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Defunding the Linda Mama Programme: A Threat to Women's Access to Pre and Post Natal Care in Kenya

Keywords: women's rights in Kenya, Pre and Post Natal Care in Kenya, Linda Mama Programme

Summary. It can be said that it is indeed magical to bring life into the earth. Nonetheless, this remains a daydream for a significant number of mothers, as global statistics estimate a global maternal mortality ratio (MMR) of 223 deaths per 100,000 live births. This falls crucially below the SDGs target of 70 deaths/100,000 live births by 2030. In Kenya, the MMR still falls below the SDGs target, as it stands at 362 deaths/100,000 live births.

Recognising Kenya's international and constitutional mandate to realise the right to the highest attainable standard of health, Kenya in 2013, initiated a free maternal programme, Linda Mama. Implemented under the National Health and Insurance Fund (NHIF), the scheme ensured that each expectant mother is covered for a period of twelve months after confirmation of pregnancy and is entitled to antenatal care, skilled delivery and postnatal care. This programme was intended to benefit the vulnerable and reduce inequalities in access to pre and postnatal care, eventually reducing Kenya's MMR. Albeit riddled with various implementation challenges, the number of skilled deliveries continues to rise, and current public health facilities are handling over one million deliveries, translating to a 78.3% increase in accessibility to pre and postnatal care.

The fate of the Programme, however, hangs on a risky balance due to the impending implementation of the new Social Health Insurance Fund (SHIF). This initiative, part of the current government's Bottom-Up Economic Agenda, aims to target household contributions rather than the salaried employee contribution in the NHIF. Consequently, the schemes and programmes currently run under the NHIF, including the Linda Mama Programme, have been terminated. Despite assurances promising that pregnant women will be well catered for under the SHIF, the abrupt defunding of the Programme before the roll-out of SHIF poses a great risk to the life of the mother and baby who may be unable to access pre- and post-natal care due to financial constraints.

This paper thus investigates the threat posed to women's right to access pre and postnatal care amidst the abrupt defunding of the Linda Mama Programme. It argues that the defunding of the programme is a regressive action towards the State's international and constitutional obligations to fulfil and promote not only the right to women's access to reproductive healthcare but also the right to life and gender equality commitments. Moreover, the paper argues the shift to the SHIF, albeit with the aim of increasing the base of contribution to the public health insurance scheme, embarks on the use of the Means Testing Instrument (MTI) which fails to consider the financial realities of

women in Kenya, especially those from vulnerable and marginalised communities whose access to pre and postnatal care may be inhibited due to inadequate funds. To add, the paper proposes that rather than the abrupt defunding of the programme, the State should find mechanisms of making its access more efficient under the new SHIF programme to ensure that Kenya does not slack in its commitment to achieve the SDGs target of the global MMR.

Zakończenie finansowania programu Linda Mama: Zagrożenie dla dostępu kobiet do opieki przedporodowej i poporodowej w Kenii

Słowa kluczowe: prawa kobiet w Kenii, opieka przedporodowa i poporodowa w Kenii, program Linda Mama

Streszczenie. Można powiedzieć, że dawanie życia na świat to prawdziwa magia. Niemniej jednak, dla znacznej liczby matek pozostaje to jedynie marzeniem, ponieważ globalne statystyki szacują globalny współczynnik umieralności matek (MMR) na 223 zgony na 100 000 żywych urodzeń. Jest to wynik znacznie poniżej celu zrównoważonego rozwoju, który zakłada 70 zgonów na 100 000 żywych urodzeń do 2030 r. W Kenii MMR nadal jest poniżej celu zrównoważonego rozwoju, ponieważ wynosi 362 zgony na 100 000 żywych urodzeń.

Uznając międzynarodowy i konstytucyjny mandat Kenii do realizacji prawa do najwyższego możliwego poziomu opieki zdrowotnej, w 2013 r. Kenia zainicjowała bezpłatny program opieki macierzyńskiej Linda Mama. Program, realizowany w ramach Narodowego Funduszu Zdrowia i Ubezpieczeń (NHIF), zapewniał każdej kobiecie w ciąży ubezpieczenie przez okres dwunastu miesięcy od potwierdzenia ciąży oraz prawo do opieki prenatalnej, porodu z udziałem wykwalifikowanego personelu oraz opieki poporodowej. Celem programu było przyniesienie korzyści osobom w trudnej sytuacji i zmniejszenie nierówności w dostępie do opieki prenatalnej i poporodowej, co ostatecznie doprowadziło do obniżenia wskaźnika MMR w Kenii. Pomimo licznych wyzwań związanych z wdrażaniem, liczba porodów z udziałem wykwalifikowanego personelu stale rośnie, a obecne publiczne placówki zdrowia obsługują ponad milion porodów, co przekłada się na 78,3% wzrost dostępności opieki prenatalnej i poporodowej.

Los programu wisi jednak na włosku ze względu na zbliżające się wdrożenie nowego Funduszu Ubezpieczeń Zdrowotnych Społecznych (SHIF). Inicjatywa ta, będąca częścią rządowej Agendy Ekonomicznej Oddolnego, ma na celu ukierunkowanie składek gospodarstw domowych, a nie składek pracowników etatowych na NHIF. W związku z tym programy i programy realizowane obecnie w ramach NHIF, w tym Program Linda Mama, zostały zakończone. Pomimo zapewnień, że kobiety w ciąży będą dobrze zaopiekowane w ramach SHIF, nagłe wstrzymanie finansowania programu przed jego uruchomieniem stanowi poważne zagrożenie dla życia matki i dziecka, które mogą nie mieć dostępu do opieki przedporodowej i poporodowej z powodu ograniczeń finansowych.

Niniejszy artykuł analizuje zatem zagrożenie dla prawa kobiet do dostępu do opieki przedporodowej i poporodowej w związku z nagłym wstrzymaniem finansowania programu Linda Mama. Autorzy artykułu argumentują, że wstrzymanie finansowania programu jest działaniem regresywnym wobec międzynarodowych i konstytucyjnych zobowiązań państwa do wypełniania i promowania nie tylko prawa kobiet do dostępu do opieki zdrowotnej w zakresie zdrowia reprodukcyjnego, ale także prawa do życia i zobowiązań dotyczących równości płci. Ponadto, w dokumencie argumentuje się, że przejście na SHIF, choć w celu zwiększenia podstawy składki na publiczny system ubezpieczeń zdrowotnych, opiera się na wykorzystaniu Instrumentu Badania Dochodów (MTI), który nie uwzględnia realiów finansowych kobiet w Kenii, zwłaszcza tych z wrażliwych i zmarginalizowanych społeczności, których dostęp do opieki przedporodowej i poporodowej może być utrudniony z powodu niewystarczających funduszy. Ponadto, w dokumencie proponuje się, aby zamiast nagłego wstrzymania finansowania programu, państwo znalazło mechanizmy usprawniające dostęp do niego

w ramach nowego programu SHIF, aby zapewnić, że Kenia nie zrezygnuje ze swojego zobowiązania do osiągnięcia Celów Zrównoważonego Rozwoju, jakim jest globalny wskaźnik MMR.

1.0. Introduction

According to statistics from the Ministry of Health, approximately 830 women die each day from preventable conditions related to pregnancy and childbirth, with 99% of these deaths occurring in developing countries[1]. The primary causes—severe bleeding, puerperal infections, preeclampsia and eclampsia, delivery complications, and unsafe abortions—constitute nearly 75% of maternal fatalities[2]. Further, Maternal mortality remains unacceptably high in Kenya, with 362 mothers dying per 100,000 live births[3]. This high mortality rate is partly attributable to inadequate access to skilled care during delivery. A significant barrier to accessing skilled delivery care is the out-of-pocket (OOP) payments required from women by healthcare providers to obtain services[4].

From a legal standpoint, these statistics highlight the critical necessity for skilled healthcare before, during, and after childbirth. The inauguration of the 2010 constitution saw the passage of Article 43 of the Constitution of Kenya, hereinafter referred to as the CoK[5]. Article 43 states that every person has the "[…] right to the attainable standard of health, which includes the right to access the health care services, including reproductive health care"[6]. In light of these provisions, three years later, the government of Kenya initiated the Linda Mama Programme, aimed at abolishing fees for maternity services in Kenya. This initiative was commendable as it aimed to meet international standards, particularly under the UNHCR and the International Covenant on Economic, Social and Cultural Rights (ICESCR). Particularly, Article 12 of ICESCR asserts the right to health, encompassing "the enjoyment of the highest attainable standard of physical and mental health"[7]. The Linda Mama Programme, therefore, was a significant step towards fulfilling these obligations, ensuring that women have access to essential maternal healthcare services without financial barriers. Further, in October 2016, the free maternity policy

[1] Ministry of Health Kenya, *Guidelines for Postnatal Care 1: Healthy Mothers and Newborns* 2016, p 8.

[2] Guidelines for Postnatal Care 1.

[3] Doris Kathia, 'A Critical Examination of Linda Mama Programme' (NAYA Kenya, 31 October 2023) https://nayakenya.org/2023/10/31/a-critical-examination-of-linda-mama-programme/ [Accessed on: 01.07.2024].

[4] Davidson Stuart, "Examining Barriers to Maternal Health Care in Kenya Using the Three-Delay Framework" (2015) *The Prognosis*, pp. 29-31.

[5] The Constitution of Kenya 2010, art. 43.

[6] The Constitution of Kenya (n 5).

[7] International Covenant on Economic, Social and Cultural Rights, G.A. Res. 22001 (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316, 993 U.N.T.S. 3 (1966).

underwent revisions to encompass private healthcare providers. Management of the policy was transferred from the Ministry of Health (MOH) to the National Hospital Insurance Fund (NHIF), leading to its rebranding as the "Linda Mama Program"[8].

This could be viewed as a commendable step towards upholding the right to accessible healthcare. However, just recently in 2024, the current government abruptly shifted its stance, replacing the NHIF program with a newly rebranded system called Social Health Insurance Fund (SHIF). While touted as a shiny new initiative, this change carries significant implications. Notably, it seeks to defund the Linda Mama programme before its roll-out, thus posing a great risk to the life of the mother and baby, who may be unable to access pre- and post-natal care due to financial constraints. For instance, the budget allocation for Linda Mama in the financial year 2023/2024 was approximately Kshs 5 billion[9]. However, this amount was significantly reduced by 59% in the financial year 2024/2025 to an approximate amount of Kshs 2 billion[10].

This paper thus investigates the threat posed to women's right to access pre and postnatal care amidst the abrupt defunding of the Linda Mama Programme. It argues that the defunding of the programme is a regressive action towards the State's international and constitutional obligations to fulfil and promote not only the right to women's access to reproductive healthcare but also the right to life and gender equality commitments. Moreover, the paper argues the shift to the SHIF, albeit with the aim of increasing the base of contribution to the public health insurance scheme, embarks on the use of the Means Testing Instrument (MTI) which fails to consider the financial realities of women in Kenya, especially those from vulnerable and marginalised communities whose access to pre and postnatal care may be inhibited due to inadequate funds. To add, the paper proposes that rather than the abrupt defunding of the programme, the State should find mechanisms of making its access more efficient under the new SHIF programme to ensure that Kenya does not slack in its commitment to achieve the SDGs target of the global MMR.

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[8] Stacey Orangi et al., "Examining the Implementation of the Linda Mama Free Maternity Program in Kenya" (2021) *International Journal of Health Planning and Management*, pp. 1-2.

[9] Moraa Obira, "No More Linda Mama? What you Need to Know About SHIF" *Nation Media Group* (13th May 2024).

[10] See, Government of Kenya the Ministry of Treasury and Economic Planning, "Supplementary II Budget for Financial Year 2023/2024" that allocates Kshs 5 million to Linda Mama contrasting with; Government of Kenya the Ministry of Treasury and Economic Planning, "Program Based Budget for Financial Year 2024/2025" which allocates Kshs 2.049 billion to Linda Mama.

2.0. Legal Framework on Access to Reproductive and Maternal Healthcare in Kenya

2.1. International Framework

From an international standpoint, the 1948 Universal Declaration of Human Rights serves as a seminal policy statement and call to action, affirming the fundamental human right to health. It articulates that every individual is entitled to a standard of living adequate for health and well-being, encompassing access to medical care and protection in instances of illness or disability[11]. In the 1960s, the United Nations advanced two pivotal international covenants that expanded upon the principles set forth in the Universal Declaration of Human Rights: the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR)[12]. Importantly, the ICESCR, assumes particular significance with regard to the right to health. Article 12 of the ICESCR delineates the right to health as encompassing "the enjoyment of the highest attainable standard of physical and mental health". This covenant underscores the global commitment to safeguarding health as an inherent human entitlement, emphasising the imperative of attaining optimal physical and mental well-being for all individuals[13].

Further, The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), ratified on 9th March 1984, in Article 12, emphasises that State parties must undertake appropriate measures to eliminate gender-based discrimination in healthcare[14]. This includes ensuring equal access to healthcare services, including those related to family planning, without discrimination between men and women. Similarly, the International Covenant on Economic, Social and Cultural Rights, which Kenya acceded to on 1st May 1973, stipulates in Article 10 that special protection should be provided to mothers during a reasonable period before and after childbirth[15].

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[11] UN Universal Declaration of Human Rights, G.A. Res. 217A (III), art. 13.1, U.N. GAOR, 3d Sess., at 71, 74, U.N. Doc. A/810 (1948).

[12] International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 49, U.N. Doc. A/6316 (1966); International Covenant on Economic, Social and Cultural Rights, G.A. Res. 22001 (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316, 993 U.N.T.S. 3 (1966)

[13] ICESCR (n 12).

[14] Convention on the Elimination of All Forms of Discrimination against Women (adopted 18 December 1979, entered into force 3 September 1981) 1249 UNTS 13, art 12.

[15] International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 49, U.N. Doc. A/6316 (1966).

From an African perspective, Article 16 of the African Charter on Human and Peoples' Rights (The Banjul Charter) asserts that every individual has the right to achieve the highest attainable standard of physical and mental health. The Charter places an obligation on State parties to enact measures aimed at safeguarding the health of their populations and ensuring access to medical care in times of illness[16].

Further, the United Nations (UN) has set up various international agencies to enhance global economic and social progress, which seemingly have relevant influence towards the implementation of these rights. Among these, the World Health Organization (WHO) plays a crucial role not only in promoting health but also in establishing international health regulations[17]. According to its constitution, the WHO asserts the right to achieve the highest possible standard of health, defining health comprehensively as not just the absence of disease but a state of complete physical, mental, and social well-being.

2.2. Kenyan Context

Article 43 of the Constitution of Kenya mandates the state to ensure the right to health for all its citizens[18]. Further, Article 21 of the CoK requires the government to observe, respect, protect, promote, and fulfil this right comprehensively[19]. This includes providing accessible healthcare services, essential medical care, and facilities, as well as implementing health policies that prioritise the well-being of individuals, families, and communities across Kenya.

Moreover, Article 28 of the Constitution of Kenya establishes that every person has inherent dignity and the right to have that dignity respected and protected[20]. Relating this to maternal health, this provision underscores the obligation of the State and healthcare providers to ensure that pregnant women and mothers are treated with respect, compassion, and care[21]. In the case of ***Republic Vs Minister for Home Affairs and 2 Others Ex-parte Leonard Sitanize*** the Court had this to say on the very subject.

> Human dignity is of fundamental importance to any society including Kenya and is indeed a foundational value which informs the interpretation of many and perhaps all other fundamental rights[22].

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16 African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) 1520 UNTS 217, art 16.

17 Eleanor D. Kinney, 'The International Human Right to Health: What Does This Mean for Our Nation and World?' Indiana Law Review Vol. 34:1457 pg 4.

18 The Constitution of Kenya (n5).

19 The Constitution of Kenya, art 21(1).

20 The Constitution of Kenya, 2010 art. 28.

21 The Constitution of Kenya (n20).

22 *Republic v Minister for Home Affairs and 2 Others Ex-parte Leonard Sitanize (2005) eKLR.*

From a legislative perspective, Kenya's Health Act of 2017 reaffirmed the right to reproductive health care, specifically enshrining the provision of free maternity care under Section 5(3)(b)[23]. This legislative provision underscores the State's commitment to ensuring that maternal health services are accessible to all women, without financial barriers, thereby promoting maternal well-being and reducing maternal mortality rates. Section 6(1)(b) guarantees the right to access appropriate healthcare services necessary for safe pregnancy, childbirth, and the postpartum period, aiming to optimise the health outcomes of both parents and infants[24]. Additionally, section 5(2) of the Act mandates that every person has the right to be treated with dignity, respect, and their privacy respected during healthcare provision[25]. These provisions collectively emphasise the State's commitment to ensuring comprehensive maternal and reproductive health services that prioritise the well-being, dignity, and rights of individuals throughout the reproductive journey.

3.0. Linda Mama Programme – A Milestone Towards the Access to Reproductive Healthcare

The Linda Mama Programme is a crucial initiative in Kenya's healthcare system, launched on June 1, 2013, aimed at improving maternal and child health outcomes[26]. The Linda Mama Programme was launched to address critical gaps in maternal and child healthcare across Kenya. Its primary objectives include enhancing access to prenatal care, promoting skilled birth attendance, improving postnatal care services, and increasing the uptake of family planning services[27]. These efforts aimed to significantly reduce maternal and infant mortality rates, aligning with international and domestic commitments to uphold the right to health and well-being, as enshrined in Kenya's Constitution and various international human rights instruments.

From a budgetary perspective, nearly 3.8 billion Kenyan shillings were allocated in the 2013-2014 financial year[28]. The programme since its inception in 2013 to 2016 achieved notable successes in improving maternal and child health outcomes nationwide by ensuring 900,000 deliveries. In 2016, the Linda Mama Programme

[23] The Health Act 2017, s 5(3) (b).
[24] The Health Act 2017, s 6 (1) (b).
[25] The Health Act 2017, s 5 (2).
[26] Implementation Manual for Programme Managers Linda Mama Boresha Jamii (December 2016).
[27] Implementation Manual (n 26).
[28] Implementation Manual (n 26).

was integrated with the National Hospital Insurance Fund (NHIF) to enhance its effectiveness[29].

Financial year	2012/13	2013/14	2014/15	2015/16	Cumulative number of **beneficiaries**
Number of deliveries in public facilities	461,995	627,487	811,645	900,000	2,801,127

Figure 1. Excerpt from the Implementation Manual for Programme Managers Linda Mama Boresha Jamii (December 2016)

Despite its achievements, the Linda Mama Programme had several challenges that impacted its effectiveness and reach. First, the NHIF premium contributions though increasing, the health demand through payouts were also increasing leading to insufficiency of funds to achieve free maternal healthcare[30]. Moreover, the high attrition rates whereby the number of members who contributed to NHIF on a monthly basis reduced due to the voluntary nature of contributions further complicated the financial sustainability of the Program[31]. Second, insufficient accountability mechanisms within the Ministry of Health led to an inability to distinguish between actual and fictitious reported deliveries[32]. Other challenges that engulfed NHIF and negatively impacted on the Linda Mama Programme include cumbersome empanelment of service providers, delayed reimbursements to service providers, low insurance coverage and weak health financing model[33].

In 2014, a case was filed at the High Court of Kenya, ***Josephine Oundo Ongwen v The Attorney General and 4 Others reference*** highlighting some of the challenges experienced at various hospitals despite budget allocations to the Linda Mama Programme[34]. In August 2013, Josephine gave birth unassisted on the floor at Bungoma County Referral Hospital due to inadequate care and resources. She was forced to buy her own medical supplies and suffered physical and verbal abuse from the nurses even though the State had made allocations under Linda Mama. A petition was filed on her behalf against various governmental bodies, claiming violations of her constitutional and international human rights, including the right to health and freedom from discrimination. The Court found that Josephine's abuse

[29] Orangi S. and others, 'Examining the Implementation of the Linda Mama Free Maternity Program in Kenya' (2021) 36 *International Journal of Health Planning and Management* 6 2277.

[30] National Health Insurance Board, "Regulatory Impact Statement for the National Health Insurance Fund Act, Regulations, 2023" (April 2023), p. 15.

[31] National Health Insurance Board, (n 30).

[32] National Health Insurance Board, (n 30), p. 16.

[33] National Health Insurance Board, (n 30), pp. 17-19.

[34] *Josephine Oundo Ongwen V. The Attorney General & 4 Others 2014 eKLR.*

violated her dignity and rights against cruel treatment, attributing neglect to the National and Bungoma County governments' failure to ensure accessible, quality healthcare and maternal health policy guidelines, emphasising systemic healthcare shortcomings needing policy reform for rights protection[35].

Despite the difficulties faced in implementing the Linda Mama Programme, the programme undeniably benefited numerous women and their children, underscoring its pivotal role in maternal and child health care in Kenya.

4.0 The Move to the Social Health Insurance

Due to the challenges under NHIF[36], the government of the day, elected in 2022, decided to do a complete overhaul to the social health insurance scheme[37]. This move entailed repealing the National Health Insurance Fund Act 1998 and replacing it with the Social Health Insurance Act 2023 (SHIA)[38]. According to SHIA, the move would be beneficial towards ensuring the achievement of the Universal Health Coverage (UHC) by creating a wider pool of resources for healthcare financing, streamlining the social health insurance system in Kenya and also ensuring access to a wider variety of health benefits package to the citizen in the overall realisation of the right to the highest attainable standard of health[39]. While the government is persistent and determined to implement the SHIA, it is fundamental that we scrutinise it in a bid to understand what it entails and what it provides for the people of Kenya. This analysis is pivotal in laying the foundation of the discussion in this paper and will enhance the contextual understanding of why the government decided to defund Linda Mama.

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[35] *Josephine Oundo Ongwen (n 34) para 59-64; 68-70.*

[36] National Health Insurance Fund, "Regulatory Impact Assessment for the National Health Insurance Fund Act, Regulations,2023" (April 2023), pp. 15-19; National Health Insurance Fund, "Strategic Plan 2018-2022" (2018), p. 5; Benta Moige, Zaina Kombo and Lavendar Namdiero, "Is NHIF at a Crossroads? Exploring the Complexities and Solutions for Equitable Healthcare Access" (2023) Amnesty International.

[37] Republic of Kenya the National Treasury and Economic Planning, "Medium term 2023 Budget Policy Statement: The Bottom-Up Economic Transformation Agenda for Inclusive Growth" (February 2027), p. 6, para 27-29. Republic of Kenya the National Treasury and Economic Planning, "Medium Term 2023 Budget Policy Statement: The Bottom-Up Economic Transformation Agenda for Inclusive Growth" (February 2023), p. 6 para 22; The Standing Committee on Health, "Report on the Social Health Insurance Bill, 2023" (2023) The Senate, Thirteenth Parliament of Kenya, Second Session, p. 10.

[38] The Standing Committee on Health, "Report on the Social Health Insurance Bill, 2023" (2023) The Senate, Thirteenth Parliament of Kenya, Second Session, p. 10.

[39] The Social Health Insurance Act, 2023 s 3. Also see the Constitution of Kenya, 2010, art. 43(1).

4.1. Deconstructing the Social Health Insurance Act

On 19th October 2023, the SHIA was passed by the President, ushering in the beginning of the move, from NHIF to SHIA[40]. This paper shall deconstruct the SHIA in three main ways, beginning with the three Funds it establishes under the Act, and the tariffs benefits package from the SHI scheme.

4.1.1. The Funds Established by the Social Health Insurance Act

The Act establishes three funds which include the Primary Healthcare Fund: the Social Health Insurance Fund and the Emergency, Chronic and Critical Illness Fund.

4.1.1.1. The Primary Healthcare Fund

The primary objective of the Fund is to ensure the purchase of primary healthcare services from primary healthcare facilities based on the set tariff[41]. Section 2 of SHIA as well as the Primary Health Care Act 2023, define primary health care as the essential healthcare based on practically, scientifically sound and socially acceptable methods and technology that is made universally accessible to individuals and families at the most basic level of organisation in the community[42]. This in Kenya means healthcare services[43] that are offered in households, levels 1,2 and 3 healthcare facilities which include dispensaries and community-based hospitals[44].

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[40] The Social Health Insurance Act, Cover Page (Date of Assent); Office of the President of Kenya, "President Ruto: New Healthcare Plan Will Leave No one Behind" (19th October 2023); Kennedy Kimathi, "President Ruto: New Health Laws Will Transform Healthcare in Kenya" (October 21, 2023) Nation Media Group.

[41] The Social Health Insurance Act 2023, s 20.

[42] The Social Health Insurance Act, 2023 s 2; The Primary Health Care Act 2023.

[43] These services according to section 6(2) of the Primary Healthcare Act 2023 include promotive, preventive, curative, rehabilitative and palliative care.

[44] Republic of Kenya Ministry of Health, "Norms and Standards for Health Service Delivery" (2006). pp. 2-8; A further explanation of the categorisation of health institutions include; Level 1 – includes the household and community level of healthcare service such as preventive, health promotion and education, early detection of conditions, screening and referral; Level 2 entails the health clinics, dental clinics, dispensaries, mobile care clinics, home based care services; Level 3 commonly referred to as general hospitals includes a comprehensive health centre that offers curative, preventive, promotive and rehabilitative health services including maternity theatre services; Level 4 entails a primary care hospital which offers services that compliment primary healthcare services to allow for more comprehensive care; Level 5 is a secondary referral hospital that provides services offered in a level 4 facility and more comprehensive set of services together with internship services for medical staff, research and serve as training centres for paramedical staff; Level 6 which are the specialised hospitalised commonly known as the National Teaching and Referral Hospitals that offer specialised services exclusively among others radiological services, oncology services *etc*.

The contribution towards this fund shall be made by the National Assembly according to the budgetary allocations for the year[45].

4.1.1.2. The Social Health Insurance Fund

Section 25 of the Act establishes the Social Health Insurance Fund (SHIF) which shall constitute all contributions made by Kenyan households and citizens; monies appropriated by the National Assembly for indigent and vulnerable persons; and, gifts, grants and donations[46]. Every Kenyan, is compulsorily required to register and be a member of the SHIF inclusive of children[47]. Interestingly, the SHIA provides that in order to access any government services, every citizen will have to show that they are a compliant member of the SHIF[48] .

While every Kenyan shall be required to be registered under SHIF, the Act provides that contributions will be household-based. This means that each and every Kenyan household shall be contributing to the Fund[49]. A household has been defined as a social unit consisting of an eligible contributor, whether contributing by self, or paid for and their beneficiaries[50]. The Act goes ahead to clearly define who is a beneficiary for the purpose of a household and it includes the contributor; their spouse; children below 21 years; children between 21 years and 25 years who are undertaking a full-time course at an institute of higher learning and any other dependent of the contributor for instance a person living with disability[51]. With specificity and ironically, the SHI Regulations provide that any person who has attained the age of 25 years, irrespective of them having income, shall be considered as a household for the purpose of contributing to the Fund[52].

Contributions to the Fund shall be made first through a statutory deduction of every salaried employee at a rate of 2.75% of the gross salary[53]. This is irrespective of whether both contributors are of the same household or not, so long as they earn a monthly salary. Second, for those not earning a salary, they shall be making an annual contribution at a rate of 2.75% according to the proportion of their income as established by the means testing instrument[54]. This instrument shall be used to measure the economic capacity of a household depending on housing character-

[45] The Social Health Insurance Act, 2023 s 21.
[46] The Social Health Insurance Act, 2023 s.25.
[47] The Social Health Insurance Act, 2023 s. 26(1). For children see s. 26 (3).
[48] The Social Health Insurance Act, 2023 s. 26(5).
[49] The Social Health Insurance Act, 2023 s 27(1)(a).
[50] The Social Health Insurance Act, 2023 s 2.
[51] The Social Health Insurance Act, 2023 s 2.
[52] The Social Health Insurance (General) Regulations, 2024 s 20.
[53] The Social Health Insurance Act 2023, s 27(2)(a).
[54] The Social Health Insurance Act 2023, s 27(2)(b); The Social Health Insurance (General) Regulations, 2024 s 17(1).

istics, access to basic services, household composition and any other relevant socio-economic factor to ascertain whether their income is sufficient for contribution to the scheme[55]. Arguably, the Act and regulations do not mention what shall be the threshold of determining the capability of a person in the informal sector for contributing to the scheme and the frequency at which such an assessment shall be done. For both the formal and informal sectors, contributions shall not be below Kshs 300[56]. The National Assembly through the budgetary allocation as well as the county governments shall channel monies into the fund for persons considered as indigent by the MTI and those in lawful custody[57].

4.1.1.3. The Emergency, Chronic and Critical Illness Fund

This Fund has been established to assist in the easing of the burden of the high cost of managing chronic illnesses after the depletion of the social health insurance cover and further cover the costs of emergency treatment[58]. Sources of the Fund shall be made from monies appropriated by the National Assembly, gifts, grants, donations or endowments and such monies from any other lawful source[59].

4.1.2. The Benefits Package of the Social Health Insurance Fund

Every person registered under the SHIF shall be entitled to the essential health-care benefits package as prescribed under the Act[60]. This package shall be based on tariffs, which the Ministry of Health shall be reviewing from time to time[61]. The tariff benefits package thus allows the Ministry of Health with the advice of the Benefits Package Tariffs Advisory Panel to set the prices that will be reimbursed for provided health care goods and services, payment rules for purchasers and providers valid for a specified period[62]. This is in alignment with Kenya's commitment to UHC whereby a public health insurance must clearly ascertain three dimensions of coverage that is, the persons being covered, the services being covered and how much will be paid[63]. The World Health Organisation notes that price setting is

[55] The Social Health Insurance (General) Regulations, 2024 s 21(3).
[56] The Social Health Insurance (General) Regulations, 2024 s 16(2) & s 17(2).
[57] The Social Health Insurance Act s 27(2) (c and d).
[58] The Social Health Insurance Act, 2023 s 28.
[59] The Social Health Insurance Act, 2023 s 29.
[60] The Social Health Insurance Act, 2023 s 31.
[61] The Social Health Insurance Act, 2023 s 32.
[62] The Social Health Insurance (General) Regulations, 2024 s 42; Leila Doshmangir, Arash Rashidian et al., "Setting Health Care Services Tariffs in Iran: Half a Century Quest for a Window of Opportunity", (2020) 19 International Journal for Equity in Health 112.
[63] Government of Kenya, Ministry of Health, "Kenya Universal Health Coverage Policy 2020-2030: Accelerating Attainment of Universal Health Coverage" (2020); Sarah Barber, Luca Lorenzoni and Paul Ong, "Price Setting and Price Regulation in Health Care: Lessons for Advancing Universal

crucial for the quality of healthcare services provided since a lower tariff would mean poor quality services, especially where the patient does not have the ability to cater for the extra cost out of pocket or through a private health insurance cover[64].

According to the SHIA General regulations, the process of designing, reviewing and setting the benefits package shall be guided by, among others, equity, cost-effectiveness, burden of disease, population and access to healthcare[65]. It is important to point out that according to the latest call for public participation regarding the benefits' tariff package, there was no indication of a cover for prenatal care for expectant mothers[66]. Moreover, maternal services such as normal delivery and caesarean section are capped at Kshs 11,200 for only 48 hours and Kshs 32,600 for only 72 hours respectively[67].

5.0. Defunding Linda Mama: A Risk to Women's Right to Access Maternal Healthcare

One of the greatest assurances provided by the Linda Mama programme was that expectant mothers would receive access to two pre and postnatal care visits, inclusive of free normal delivery and caesarean section[68]. With the current move to SHIF this assurance is now not guaranteed as there is no free maternity health program under the scheme. Moreover, in the transition period towards NHIF, the government has defunded the programme by not addressing pending bills[69] and slashing its budget by 59%, from Kshs 5 Billion to 2 Billion in the current budget[70]. In analysing the risk, the defunding of the Linda Mama programme has towards women's right to reproductive healthcare, especially access to maternal healthcare, this paper shall first discuss the consequences the move to SHIF has on the Lin-

Health Coverage" (2019) Geneva World Health Organisation, Organisation for Economic Co-operation and Development, p. 2.

[64] Sarah Barber, Luca Lorenzoni and Paul Ong, "Price Setting and Price Regulation in Health Care: Lessons for Advancing Universal Health Coverage" (2019) Geneva World Health Organisation, Organisation for Economic Co-operation and Development, pp. 3-7.

[65] Social Health Insurance (General) Regulations 2024, s 4.

[66] The Government of Kenya, Ministry of Health, "Tariffs to the Benefit Package Under the Social Health Insurance Act No.16 of 2023" (2024).

[67] The Government of Kenya, Ministry of Health, "Tariffs to the Benefit Package Under the Social Health Insurance Act No.16 of 2023" (2024).

[68] For more information with regards to the benefits for the Linda Mama Programme: https://sha.go.ke/.

[69] Institute of Public Finance, "Annual National Shadow Budget 2024/25: Budgeting in an Era of Fiscal Consolidation - Protecting Key Priorities" (2024), p. 79.

[70] See, Government of Kenya the Ministry of Treasury and Economic Planning, "Supplementary II Budget for Financial Year 2023/2024" that allocates Kshs 5 million to Linda Mama contrasting with; Government of Kenya the Ministry of Treasury and Economic Planning, "Program Based Budget for Financial Year 2024/2025" which allocates Kshs 2.049 billion to Linda Mama.

da Mama Programme. Second, it shall analyse how these negative consequences coupled up with the implementation of SHIF will adversely affect women's right to reproductive healthcare rights, especially access to maternal healthcare.

5.1. What does the Move to Social Health Insurance Mean to Linda Mama?

As earlier mentioned, the repeal of the NHIF Act and the beginning of the transition to the SHIF signified that all programs under NHIF would no longer be operational[71]. This was inclusive of the Linda mama program which is a free maternal healthcare program that offered expectant women two pre and postnatal visits as well as access to free skilled normal delivery and caesarean section[72]. Under the SHIA benefits package that was released for public participation it is evident that maternal healthcare will now be offered at Kenya's health facilities from Level 1 to Level 6[73]. However, this is capped at a certain amount that is Kshs 11,200 for skilled delivery and Kshs 32,000 for Caesarean section[74]. The benefits package does not, however, cover prenatal and postnatal visits that were offered under the Linda Mama package[75]. Moreover, it caps the number of days the woman ought to stay in the hospital to only 48 hours for skilled delivery and 72 hours for caesarean section[76]. Post this number of hours the expectant mother will be expected to cater for their own cost either out of pocket or through private insurance. This is different from what was available under the Linda Mama programme whereby the expectant mother was freely entitled to two pre- and post-natal care services as well as skilled delivery which could either be through normal delivery caesarean section[77].

Apart from the repealing of the programme and reduction of the benefits, the transition to SHIF has left the programme with numerous pending bills and a slash of the budget despite the demand for maternal healthcare being on the rise. The Linda Mama programme prior to that had unknown pending bills as hospitals reported that they were not being reimbursed for offering Linda Mama services[78]. Moreover, in the current financial year, there is an allocation of Kshs 2

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71 The Social Health Insurance Act, 2023 s 54.

72 Government of Kenya Ministry of Health, "Regulatory Impact Statement for The Social Health Insurance (General) Regulations, 2024" (January 2024), p. 21; Moraa Obira, "No More Linda Mama? What you Need to Know About SHIF" *Nation Media Group* (13th May 2024).

73 The Government of Kenya, Ministry of Health, "Tariffs to the Benefit Package Under the Social Health Insurance Act No.16 of 2023" (2024).

74 *Ibidem*.

75 *Ibidem*.

76 *Ibidem*.

77 See (n 68).

78 Office of the Auditor General, "Performance Audit Report on Implementation of the Linda Mama Programme by the National Health Insurance Fund" (2022), pp. 33-35; Mercy Kahenda, "Hospitals Threaten to Paralyse Services Over Delayed Linda Mama Funds" The Standard (April

billion from Kshs 5 billion in the previous financial year to the Linda Mama programme despite the country not fully transiting to the SHIF[79]. This 59% budget cut raises significant concerns about the fate of maternal health care, especially in regard to whether the funds will be used to continue offering the services during the transition period as there is still increased demand of over 1 million expectant mothers[80] or will they be used to repay the remaining part of the pending bills owed to the programme. This thus means that even before the benefits package under SHIF commence, expectant mothers might have to cater for the cost for access to maternal healthcare which is a set back from the free maternal healthcare services offered under the Linda Mama Programme. The move to SHIF has thus completely repealed Linda Mama, reduced its benefits and thus introduced a model whereby the expectant mothers might have to cater for their own cost, especially during the transition period because of the defunding of the program and the failure to settle pending bills.

5.2. The Risk to Women's Rights to Access Maternal Healthcare Through the Move and Later Implementation of SHIF

Article 43(1) of the Constitution of Kenya, coupled with international legal frameworks such as the ICESCR, ACHPR, Maputo Protocol and CEDAW obligate Kenya towards ensuring that it realises the right to the highest attainable standard of health inclusive of reproductive healthcare[81]. Furthermore, noting that Kenya's maternal mortality ratio is still significantly high at an estimated ration in 2020 of 530 per 100,000 live births[82], Kenya is mandated to ensure that it provides affordable access to quality maternal healthcare and meets the SDG target of reducing its

2024) Institute of Public Finance, "Annual National Shadow Budget 2024/25: Budgeting in an Era of Fiscal Consolidation - Protecting Key Priorities" (2024), p. 79.

[79] See, Government of Kenya the Ministry of Treasury and Economic Planning, "Supplementary II Budget for Financial Year 2023/2024" that allocates Kshs 5 million to Linda Mama contrasting with; Government of Kenya the Ministry of Treasury and Economic Planning, "Program Based Budget for Financial Year 2024/2025" which allocates Kshs 2.049 billion to Linda Mama.

[80] Health sector working group estimates to target 1.4 million mothers in 2024/2025 Financial year through the Linda Mama Programme. See, Ministry of Health, "Sector Working Group Report: Medium Term Expenditure Framework (MTEF) for the Period 2024/25-2026/27" (2023) pg 213.

[81] The Constitution of Kenya 2010, art 43(1)(a); International Covenant on Economic, Social and Cultural Rights 1976, art 12; The African Charter on Human and People's Rights 1986, art 16(1); Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, art 14; Convention on the Elimination of Discrimination Against Women 1981, art 12(1 &2).

[82] World Health Organisation and Integrated African Health Observatory, "Maternal Mortality: The Urgency of a Systematic and Multisectoral Approach in Mitigating Maternal Deaths in Africa" (March 2023) Analytical Factsheet; World Bank Group, "Maternal Mortality Ratio Data" (2023) Can be accessed at: https://data.worldbank.org/indicator/SH.STA.MMRT?locations=KE [Accessed on: 28.06.2024] Tamia Nuna, "Addressing Maternal Mortality and Morbidity in Kenya" (2023) Network for Adolescent and Youth of Africa.

mortality ratio to less than 70 per 100,000 live births[83]. The government with the introduction of the Linda mama Programme had indeed taken progressive steps towards ensuring affordable access to maternal healthcare programs especially to the vulnerable women who came from economically disadvantaged backgrounds and could not afford access to their right to the highest attainable standard of maternal healthcare[84]. The transition and implementation to SHIF would thus be a retrogressive measure and setback to the progressive steps made towards realising the right to the highest standard of maternal healthcare.

To begin with, the cost of access to maternal healthcare is expected to increase as expectant mothers would be required to cater for additional costs either through their out-of-pocket payments or through private insurance. Within the transition period of January to March 2024, this was already being experienced with various media houses in Kenya reporting that expectant women were being turned away because there were no funds being channelled to the Linda Mama program and NHIF overall[85]. Moreover, this is expected to continue as with the current budget estimates, Linda Mama's budget has been slashed by 59% to 2 billion shillings. This breeds uncertainty as it is not guaranteed whether such funds will be used for catering for the pending bills or running the program during the transition period. To add, according to the benefits package by the Ministry of Health, maternal healthcare would only be catered for at a rate of Kshs 11,200 for only 48 hours for normal delivery and Khs 32,000 for only 72 hours for caesarean section. This shows that in the event complications arise during the pregnancy, the expectant woman will be expected to cater for their own costs despite the high contributions being made of 2.75% according to a person's income.

The scrapping of the Linda Mama programme would also mean that women who come from vulnerable economic backgrounds will have greater barriers in accessing the right to access maternal healthcare creating room and opportunity for inequality. Even though the move to SHI plans to cater for the cost of the indigent in contribution to SHIF, this is subject to the discretion of the Means Testing Instrument. This instrument according to SHI Regulations will be assess-

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[83] Sustainable Development Goal Target 3.1 to reduce the global maternal mortality ratio to less than 70 per 100,000 live births; United Nations General Assembly, "Resolution Adopted by the General Assembly: Political Declaration of the High-Level Meeting on Universal Health Coverage" 5th October 2023, A/RES/78/4 p 11 para 63 – commitment to reduce maternal mortality.

[84] Ministry of Health, "Health Sector Report: Medium Term Expenditure Framework (MTEF) for the Period 2024/25-2026/27" (December 2023), p. 71; Office of the Auditor General, "Performance Audit Report on Implementation of the Linda Mama Programme by the National Health Insurance Fund" (2022) pp. 22-23.

[85] Angeal Oketch and Lilys Njeru, "Questions Over Sh 20 billion NHIF Payments Delay as Patients Suffer" Nation Media Group (March 26, 2024); Felix Aosha, "CS Nakhumicha to Hospitals: Don't Turn Away Patients, Accept NHIF" The Star (17th April 2024); Magdalene Saya, "Report: Delay in Pre-Authorisation of Requests Denied Patients Timely Care" The Star (5th March 2024).

ing a household's economic lifestyle to ascertain whether a certain household is to be categorised as indigent for the purposes of contributing to the scheme[86]. The SHIA Regulations however fail to establish what is the threshold that one would be required to meet for them to be declared to be indigent thus leaving room for great discretion. Furthermore, there is no guarantee the number of times this assessment will be done, in the event a certain household loses their income-generating activity and needs assistance with contributions or conversely, where they would be required to be removed from the indigent program. This MTI will thus pose more difficulty to expectant mothers who come from vulnerable backgrounds who may not be able to pay the Kshs 300 because they will now have to be subjected to the MTI to determine whether they can afford to make the contributions for them to access the maternal health services. Ironically, even those above the age of 25 and who do not earn an income will further be required to make annual contributions of Kshs 300 to the SHIF program[87], thus evoking questions how women from vulnerable economic backgrounds will obtain the annual Kshs 300 per month. This is most especially noting that statistics from the 2019 population census show that 19.5 million people in Kenya live below the poverty line, earning less than Kshs 3,947 in rural areas and Kshs 7,193 in urban areas according to the 2021 prices. Among these, 1.3 million live in peri-urban and 4.2 million live in core urban areas with an estimated 60% of them living in slums and informal settlements[88].

While indeed the SHIF was aimed at streamlining the health insurance process to ensure affordability, reliability and sustainability, the scrapping of the Linda Mama Programme is a major setback towards promoting gender equality in Kenya. The Constitution of Kenya vide article 27(6) recognizes that certain individual groups including women were groups that suffered from discrimination in the past and that the State should take measures towards ensuring that this discrimination is reduced[89]. Before the promulgation of Kenya's Constitution, there was no access to free maternal health programs, forcing women to deliver in their homes with no skilled delivery due to the high cost of maternal services and inaccessibility to health services due to long distance[90]. However, with the enrolment of the Linda

[86] The Social Health Insurance (General) Regulations, 2024 s 17(1); 21(3).

[87] The Social Health Insurance (General) Regulations, 2024 s 20.

[88] UN Habitat, "Kenya 2023 Country Brief: A Better Quality of Life For All in an Urbanizing World" (2023), p. 2; The World Bank, "Kenya Poverty and Equity Assessment 2023, From Poverty to Prosperity: Making Growth More Inclusive" (2023), p. 1; The Kenya Institute for Public Policy Research and Analysis, "Kenya Economic Report 2020: Creating an Enabling Environment for Inclusive Growth in Kenya" (2020) pg 5.

[89] The Constitution of Kenya 2010, art 27(6).

[90] Kenya National Commission on Human Rights, "Realising Sexual and Reproductive Health Rights in Kenya: A Myth of Reality?" (April 2012) A Report of the Public Inquiry into Violations of Sexual and Reproductive Health Rights in Kenya, pp. 40-67.

Mama programme, despite having challenges, saw over 1 million mothers get access to free maternal health services inclusive of skilled delivery as well as prenatal and postnatal visits[91]. The move to SHIF, albeit aiming to increase the benefit package for other diseases not previously catered for under NHIF and streamline the process of procuring health services, the scrapping of the free maternal health program is a great setback towards promoting gender equality and eliminating discrimination against women. It will mean that many women's right to access maternal healthcare part of reproductive healthcare would be impeded by the move. Women from disadvantaged backgrounds, would have to be subjected to the MTI to ascertain whether they fall within the threshold of an indigent so that the State would allocate funds for their contributions to SHIF. Even with that, the benefits package just released for public participation shows that SHIF will still not provide for free maternal healthcare since it is only limited to certain amounts per hour spent in the hospital. Furthermore, there is no guarantee of prenatal visits which are very important in diagnosing whether there will be any complications in the pregnancy.

6.0. Conclusion and Recommendations

The transition from the Linda Mama program to SHIF marks a significant shift in Kenya's approach to maternal healthcare provision. Linda Mama, offering free maternal services including prenatal and postnatal care, has been a lifeline for many expectant mothers, particularly those from economically disadvantaged backgrounds. However, with the introduction of SHIF, these essential services have been curtailed, leaving many women without crucial support during pregnancy and childbirth. The removal of free maternal healthcare under Linda Mama has created profound implications for access to essential services. Prenatal and postnatal visits, integral for monitoring and ensuring the health of both mother and child, are no longer guaranteed. This loss not only threatens the health outcomes of expectant mothers but also diminishes their ability to access timely medical interventions and support. The defunding of Linda Mama alongside the introduction of SHIF has placed undue financial burdens on expectant mothers. Now required to bear out-of-pocket expenses or rely on private insurance for maternity care, women face increased financial strain, especially in cases of prolonged hospital stays or complications during delivery. This financial barrier further exacerbates existing

[91] Ministry of Health, "Health Sector Report: Medium Term Expenditure Framework (MTEF) for the Period 2024/25-2026/27" (December 2023), p. 71; Office of the Auditor General, "Performance Audit Report on Implementation of the Linda Mama Programme by the National Health Insurance Fund" (2022), pp. 22-23.

disparities, disproportionately affecting women from marginalised communities, who struggle to afford even basic healthcare services. The discontinuation of Linda Mama represents a setback for gender equality efforts in Kenya. By removing a program specifically designed to address the maternal health needs of vulnerable women, the government risks widening disparities and perpetuating inequality.

Access to maternal healthcare is not just a health issue but a fundamental human right, essential for ensuring women's dignity, autonomy, and well-being. Kenya is obligated under its Constitution and international legal frameworks to ensure affordable and accessible healthcare for all citizens, including comprehensive maternal services. The move to SHIF, without provisions for free maternal healthcare, raises concerns about the government's commitment to fulfilling these obligations. Upholding the right to health, particularly maternal health, requires policies that prioritise inclusivity, equity, and the well-being of vulnerable populations.

As Kenya navigates the transition to SHIF, it is imperative to reconsider the impact on maternal healthcare access. A comprehensive strategy should be devised to mitigate the adverse effects of discontinuing Linda Mama, including reinstating free maternal healthcare services through Linda Mama or providing adequate benefits under SHIF by including prenatal care and not capping the benefits therein to a limited number of hours and price. Additionally, there is a pressing need for transparent and inclusive policy-making processes that involve stakeholders, including women's rights advocates and healthcare professionals, to ensure that the needs of vulnerable populations are prioritised and addressed effectively. Transparent and inclusive decision-making also extends towards the State giving clear guidelines on how the MTI is to be implemented and its adherence to human rights standards such as human dignity and the right to privacy.

The decision to dismantle Linda Mama is not just a policy change but a matter of profound consequence for countless expectant mothers across Kenya. It represents a turning point in the country's commitment to maternal health and gender equality. To safeguard the well-being and rights of women, especially those most marginalised, urgent action is needed to restore and strengthen access to comprehensive maternal healthcare services under the new healthcare framework. In conclusion, while the transition to SHIF aims to improve healthcare sustainability, it must not come at the cost of sacrificing essential maternal health services. Protecting and promoting maternal health is not only a moral imperative, but a legal obligation that Kenya must uphold to ensure a future where every woman can access the care she needs to thrive.

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