(b). Changes seen with FMS

Various expressions of change were revealed by the community *"for mothers who could not afford, this is a really benefit"*, *"beddings are clean, there is warm water and food is good"*, *" the staff listen to us"*, *"the toilets are clean"*, *"there are less abortions now"*, *"the beds are not enough"*, *"the staff are not enough"*. These sentiments indicate that through the FMS program the burden of maternal care was off lifted from many families. In addition there is noted improvement of care in some facilities, while there is need for provision of better services in others.

(c). How FMS can be further improved to benefit clients

Sentiments on how best the FMS program could improve were provided by the community, this included; *"at the periphery there is inadequate staff, equipment and medicine. We would rather use the regional hospital because there is better service, but the challenge we get, is that we have to pay for fuel for the ambulance, why not provide everything to the lowest level"* . The community members suggested improvement of quality of service on various aspects including the provision of adequate staff, more space in maternities, provision of functioning theatres and ambulances among other components of the health system structure. This indicates that as much as there was opportunity to utilise the FMS, there was great need to improve on functionality for improved quality of care. Other suggestive sentiments were *"the FMS package should include towels, nappies and a few clothing for the babies"*, *"all other services should be made free"*. This indicates that there may be a need to redefine the scope of FMS to include other services and supplies related to deliveries.

There was general acceptance of the FMS program from the community when many expressed their appreciation of the service, they said *"we appreciate this offer"*, *"thanks to the government"*, *"this offer should continue"*. This indicates that the program is a worthwhile service that is needed by the community.

4.0 Discussion

After the introduction of the FMS there was increased utilization of services evidenced by the increased proportions of normal deliveries (22%) and the caesarean sections (17%) during the first year of implementation. Complications related to maternal care declined slightly from 4.3% (2012/13) to 3.8% (2013/14) with the biggest notable decline in obstructed labour, while the rate of the other complications (APH,PPH) remained the same as the previous year of implementing FMS. These findings may indicate that primary health workers were more able to detect signs of impending obstructed labour much earlier than was in the previous years and thus providing appropriate service actively to avoid obstructed labour. However the management of APH and PPH may not have been satisfactory. Reasons that may have led to this include inadequate staffing despite the increased workload and minimal mentorship for staff as reported by key informants. As much as demand of service is evidenced by these findings, there is need to ensure the service meets the recommended standards and quality. The Ministry and other stakeholder need to ensure that they put in place the required inputs so as to address the high service demand and balance this with the required standards.

Despite increased availability of service, functionality of various amenities and equipment for maternal and neonatal care was found wanting especially at the lower level health facilities. For instance about 50% of the available ambulances were not functioning at the time of the survey, basic amenities; toilets and bathrooms were not in use and not all facilities had running water in the maternities. Clients who had benefitted from the FMS expressed their dissatisfaction with the health facility amenities and rated it lowest at 0.40 out of a maximum 1 point compared to the interpersonal skills of staff that they rated at 0.80. These inadequacies affect the quality of care.

The FMS scope in terms of coverage of service may need to be redefined. Key informants had different understandings of what the FMS program should offer despite the circular of April 2014 from the Ministry of Health which stated clearly that the program would only reimburse for services related to deliveries and any complications related to the deliveries. Many key informants felt the scope of FMS was not adequate and conditions related to early pregnancy and new born care should be included. The different perceptions of the scope of FMS indicate the need for proper definition of the scope of FMS towards provision of holistic care for better outcomes.

There were reimbursement processes that were reported to be inefficient including the timeliness and the coordination mechanism from the National to the county levels and vice versa. These need to be

streamlined. It was also not clear from the implementers in the counties as to exactly what the funds from FMS were to be utilized for though various key informants suggested that these funds should be re-invested into maternal care. In line with proposed scope of FMS to include more service as suggested by various stakeholders, the funds to reimburse will need to be reviewed to be inclusive of all the changes made. The complex issues of reimbursement may require the re-organisation of the disbursement model in agreement and in consultation with the Counties. As noted from the implementing key informants, maternal care was expressed as linked to other services that exist within the health facilities so that it is difficult to cost this care as only maternal care as it impinges on other services especially in situations of complications. Possibly the reimbursement could be based on agreed on FMS indicator targets for counties and payment of FMS funds would be in the form of increasing the health funding to the counties rather than re-imbursing as the FMS project singly. The counties would then decide how to re-invest these funds to improve maternal care.

The FMS was noted to be a worthwhile program which requires a coordinated mechanism that needs to be strengthened and streamlined. This includes effective communication and continuous monitoring of service delivery. Apart from availing the services within the FMS programme, all elements of health systems strengthening should be on check to maintain quality of care. This may require the engagement of various stakeholders (reproductive health, finance, community resource persons) to be tasked to oversee the implementation and monitoring of the program.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1 CONCLUSIONS

The free maternity program was directly targeted at addressing a clear need for health that clients have expressed. It has helped to reduce the barriers to maternity services that many persons in Kenya were facing. As it is, there are already a number of mothers who are benefiting from it. However, the program is still faced with a number of operationalization challenges, which form the basis of the recommendations arising from this assessment.

i) The higher utilization suggests a real demand for services has been increased, arising from the reduction in the financial barriers to accessing maternal health services

ii) The varied trends in utilization across many different maternal health services, together with the responses from Key Informants, and from the Focus Group discussions suggest lack of clarity about the scope of interventions included as part of the Free Maternity Services

iii) The high utilization without coherent evidence of increased investments to cater for this (more infrastructure, staff, commodities) suggest reduced quality of service delivery due to less available investments

iv) The Key Informants and FGD responses on health workforce productivity and quality of care plus no evidence of improvements in readiness to provide maternity services suggest reductions in quality of care (reducing client experiences, little evidence of better patient safety measures and of assuring / monitoring adherence to expected care standards)

v) The weak guidance on the use of the refunds as reported by Key Informants, plus their virtualization based on deliveries suggest poor targeting of the reimbursements and therefore inefficiencies may arise in the use of the refunds to improve maternity services

5.2 RECOMMENDATIONS

Overall, this is a policy direction that needs to be more entrenched into the service delivery to address the health needs of the country. The key areas the sector needs to prioritize relate to the following:

- At the policy level, the Government needs to urgently formulate a clear, and coherent policy guideline for operationalization of the Free Maternity Services across the country. This needs to focus on the intent of the FMS, together with key issues that will need to be implemented and monitored to assure the achievement of this intent.
- At the strategic level, the Government needs to:

- Define succinctly the set of interventions that make up the free maternity services. It is recommended that these relate to all the interventions that directly / indirectly influence delivery outcomes to ensure the FMS approach is able to achieve its goals. These include the ANC services, delivery, post natal services (including care for the newborn / infant)
- Integrate the FMS policy guidelines into the overall efforts to reduce financial barriers to accessing health services, to ensure it is institutionalized into the overall financing strategy for health.
- Define a more comprehensive, institutionalized system for financing the FMS that builds on the country efforts to improve equity in financing – especially exploring the scope for social health insurance mechanisms.

- At the operational level, the sector need to focus on the following:
  - Put in place clear strategies that national and county governments need to jointly assess, map and plan investments to improve quality of service delivery for FMS through prioritising investments in Human Resource, infrastructure and commodities based on the anticipated demand for FMS. These should be at facility level, aggregated to county and national levels
  - Define the strategies that counties need to assess, map and plan for investments needed to improve readiness to provide FMS by facilities through prioritising skills building, equipment availability (including water/electricity), and other facilitator investments needed to provide the services
  - Provide Standard Operating Procedures (SOPs) to guide facilities on key actions they need take and monitor to improve client experiences, patient safety, and ensure adherence to care standards to improve on the quality of care provided for FMS clients
  - Define a more independent, and real time system for capturing information relating to the agreed FMS that would provide transparent information on service provision outputs and capacities. County-wide Electronic Health Records Systems need to be scaled up to facilitate this.

ANNEXES

ANNEX 1: SAMPLED REGIONS

Region	County	Random Sample	No. of County	Weight 1	No. Facilities
Rift Valley South	*Bomet*[1], Kericho, *Kajiado, Nakuru,* Laikipia, *Narok,* Samburu	4	7	0.14	1,358
Rift Valley North	Baringo, E/Marakwet, *Nandi, T/Nzoia, U/Gishu, W/Pokot,* Turkana	4	7	0.12	1,142
Nyanza South	*Kisii,* Migori, Nyamira	1	3	0.05	497
Nyanza North	*Kisumu,* Siaya, Homabay	1	3	0.06	577
Western	Bungoma, Busia, *Kakamega, Vihiga*	2	4	0.06	600
Coast North	*Kilifi,* Tana River, Lamu	1	3	0.04	365
Coast South	*Mombasa*, Kwale, *T/Taveta*	2	3	0.05	505
Upper Eastern	*Isiolo,* Marsabit, Meru*, Tharaka Nthi, *Embu*	2	5	0.09	923
Lower Eastern	*Machakos,* Makueni, Kitui	1	3	0.10	949
Central 1	Kiambu*, *Muranga*	1	2	0.08	739
Central 2	*Nyeri,* Nyandarua, *Kirinyaga*	2	3	0.08	830
Nairobi 1	Dagoreti, Westlands, Langata, Kamukunji	1	1	0.09	918
Nairobi 2	Embakasi, Starehe, Kasarani, Makadara				
North Eastern	*Garissa,* Wajir, Mandera	1	3		
Total		*23*	*47*		*9,771*

[1] *The highlighted counties were the sampled ones.*

ANNEX 2: SAMPLED FACILITIES BY COUNTIES

County	Number of Facilities	Public Facilities		Achieved Sample	
		Client-Perceived Quality of Maternity Services	Facility Evaluation Tool (Readiness For Care)	Client-Perceived Quality of Maternity Services	Facility Evaluation Tool (Readiness For Care)
Nairobi	26	49	26	61	23
Mombasa	12	19	12	7	14
Kilifi	15	24	15	6	15
Taita Teveta	15	26	15	0	0
Garissa	12	23	12	17	16
Kakamega	22	40	22	42	24
Vihiga	11	19	11	16	10
Nandi	18	24	18	2	1
T/Nzoia	13	18	13	5	2
U/Gishu	15	28	15	18	7
W/Pokot	12	17	12	10	6
Kisumu	23	39	23	17	9
Kisii	20	34	20	13	17
Isiolo	8	12	8	8	8
Embu	12	19	12	12	18
Meru	1	4	1	4	1
Kirinyaga	11	20	11	13	11
Muranga	14	22	14	18	10
Nyeri	15	25	15	14	10
Kiambu	1	4	1	4	1
Kajiado	13	21	13	23	12
Bomet	15	24	15	0	10
Nakuru	20	35	20	0	10
Narok	16	22	16	0	10
Machakos	20	35	20	33	20
Total Expected	**360**	**603**	**360**	**386**	**283**

ANNEX 3: CLIENT – PERCEIVED QUALITY OF MATERNITY SERVICES

MINISTRY OF HEALTH

AN ASSESSMENT OF THE FREE MATERNITY SERVICES (FMS) PROGRAMME

CLIENT-PERCEIVED QUALITY OF MATERNITY SERVICES

INTRODUCTIONS

- I am here today working on a project that will be assessing the effects of implementing the FMS programme by the Ministry of Health.
  - We are collecting information from mothers who have benefitted from the FMS service to understand their rating of the services they received.
  - This information will be gathered by asking you some questions related to the service you received

Purpose: The information collected will be used to describe the level of satisfaction that mothers have related to this service and thus inform on areas that require service improvement for effective and efficient FMS implementation.

Data Source:

Inclusion Criteria:

- Postpartum women who have delivered in a health care facility. (anytime between day 0-42). May be recruited from the post-natal ward or post-natal/child welfare clinic.

Exclusion criteria:

- Women who delivered at home.
- Women who delivered on the way to a facility.
- Women who had stillbirths.
- Women with early neonatal deaths.

Informed Consent (verbal):

Are you willing to participate in a short interview with me of about 20 minutes, in which I will ask you about the maternity services you received. The questions asked will be about your thoughts and opinions on these issues. There are no right or wrong answers. Your responses will remain anonymous.

Your participation is completely voluntary. You may choose to stop answering at any point. Your participation, and the answers you provide, will not impact on your care at this hospital in any way.

Date: ___ / ___ / _____ **(DD-MM-YYYY)**

County: _____

Sub-county: _____

Facility Name: _____

Enumerator's Name _____

Client Number: _____

SECTION A: GENERAL INFORMATION

1. Age (years): _____

2. Parity: _____+_____

3. Education level (Tick one):

- ☐ No Education
- ☐ Primary Level
- ☐ Secondary Level
- ☐ Tertiary Level

4. Distance to reach facility from home (either by time on foot or by vehicle)

4.1: time by foot: _____ (Hrs/Minutes)

4.2: time by vehicle: _____ (Hrs/Minutes)

SECTION B: PERCEIVED QUALITIES OF FMS

Respondents will express their opinion or experience on a four-point Likert scale (1 - 5), where Completely Disagree (1), Disagree (2), Agree (3), Completely Agree (4) and Don't Know (5).

For each aspect/question please tick in the appropriate box provided on the right.

Aspects	Completely Disagree (1)	Disagree (2)	Agree (3)	Completely Agree (4)	Do not know (5)
Q5: Health Facility					
5.1 In your opinion, the number of health staff in the health facility is **adequate.**					
5.2 In your opinion, the health staff in the health facility are **well suited** to treat women's health problems.					
5.3 In your opinion, the waiting rooms, examination rooms and other rooms of the health facility are **adequate** for women's health problems.					
5.4 In your opinion, the provision of clean drinking water for women in the facility is **adequate.**					
5.5 Hand washing facilities for women in the facility are **adequate.**					
5.6 Bathing facilities for women in the facility are **adequate.**					
5.7 Toilets for women in the facility are **adequate.**					
5.8 In your opinion, the overall environment of the health facility is **very clean**.					
5.9 In your opinion, the equipment in the health facility is **well suited** for detecting women's health problems.					
5.10 The distance from your home to the health facility is **very far.**					

Aspects	Completely Disagree (1)	Disagree (2)	Agree (3)	Completely Agree (4)	Do not know (5)
6. Health Care Delivery					
6.1 In your opinion, the health staff in the health facility examines pregnant and postpartum women **well**.					
6.1 In your opinion, the health staff in the health facility is **very capable** of finding out what is wrong with the patients.					
6.2 In your opinion, the health staff in the health facility prescribe the **drugs that are needed**.					
6.3 In your opinion, the drugs supplied by this health facility are **good.**					
6.4 In your opinion, patients can obtain drugs from this health facility **easily**.					
6.5 The health facility provided **very much privacy** during vaginal examination and delivery.					
6.6 You felt **very much** of unnecessary and humiliating procedures during antenatal and delivery care.					
6.7 In your opinion, the information of danger signs of delivery and postpartum provided by health staff is **adequate.**					

Aspects	Completely Disagree (1)	Disagree (2)	Agree (3)	Completely Agree (4)	Do not know (5)
7.0 Interpersonal Aspects					
7.1 In your opinion, the health staff in the health centre are **very open** with the patients.					
7.2 In your opinion, the health staff in the health facility are **very compassionate** towards the patients.					
7.3 In your opinion, the health staff are **respectful** towards the patients					
7.4 In your opinion, the time that the health staff devote to their patients is **adequate**.					
7.5 In your opinion, the health staff in the health facility are **very honest.**					
8.0 Overall					
8.1 You were **completely satisfied** with the services provided to you					
8.2 In the case of your **future delivery** or next baby, will you again use this the health care facility?	yes	No	Undecided/do not know		
8.3 Is there any service you have paid for for your maternal care (ANC, Delivery, PNC)	Yes	No		If Yes, which service? _____ _____	

ANNEX 4: FACILITY EVALUATION TOOLS
[READINESS FOR CARE]

Serial No. | | | |

MINISTRY OF HEALTH

AN ASSESSMENT OF THE FREE MATERNITY SERVICES (FMS) PROGRAMME

FACILITY EVALUATION TOOL

[READINESS FOR CARE]

Date: ___ / ___ / _____ (dd-mm-yyyy)

County: _____

Facility Name: _____

Level: _____

Survey Team Details

Name	Title	Tel	Email address

Information to read to respondent/s:

Introductions

- I am here today with my colleagues working on a project that will be assessing the effects of implementing the FMS programme which is part of the Ministry of Health.
- We are collecting information to learn how the implementation process has progressed and the effects on the quality of health care
- We are interested in hearing from those who are directly involved with this programme

Purpose: The information collected from these tool will be used to describe the readiness of this facility to implement the FMS programme. The effects of FMS on the health services delivery will also be described. In addition, the information gathered will be used to provide inputs for the development of the FMS policy and also provide recommendations for the effective and efficient implementation of the FMS programme.

Data Source: MCH personnel who are knowledgeable on standard MCH services. This may include Nurses

Facility Type *(√-tick that apply)*

1. Referral Hospital (level 6) [ ]
2. Regional Hospital (level 5) [ ]
3. County hospital (level 4) [ ]
4. Sub- County Hospital (level 4) [ ]
5. Health Centre (level 3) [ ]
6. Dispensary (level 2) [ ]
7. Private Health Hospital [ ]

8. Faith Based Health Facility [ ]

Statement	Response		Comments
	Yes	No	
1.0. Indicate the MNCH services provided by the facility (√-tick all that apply)			
1.1 Immunization			
1.2 Child Health			
1.3 Antenatal Care			
1.4 Maternity			
1.5 Clinical Laboratory			
1.6 Operative services			
1.7 Any Other (specify) _____ _____ _____ _____ _____ __			

1.8 Indicate type of essential obstetric care services provided by the facility. (Tick ppropriately)

1. Basic 2. Comphrehensive

Aspect	Response		If Yes, Functional?		Comment
	YES	NO	YES	NO	
What referral systems are available in this health facility?					
1.8.1 Ambulance (verify)					
1.8.2 Communication (verify):					
Telephone					
Emergency Hotline					
Radio system					
Other (specify)					

Aspect	Total # in health facility	# in ANC	# in maternity	# in PN/CWC	Remarks (eg. one personnel working in all depts mentioned)
2..0 Indicate the personnel who work in the health facility					
2.1 Gynaecologists					
2.2 Paediatricians					
2.3 Medical Doctors (general practitioners)					
2.4 Clinical Officers					
2.5 Nurses					
2.6 Pharmacist/ Pharmacy					

technicians					
2.7 laboratory technologists/technicians					

Aspect	# Present	#Absent	Reasons for absence
3.0 Staff Availability in the maternity			In Training Maternity/Sick Leave Official Mission On Leave Other (Specify)……

Aspect	Response		If Yes, Number
	YES	NO	
3.1 Are there any staff in the facility trained in the following areas of RH? (tick appropriately)			
3.1.1 EMONC – Emergency Obstetric and Newborn Care;			
3.1.2. PMTCT			
3.1.3 PAC – Post Abortion Care:			
3.1.4 FP – Family Planning;			
3.1.5 ARH – Adolescent Reproductive Health			
3.1.6 FANC – Focused Antenatal Care:			
3.1.7 IMCI-integrated management of childhood illnesses			
3.1.8 VIA/VILI – Visual inspection with acid /visual inspection with lugol's iodine			
3.1.9 Other (Specify)_____			
3.2. Do the staff in the department have CMEs?			If YES, How often? ----------
3.3. General observations and comments on staffing and training updates _____ _____			
4.0. ANC Clinic General Features	YES	NO	COMMENTS
4.1 Is the working space adequate?			
4.2 Is there adequate furniture?			
4.3 Is privacy guaranteed?			

4.4 What IEC/Reference materials are available?			
4.4.1Focus Antenatal Care (FANC) guidelines			
4.4.2 FP Guidelines			
4.4.3 Community Mid-wifery guidelines			
4.4.4 Others (specify) _____ _____			
4.5 Observe the waiting time for 3 mothers at the ANC before they are attended to by the nurse. (the time from when the mother arrived at the facility to when they were attended to by the HCW)			
1st mother _____(mins)			
2nd mother _____(mins)			
3rd mother _____(mins)			

4.6 Are the following equipments available and functional?			IF YES, FUNCTIONAL,.	
	YES	NO	YES	NO
4.6.1. BP machine				
4.6.2. Stethoscope				
4.6.3. Thermometer				
4.6.4. Weighing machine				
4.6.5. Fetoscope				

5. Are the following essential commodities currently available in the facility?	YES	NO	In the last 1 month have there been any stock outs.(YES=1, NO=2)	If Yes, how many days of stock out.
5.1 Iron/foliate supplements				
5.2 Vitamins supplements				
5.3 Malaria Prophylaxis				
5.4 Tetanus Toxoid				
5.5 HIV rapid test kits				
6. Family Planning; What family planning services does this facility offer?	YES	NO	COMEENT	
6.1 Male condoms				
6.2 Female condoms				
6.3 Oral contraceptives				
6.4 Emergency Contraceptive Pills				
6.5 Injectables				
6.6 Implants –(Norplant, IUCDs)				

4.6 Are the following equipments available and functional?			COMMENT
7. General Features maternity	YES	NO	
7.1 Are maternity in patient services offered 24hrs a day			
7.2 What service delivery guidelines/ or references are available in the maternity unit?			
7.2.1 Emergency Maternal Obstertric and New born care guidelines (EMONC)			
7.2.2 Focus Antenatal Care (FANC) guidelines			
7.2.3 FP Guidelines			
7.2.4 Community Mid-wifery guidelines			
7.2.5 IMCI guidelines			
7.2.6 IPC guidelines			
7.2.7 others specify)_____			
7.3 What Job Aids are available;			
7.3.1 New Born Resuscitation			
7.3.2 Immediate new born care			
7.3.3 The warm chain chart			
7.3.4 Active management of the third stage of labor (AMTSL) poster			
7.3.5 Kangaroo Mother Care			
7.3.6 Procedure on use of Vacuum Delivery			
7.3.7 $MgSO_4$ administration flow chart			
7.4 General cleanliness (observe & describe) _____			
Are the following amenities available?	YES	NO	FUNCTIONAL (1=YES, NO=2)

7.4.1 Toilet/s for the mothers?			
7.4.2 Bathroom for the mothers ?			
7.4.3 Running Water			
7.5 General arrangements (observe & describe): _____			
7.6 Furniture in the maternity ward	YES	NO	NUMBER
7.6.1 Beds			
7.6.2 Are there any mothers sharing beds			
7.6.3 Baby Cots			

8.0 Essential New Born Commodities	YES	NO	NUMBER
8.1 Is there a Nursery?			
8.2. A firm suitable surface (e.g.Table / resuscitaire) for newborn resuscitation			
8.3 Are there Incubators?			
8.4 Number functioning			
8.5 Other functional heat sources			
8.6 Working bag valve mask for newborn resuscitation			
8.7 Working and clean suction equipment for newborn resuscitation			
8.8 Are there disposable cord ties or clamps			
8.9 Availability of Towel or blanket to wrap baby			
8.10 High flow oxygen source (Cylinder with functional flow meter or wall oxygen).			
9.0 Delivery Essentials (check for the availability of following)			

9.1 Delivery packs?			
9.2 Episiotomy sets?			
9.3 Vacuum extractor?			
9.4 Manual vacuum aspiration (MVA) or dilation and curettage (D&C) kit ?			
9.5 Surgical sutures			
9.6 Is there an operating theatre?			
(If Yes, check for availability/function of all these aspects)			IF YES, FUNCTIONAL (1=YES, NO=2)
9.6.1 Operating table			
9.6.2 Operating light			
9.6.3 Anaesthesia-giving set			
9.6.4 Scrub area adjacent to or in operating room			
9.6.5 Tray/drum/package with sterilized instruments ready to use			
9.6.6 Halothane or ketamine			
9.6.7 Health worker who can perform caesarean section present or on call 24 hours/day			
9.6.8 Anaesthetist present or on call 24 hours/day			
Labour Ward, Delivery & PN ward			
9.7 Is there privacy in the labour ward?			
9.8 Are there delivery bed/s			(Number) ……
9.9 Are partographs available			
9.9.1 If Yes, are they in use			

(If Yes again)			
9.9.2 Sample 3 files from the delivery ward and/or Post natal ward and determine out of the 3 how many had the following in the partographs 1. Mothers bio data documented _____ /3 2. Foetal condition documented _____/3 3. Progress of labour (cervical dilatation and descent of foetal head documented _____/3 4. Maternal condition (vital signs documented) _____/3 5. Birth information recorded after delivery _____/3 *From the Post natal ward records, check if* 6. Baby examination was done and documented _____/3 7. Post natal mother examination was done & documented ____/3			
10. Infection Prevention Materials, Instrument Processing Equipment (Universal precautions) Are the following available:	YES	NO	COMMENT
10.1 Decontamination set			
10.2 Antiseptic lotion			
10.3 Detergents			
10.4 Chlorine (Jik)			
10.5 Containers for storage			
10. 6 Availability of Running Water			
10. 7 Availability of sharps containers			
10.8 Functioning Autoclave			
10.9 Functioning Boiler			
10.10 An incinerator			

10.11 A placenta Pit				
11. Are the following supplies available:				
11.1 Gloves				
11.2 Linen				
11.3 Cotton wool				
12. Are the following essential commodities currently available in the facility?	YES	NO	In the last 1 month any O/S (Yes=1, No=2)	If Yes, how many days of stock out.
12.1 Oxytocin injectable				
12.2 Magnesium sulphate injectable				
12.3 Ampicillin powder for injection				
12.4 Gentamycin injection				
12.5 Metronidazole injectable				
	YES	NO	In the last 1 month any O/S (Yes=1, No=2)	
12.6 Sodium Chloride Solution				

13. Reproductive Health	YES	NO	COMMENT
Does the facility offer the following services			
13.1 Post abortive care			

13.2 Breast cancer screening *If yes which ones*----------			
13.2.1 Clinical breast examination			
13.2.2 Mammography			
13.2.3 Ultrasound			
13.3 Cervical cancer screening *If yes which ones*----------			
13.3.1 Pap smear			
13.3.2 VIA/VILLI			
13.4 Youth friendly services			
14. Maternal Mortality			
14.1 How many maternal deaths occurred in the last 12 months? _____			
14.2 Of these, how many had maternal mortality audits conducted? _____			
15. Reports (monitoring and evaluation) & supervision	YES	NO	COMMENT
Are the following registers available?			
15.1.1 ANC Register			
15.1.2 Maternity Register			
15.1.3 PNC Register			
15.1.4 Other (Specify) : _____			
15.2 Does the facility prepare monthly summary reports? (verify)			
15.2.1 If Yes, name the last monthly summary report prepared			

15.3 In the last 3 months have you received any support supervision for your work?			
15.3.1 If Yes was this from ; 1. County level 2. National Level 3. Both	*Indicate the Code*		
15.4 What were some of the supervisor actions taken? (tick appropriately)			
15.4.1 Reviewed your records _____			
15.4.2 Provided verbal feedback_____			
15.4.3 Discussed problems_____			
15.4.4 Provided written documentation of their feedback (verify)_____			
15.4.5 Participated in quality of care improvement activities _____			
15.5 If there is no supervision received in the last 3 months, when was the last supervision (month/year)	Mon	Year	
16. FMS Programme			
16.1 Have you received reimbursement from the FMS programme in the last 6 months (Jan –Jun 2014)?			
16.2 If Yes, how much have you received? _____			
16.3 How many times have you received? (observe for evidence)			
16.4 Are there any reimbursements that have been missed			
16.5 If YES, what are the reasons for missing (tick appropriately)			
			Comments
16.5.1 No feedback from the FMS programme after submitting a report for reimbursement _____			
16.5.2 Reports for reimbursement not prepared _____			

16.5.3 Other reasons (specify): _____			

ANNEX 6: LIST OF KEY INFORMANTS [COUNTIES]

1. Maternity In Charge
2. Medical Superintendent, County director of Health, County chief executive health officer
3. Focus Group Discussions for Adults (Female and Male Groups) sampled from catchment areas of health facility

ANNEX 7: KEY INFORMANT GUIDE QUESTIONS (Health Facility level)
AN ASSESSMENT OF THE FREE MATERNITY SERVICES (FMS) PROGRAMME

Tool: Key Informant Interview Guide

(Maternity I/C, Medical Superintendant)

Purpose: The data collected from these interviews will support to describe the implementation of FMS programme and its effects on the health services delivery. In addition, the information gathered will be used to provide inputs for the development of the FMS policy and also provide recommendations for the effective and efficient implementation of the FMS programme.

Data Source: Interviews with Maternity in Charges, Medical Superintendents at sites that Maternities will have been assessed for readiness of maternity care.

Frequency: The data collector should interview one Maternity in Charge & one Medical Superintendent at <u>every third</u> site visited

Directions to the Data Collector *Before Beginning* – Provide an introduction to a possible participant (see "Introduction"). Next, verify that the participant is a Maternity in Charge or the Medical Superintendent who works in the facility. Then, read the "Informed Consent" section. Obtain informed consent (verbally) before you begin the interview. If verbal consent is received, move to an uncrowded and relatively quiet location to begin the interview. *During the Interview* –Use the digital recorder to record the conversation, once you have obtained consent. Also write key notes in your notebook. **Estimated Time: 1 hour**
<u>Introductions</u> • I am here today with my colleagues working on a project that will be assessing the effects of implementing the FMS programme which is part of the Ministry of Health. • We are collecting information to learn how the implementation process has progressed and the effects on the quality of health care • We are interested in hearing from those who are directly involved with this programme

<u>Meeting Selection Criteria</u> Are you the maternity I/C or Medical Superintendent of this health facility? (This could also be those who usually play the	*Yes → Proceed* *No → Please ask if he/she can direct you to the appropriate individual.*

role of acting for these positions when need arises)	
Informed Consent: Are you willing to participate in a short interview with me, in which we will discuss FMS implementation, its effects on quality of care, challenges and possible solutions for improvement? The questions asked will be about your thoughts and opinions on these issues. There are no right or wrong answers. Your responses will remain anonymous. Your participation is completely voluntary. You may choose to stop answering at any point. Your participation, and the answers you provide, will not impact your job in any way. The interview should last approximately 1 hour.	*Yes → Proceed with questionnaire.* *No →* ***Do not begin interview.*** *Please ask if he/she has a colleague that would be able to discuss these issues.*
Turn on the Voice Recorder. *Record the following information on the voice recorder, and in your notebook:* - *Interview number* - *Name of Sub-County* - *Name of Health Facility*	

Sample Key informants from both public and the private sector.

MATERNITY IN CHARGE

1. Describe what has changed after the introduction of the FMS.
2. How adequately are maternal services provided in the facility?
   - Staffing; adequacy of numbers and appropriate cadre,
   - service delivery skills, guidelines/job aids,
   - support supervision (supervisor reviewed their records, provided verbal feedback, and discuss problems, provided written documentation of their feedback to the health workers, supervisor participate in quality of care improvement activities
   - Essential maternal & neonatal supplies/commodities including stock-outs,
   - Laboratory services,

- Space , adequacy, privacy
- Essential equipment; availability, functioning, (ANC, L&D, PNC)
- referral system, what is available and functionality

3. Challenges experienced?
4. What opportunities for improvement of FMS would you suggest?

Medical Superintendent

1. When did you start implementing the FMS policy in your institution? What services are covered under this policy?
2. Describe the processes involved to accomplish implementation of FMS between you and the County government and also between you and the fore-front service providers.
3. Probe about,
   - Maternal mortality audits
   - Supervisory visits
   - Functioning work place health and safety committees
   - Functioning infection prevention committee
   - Functioning work/quality improvement in place Exit interviews for clients, suggestion box for the HCWs and for the public, dispute resolution management.
   - Community outreach to promote services

4. What maternal service related changes have you observed so far? (Utilization of service, supplies, human resource, emergencies, …..).
5. What challenges have you encountered so far?
6. Suggestions for improvement.