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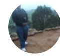

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Local perspectives on policy implementation of free maternity health services in Kenya: Implications for universal health coverage

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Abstract

Kenya introduced free maternity services (FMS) in 2013 to enable all pregnant women to give birth for free in all government public health facilities. Currently, Kenya is rolling out universal health coverage (UHC), which has been acknowledged as a priority goal for every health system and part of the 'Big Four Agenda' for sustainable national development in Kenya. FMS is one of the core services in Kenya, but since its launch, it is not clear whether the decentralized approach chosen to implement FMS is leading to UHC. This nine-month ethnographic study in Kilifi County, Kenya, was conducted between March-July 2016 and February-July 2017. A narrative approach to analysis was applied. In this article, we interrogate local perceptions of participation during the crafting and implementation of FMS. Findings show that FMS was detached from local realities, and this was a major inadequacy of the top to bottom approach. FMS did not consider local power relations and bargaining power which are requisites during policy formulation and implementation. The participants expressed desire for more localized control over resources from the national government. The findings suggest that as UHC is rolled out in Kenya, consultation of local stakeholders at the grassroots by the state departments would likely improve maternal healthcare outcomes. Such consultations must take into consideration differences in bargaining power and local power relations. Borrowing from the basic tenets of the recent anthropological theorization of constitutionality, this article proposes a bottom to top approach that leverages and integrates local views during policy-making process to create trust, a sense of ownership and accountability. *(Afr J Reprod Health 2023; 27 [5s]: 71-81).*

Keywords: Anthropology, bottom-up, free maternity services, Kilifi county, maternal health services, participation, qualitative study, universal health coverage

Résumé

Le Kenya a introduit des services de maternité gratuits (FMS) en 2013 pour permettre à toutes les femmes enceintes d'accoucher gratuitement dans tous les établissements de santé publique du gouvernement. Actuellement, le Kenya déploie la couverture sanitaire universelle (CSU), qui a été reconnue comme un objectif prioritaire pour chaque système de santé et fait partie du « Big Four Agenda » pour le développement national durable au Kenya. Le FMS est l'un des services de base au Kenya, mais depuis son lancement, il n'est pas clair si l'approche décentralisée choisie pour mettre en œuvre le FMS mène à la CSU. Cette étude ethnographique de neuf mois dans le comté de Kilifi, au Kenya, a été menée entre mars-juillet 2016 et février-juillet 2017. Une approche narrative de l'analyse a été appliquée. Dans cet article, nous interrogeons les perceptions locales de la participation lors de l'élaboration et de la mise en œuvre du FMS. Les résultats montrent que le FMS était détaché des réalités locales, ce qui constituait une insuffisance majeure de l'approche du haut vers le bas. Le FMS n'a pas pris en compte les relations de pouvoir locales et le pouvoir de négociation qui sont indispensables lors de la formulation et de la mise en œuvre des politiques. Les participants ont exprimé le souhait d'un contrôle plus localisé des ressources par le gouvernement national. Les résultats suggèrent qu'à mesure que la CSU est déployée au Kenya, la consultation des parties prenantes locales à la base par les départements de l'État améliorerait probablement les résultats des soins de santé maternelle. Ces consultations doivent tenir compte des différences de pouvoir de négociation et des relations de pouvoir locales. Empruntant aux principes de base de la récente théorisation anthropologique de la constitutionnalité, cet article propose une approche ascendante qui exploite et intègre les points de vue locaux au cours du processus d'élaboration des politiques pour créer la confiance, un sentiment d'appropriation et de responsabilité. *(Afr J Reprod Health 2023; 27 [5s]: 71-81).*

Mots-clés: Anthropologie, ascendant, services de maternité gratuits, comté de Kilifi, services de santé maternelle, participation, étude qualitative, couverture sanitaire universelle

Introduction

Local perceptions of health risk and prevention influence an individual's decision-making and choices to use biomedical health services[1,2]. However, the biomedical models of health do not necessarily account for the impact of the cultural factors (i.e., beliefs, values, and gender) that shape reproductive behaviour and practices. Cultural beliefs shape a range of factors that affect reproductive health, including fertility patterns, contraceptive use, maternal health-seeking behaviour, and choice of a birth attendant[3,4]. User fee exemption programmes have been implemented in certain low- and middle-income countries to improve the populations' access to healthcare services[5]. Community participation in priority setting in healthcare policy development has gained importance worldwide. Studies in Africa show that incorporating public views into priority setting restores trust, improves accountability, and secures cost-effective healthcare priorities[6,7]. Moreover, evidence abound that suggests that the greatest challenge is to ensure that the right participants are engaged in public processes in the development of healthcare policy[8]. Furthermore, Salter[8] explains that community participation in policy is underpinned by shared values, understanding of 'the rules of the game,' trust between its members, and an acceptance that cooperation is the best way to achieve common goals. Therefore, it is easier for community members to engage in all policy processes which include agenda-setting, evaluation of alternatives, policy formulation, implementation, and evaluation[9].

Healthcare in Kenya is financed from four primary sources: insurance (private and public) out of pocket expenditure (households), government expenditure, and donor funding [10]. Kenya introduced user fees in public health facilities since the 1980s[11]. User fees for outpatient care were suspended in 1990 due to equity concerns[12] and re-introduced in 1992. In 2013, following a presidential policy directive, Free Maternity Services (FMS) was introduced in all public health facilities. The FMS policy was financed by the National Government. Under the programme, primary healthcare facilities (PHCFs), were reimbursed Ksh2500.00 ($27.70) for every delivery, whereas the sub-county hospitals were reimbursed KSh5000.00 ($55.60) for every delivery, normal or caesarean[13]. These funds were paid directly to the facilities[13]. In **October 2016,** the National Government unveiled an expanded free maternity care programme dubbed *"Linda Mama"*[14]. The programme was managed by national hospital insurance fund (NHIF), to increase the efficiency of processing and payment of claims[15]. It provided a package of essential health services for pregnant women accessed by all in the targeted population based on need and not the ability to pay[16]. *Linda mama's* goal is to achieve universal access to maternal and child health services and contribute to the country's progress towards Universal Health Coverage (UHC)[14,17].

Several studies have been conducted in Kenya since the implementation of FMS. They mainly focused on: implementation and effects of FMS, the cost and impacts of user fees and the demand for free maternity in Kenya[18–21]. The studies showed that as much as there was a high demand for FMS, reducing barriers to access through FMS utilization was critical for improving maternal health. However, despite FMS reducing barriers to access, it was unclear which services were free, it did not cater for transport to and from health facilities, women had to pay for laboratory fees and in most cases buy supplies for delivery. Such unclear policies led to poor service quality[18].

The rise of universal health coverage (UHC) as a global policy endorsed in the Sustainable Development Goals (SGDs) appears to signal new directions in global health as it introduces a progressive language of inclusion, solidarity and social justice and advocates the right of 'everyone' to access the healthcare they need 'without financial hardship'[22]. Kenya has made progress towards universal health coverage as evidenced in the various policy initiatives and reforms that have been implemented in the country since independence[23]. According to Chuma and Okugu[24], the debate on making healthcare more accessible and equitable to all in Kenya and other sub-Saharan African countries has gained momentum in the recent past. This is evidenced in the current efforts to pilot and expand UHC in Kenya and other countries in sub-Saharan Africa as a step towards addressing inequity in access to health services[23,25]. As a core focus of the Sustainable Development Goals (SDGs), universal access to health services is a key priority in Goal 3

which aims to 'ensure healthy lives and promote the well-being for all at all ages'[26]. UHC has two main goals: enhance financial risk protection and increase access to needed care for citizens[22,26]. According to the World Health Organization[27], achieving these goals require governments' proper prioritization, budgeting and offering financial risk protection between the wealthiest and poorest, the healthy, and those that are ill[28]. In 2017, UHC was identified as one of the four pillars of Kenya's vision 2030 plan for socio-economic growth, with the aspirations of achieving full population coverage, subsidizing all costs for essential health services and cutting out-of-pocket medical expenses for households to half by 2022[29].

An earlier and recent studies in Kenya[22,30] revealed that healthcare contributions were regressive and the poor contributed a more substantial proportion of their income to healthcare than the rich, hence experiencing a disproportionately higher share of the household income spending on health. Furthermore, Chuma and Maina[31] reported that many health systems in Africa were funded primarily through out-of-pocket payments. Such out-of-pocket costs prevented people from seeking care, resulting in more severe disease and consecutive catastrophic health spending. and can cause households to slide deeper into poverty[32]. Thus, Chuma and Maina[33] referred to this situation as a "medical poverty trap," which negates the objectives of achieving UHC.

In the past two decades, Kenya has made remarkable progress towards reducing mortality rates and improving the coverage of health services[34]. Despite Kenya's success in reducing maternal mortality, considerable inequities in the uptake of health services and health outcomes continue to exist within the country[34]. Kenya is one of the many African countries committed to advancing its health system reforms by providing affordable and equitable access to essential health services. Kenya recorded an increase in facility-based deliveries from 44% in 2008 to 61% in 2015[35]. This increase has been partly attributed to the FMS policy introduced in June 2013[36]. Despite such increase in facility deliveries, studies have shown that following political expediency, FMS was hurriedly implemented and characterised by inadequate engagement of the public and various stakeholders. This hindered the successful implementation of the policy by different stakeholders[37,38].

For instance, Meessen *et al*[39] noted that for good practice in formulating reforms, involving stakeholders (elected officials, individual citizens, appointed officials, and members of interest groups) is essential in the process and also crucial for the successful implementation of a policy. Local participation increases the likelihood that a public health policy will be culturally and educationally appropriate; its format and content will better fit the cultural systems of the community[40,41]. The evidence suggests that adapting these principles of community participation to research in sub-Saharan Africa will help address the root causes of public health problems and find sustainable, culturally appropriate solutions[42]. In this manner, local communities and their civil representatives are better positioned to address public health issues important to the community and create sustainable interventions and solutions to key issues affecting them[42]. However, there is a dearth of information on how the local people perceived how their participation in the crafting of maternal healthcare policies can be vital for the realization of UHC in Kenya, a gap that this paper aims to address.

This paper draws on the theory of constitutionality as bottom-up institution-building processes that emphasize local stakeholders' views to inform priority-setting, which in the long run brings about a sense of ownership of such institutions. In this approach, the bargaining-power is crucial because local communities are heterogeneous in terms of internal power distribution and often characterized by a relative lack of power in dealing with outside stakeholders, whether the state or immigrants[43,44]. We use the basic tenets of constitutionality to explain possible ways of making FMS more accessible to the mothers and how this could be a potential catalyst in achieving UHC in Kenya. The paper explores how bottom-up institution-building approaches as framed in other fields (i.e., resource management) can also be fruitfully used in the context of health policy implementation to promote implementation of UHC in low and middle income countries.

Methods

Study setting

This study was conducted in Kilifi County in Coastal Kenya. Kilifi is classified as an arid and semi-arid area. Over 65% of Kilifi residents face seasonal water shortages with droughts and floods compromising productivity and food security. The county's dependency ratio stands at 101.45 per cent. It has high poverty estimated at 66.7% and widespread food insecurity affecting approximately 67% of the households. Majority of the population is rural-based[35]. The predominant community is the Giriama sub-tribe of the larger MijiKenda community. The primary source of livelihood for the Giriama is subsistence agriculture supplemented by wage labour in the salt mines, small trade, cashew nuts, palm wine business, and animal husbandry. Kilifi is among the top 15 contributing to the country's maternal and perinatal death burden[45]. Kenya's maternal mortality rate is still high at 342 per 100,000, while Kilifi County has a mortality rate of 289 per 100,000[35].

Study design

This qualitative study was part of a larger interdisciplinary research project called *Inclusive growth through Social Protection in maternal health programs in Kenya* (SPIKE). Data for this paper is based on one of the key themes (local participation during policy crafting) from the broader objective for this study on local perceptions of social protection schemes. The study explored emic perspectives of participation in crafting FMS policy and lessons that can be drawn to inform the rollout of UHC in Kenya. The nine-month longitudinal study was conducted among the Giriama people in Kilifi County.

Sample selection and data collection methods

The study was conducted between March-July 2016 and February-July 2017 to enable long-term exploration and interaction with indigent mothers in the health facility and household settings in Kilifi County. Purposive sampling was used to recruit the study participants. The inclusion criteria included being a pregnant mother or having delivered six months before the study, and women aged between 18-45 years. Women who met these criteria were purposefully selected and recruited at the public health facilities. Health officials concerned with maternal and child health who had been in management positions for the year preceding the study were interviewed. The first author conducted a total of 40 in-depth interviews with mothers in the health facilities. The poor mothers (see table 1) were interviewed one-on-one in the healthfacility and also in their homes. A total of 10 key informant interviews with matrons in-charge of maternal and child health clinics. The matrons were purposively selected. They were experts on issues of maternal and child health. Thus their opinion on the implementation of free maternity services was valuable. Six focus group discussions (FGDs)with 6 to 9 mothers were also conducted by SO and a trained local female research assistant in the villages. All FGDs were conducted in Swahili. The FGDs were audio recorded and transcribed by SO. The female research assistant helped in takig notes during the discussions. Since SO was fluent in Kiswahili, the language of this region, he was able to work in the original Kiswahili text. The interview transcripts were reviewed for accuracy by all the authors. Coding Participant observations were conducted in the health facilities. The four round-table discussions:- two with mothers at the health centers and two with county health officials at the county health boardroom. Each round-table discussions had four participants. Moreover, the first author conducted informal conversations with community members. The interviews explored local perceptions of social protection schemes in maternal health in Kenya.

Data analysis and presentation

Two main approaches to qualitative data analysis were used: a) the hermeneutic analysis of the ethnographic data, and b) content analysis of the interviews[46]. Transcription was done by the first author (SO) using a computer-aided transcription software (F5 transcription-free). Coding was done manually. SO, and the second author (TH) read the transcripts repeatedly to identify and list inductive codes. Informal conversations written in notebooks by the first author were also coded and included in the analysis. All authors discussed the identified codes to tease out themes for the entire study. Data analysis stopped when no new themes emerging

Table 1: The Socio-demographic characteristics of women interviewed

Age	Frequency	Level of education	Source of livelihood
18-28	14	Primary	Palm wine tapping and peasant farming
29-39	18	primary	Fish mongering and peasant farming
40-50	8	secondary	Peasant farming and fish mongering

Source (Author fieldwork notes, 2017)

from the analysis. The findings are presented in textual descriptions. The authors discussed the results of this study with various stakeholders concerned with healthcare for validation before the final dissemination process.

Ethical considerations

The research participants were informed of the nature of the study. That participation in the study was entirely voluntary, and they could withdraw from the study during interviews anytime they wished. Signed informed consent was obtained from all participants. Respect for human privacy and dignity was maintained throughout the data collection and analysis process. No participants declined to participate or withdrew from the study. Ethical approval was obtained from Maseno University Ethical Review Committee- reference number MSU/DRPI/MUERC/00206/015.

Results

Several themes emerged in this study to explain the emic perspectives of participation during the crafting of FMS policy and the implications to the UHC implementation in Kenya. They include: lack of local consultations; aligning policies to the local realities; inadequacies of top-down priority setting; and the need to understand local power relations and bargaining power.

Representativity creates a sense of trust and ownership of the policy

> *Neglecting people's needs and expectations may make healthcare services less relevant to the communities they serve. Yes, we hear there is FMS but again, not all women get the services because some stay far from the hospital. But if at all the community members are consulted and represented, I believe they can tell the government other better ways that may make all women go to the hospital to give birth (Informal conversation with a village elder May 2017Msee wa Zidi Village).*

The quote above stems from an informal conversation with a village elder in the study area. It demonstrates the need for local representation in crafting health policies. The local community members argued that one major drawback of implementing FMS as a social protection program was the lack of representation.

Moreover, from the discussions it emerged that the bottom-up approach should be a continuous process. The participants also said they wanted to have more localized control over resources from the national government through effective representation. A village headman thus noted:

> *The community members will never allow anybody to joke with resources meant to help mothers because the community has a sense of ownership if such policies have people's voices……. This should be a continuous process of educating the people (An informal conversation with the village headman).*
> *A health worker added that:*
> *If at all, we engage community members continuously…for instance, we have been involving community health volunteers during maternity health talks with mothers in the hospital and today most mothers know their right in the maternity and have changed their attitude toward free maternity (KII, Matron 06 in-Charge MCH, Kilifi county).*

Lack of local consultations

According to the participants, policymaking and discussions about FMS should incorporate people's most felt needs. These needs ought to correspond to their norms and values since this would lead to a 'local sense of ownership' of policies by the people. Many respondents felt that their opinions were ignored in this process. Participants argued that it is crucial to understand things from an insider's perspective and not just

from the national government's point of view when formulating health policies. As a result, the locals perceived the free maternity policy as the president's idea. The issue of not keeping promises in FMS context made people feel they were lied to by the government, which violated trust.

> *But why did the government lie to us, the free maternity was for getting votes, we were not even consulted on which services ought to be free. It is only for delivery (FGD participant, April 2017).*

The policy detached from the local realities

The study participants argued that FMS policy did not conform to local realities. For instance, pregnant women still experienced out-of-pocket expenditures. Additionally, there were still stikes among healthcare providers. Our informants thus explained.

> *If we say we are benefiting from free maternity, then we might lie because other women suffer like us……. I feel the policy is detached from realities on the ground. For example, we pay for laboratory fees, we buy cotton wool and other supplies during delivery and even medicine (FGD participant, May 2017).*
>
> *Free maternity has hurdles and some community members don't buy the idea of hospital delivery because it conflicts with realities on the ground, I mean the people are so poor that free is still expensive for them. In reality free maternity does not cater for laboratory test, medicine, transport to health facility and X-ray fees………. Healthcare providers have to strike for the government to listen to them even as we thought the free maternity policy will make things better for healthcare providers' welfare (Roundtable discussion with county health team officials).*

Inadequacies of top-down priority setting

During informal conversations at the health facilities, many health workers reiterated that things have been difficult since the devolution of healthcare. The county prioritizes issues that did not meet people's needs. According to the study participants, the county government did not include the local needs because of top-down priority setting by the county health management. In some cases, health workers received equipment and no human resources or experts to operate the equipment, and mothers did not get the services.

> *But the county prioritizes buying equipment that does not help us since we don't have experts to operate those machines then they are not helping mothers …as health providers, it is difficult to reject what the county has given the hospital (KII, Matron 04 in-Charge MCH).*

With regard to the decentralization of the health system, top-down priority setting should be reduced. However, this is not what respondents experienced:

> *Decentralization of government services came with merits and demerits, they decide on what to give hospitals and nobody questions when the new machinery and equipment are brought to the hospital because they were not involved in any process (Informal conversation with a female health worker).*

Local power relations and bargaining power is requisite

A lack of understanding of local power relations emerged as one of the leading errors in the reform processes of maternal healthcare services provision with the FMS. This led to confusion of the obligations of each stakeholder in the health system. In as much as there is a need to include local insider's views when formulating healthcare policies, it is also essential to recognize that there exist different power relations and bargaining power at interplay that can lead to adoption or rejection of healthcare policies at a local level. A key informant said:

> *When we are threatened or undermined by the bosses, who are we to say no? You know these policies are made up there, and we have to implement them whether they are good or bad (KII, Matron 01 in-Charge MCH).*

Local poor women who had low bargaining power could also not negotiate to get some of the services through FMS while rich women who had higher bargaining power could easily re-negotiate for better healthcare services. This is illustrated in the quote below:

> *I cannot argue with doctors when they say I am to pay for medicine or antenatal book I just pay, but I know these things are supposed to be free for expectant mothers. But here I see rich women argue with the nurses and get what they*

want, I doubt if they also pay (In-depth interview with mother aged 34 Years old).

Apart from power asymmetry, the study participants also highlighted the roles the bargaining power of different stakeholders play in bottom-up institution-building. The ability of an individual to access good healthcare is based on their economic or social status. Such economic or social status can make the local community accept, modify, maintain, or reject the existing institutions depending on their involvement during policy crafting. For instance:-

Implementing a maternal health policy has never been easy. You cannot ignore that we have different abilities to get access to healthcare. Rich women get better services than the poor because they can buy essentials when needed compared to the poor who cannot. But all these depend on how one is well empowered and better understand how the system works (Roundtable discussion with county health team officials).

Discussion

Varying dimensions of the bottom-up approach in free maternity at different societal levels emerged as the possible requisite for achieving UHC in Kenya. In this section, the key themes are discussed. Participation of community members in healthcare is not new[47]. Community participation in the health system has been a critical component of many rights-based health policies. Findings from this study show that communities' views are essential during crafting of policies to express their genuine concerns. Our findings corroborate various reports[40–42] which indicate that community participation would increase the likelihood that a policy will appropriately conform to local realities. Further reports[48,49], show that representation is a requisite in such participation and increases health policy adoption. This means that having community representation in overseeing the policy crafting will build knowledge and positive attitudes towards FMS compared to how the policy was rolled out as a presidential directive.

The lack of consultations during the formulation of FMS rendered the policy viewed by local people as a 'president's' idea with a clear political intention, which was labelled as a political tool that endedup fulfilling the politicians' interests. This is what James Ferguson refered to as anti-politics machine[50]. The findings concur with other reports[15,37], which noted that the lack of consultation made FMS policy to be understood and interpreted differently among stakeholders leading to poor implementation. However, when community members share their needs and challenges, there will be a more holistic, complex and interrelated experience with health policies[51]. Rifkin[52] argued that consultation with local people should be undertaken to ensure better acceptability and sustainability of the programme. Our findings resonate with those of Gilson[53] which suggest that 'trust' is essential in the process of institutional building. People value health systems not only for the care they receive in times of sickness but also for the contribution the systems make to the broader well-being of society[53]. Therefore, for UHC to be successful through FMS, there is important and critical that policymakers are aware of the healthcare priorities of local communities. Emic perspectives would be required in such an approach. Involving the local people in overseeing the FMS policy would strengthen local trust in politically aligned programmes and locally owned through non-political means.

Our study shows that the FMS were never 'free'. Studies in Bangladesh[54], Uganda[55], and Tanzania[56] also noted that FMS were never 'free'. Other studies have also shown that FMS was detached from local realities as women still experienced out-of-pocket expenditures[57,58]. Therefore, when locals are involved in policy crafting, measures need to be put in place to eliminate payments to enable all categories of women to benefit from the services on an equal and equitable basis. Moreover, the findings also concur with recent study by[22] which explored how 'ordinary citizens' (mwananchi) experienced and evaluated recent moves by the government to expand access to healthcare, which included reforming NHIF coverage and offering free healthcare services. These developments, clothed in a language of universality and solidarity, generated hopeful expectations for more inclusive healthcare. Yet they encountered a historically fragmented healthcare system, shaped by forms of exclusion and differentiation, a politics of patronage, and class inequalities, all of which worked against universal access[59]. Contradictions between promises of inclusion and realities of exclusion drew people's attention to entrenched

forms of neglect, failure, and differentiation, leading them to raise questions about rights to healthcare, state responsibility, solidarity and growing class inequality[59,60].

The results also show that there were inadequacies of FMS's top-down priority setting. The findings suggest that a bottom-up approach in FMS policy crafting should consider people's views. This can be essential during UHC implementation. Our findings echo the WHO's recommendations that active community participation should be promoted during the development and implementation of interventions to improve maternal and child health explicitly (MCH) outcomes[27]. Dalinjong *et al*[61] argue that when externally driven agendas are resisted locally, they should be reworked to accommodate local views, needs, and aspirations. This calls for local participation. Just as Haller *et al*[62]; described the importance of a bottom-up approach in natural resource management, based on the current study's findings, we also argue that when community members participate during maternal health institution-building process, they become part of collective efforts to assess health needs, collaborate with others, and evaluate the reform of healthcare programs. This will likely increase transparency in the management of free maternity services in Kenya and the implementation of UHC.

Ensminger[63] and other scholars emphasized the importance of bargaining up approaches that obtain information on health needs and priorities of the local communities are not common in Kenya[51]. This approach values the emic perspective and allows problems to be explored from the people's perspectives. Furthermore, a combination of insider and outsider knowledge can enhance the validity of research findings[64]. From this study, the bargaining power of women affected the way each re-negotiated the rules to gain a perceived better healthcare. Poor women with low bargaining power were exploited compared to rich women with high bargaining power. Re-negotiation is a key element of constitutionality, which, in turn, can contribute to more viable use of FMS[44]. Fourie[65] argued that when policies are codified, participation can move away from being controlled by a few influential individuals, providing a right of involvement to the marginalized and, in turn, ensuring sustainable representation. Due to variations in power relations, the role of state stakeholders in the process of constitutionality remains crucial to realize a balance between devolved governance in Kenya and an encompassing state framework that accommodates such institutional decision-making and crafting at local levels, in accord with such principles as devolution, legal pluralism, and subsidiarity[44]. We have shown in this study that making maternal healthcare policy more participatory would propel the attainment of UHC; we therefore argue that bottom-up approach could be a potential for long-term sustainable health policies.

Conclusion

This paper is majorly a reflection on the crafting and implementation of FMS in Kenya. The inclusion of universal health coverage in the Sustainable Development Goals has been acknowledged to be a move towards materialising promises of substantive citizenship based on entitlement to healthcare and social protection. This study provides lessons from emic perspectives on how to make UHC in Kenya more accessible. Lack of consultation of health services providers and the service beneficiaries made free maternity policy detached from local realities that free maternity services still excluded the poor mothers. Therefore, such failures of the top-down approach to policy decision-making trigger the push for a bottom-up approach. In this paper, we propose that for the success of UHC in Kenya, it would be appropriate to adopt a bottom-up approach that considers realities on the ground, dynamics of local power relations, bargaining power and the involvement of the local stakeholders. This would be appropriate as it gives local people a voice. Letting the community share their needs and challenges provides a more holistic, sophisticated and interrelated experience in crafting institutions that would create a sense of ownership and propel the sustainable realization of UHC in Kenya.

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Ethical clearance

Permission to proceed with the study and guarantee respect for human subjects was obtained from the National Commission for Science, Technology and Innovation (NACOSTI) and an introduction letter from the county health office. Ethical approval was obtained from Maseno University Ethical Review Committee- reference number MSU/DRPI/MUERC/00206/015.

Competing interests

The authors declare that there are no competing interests.

Contribution of authors

The main researcher (first author) was a PhD student in this multidisciplinary project. He is currently a postdoctoral fellow at the Centre for the Advancement of Scholarship, University of Pretoria. The first author conducted the ethnographic study and drafted this manuscript. The co-authors include national and international social anthropologists and an international public health specialist. The co-authors participated actively in data analysis and manuscript revision. All authors mentioned in this article approved the manuscript.

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