CASE STUDY

IMPLEMENTING LINDA MAMA IN BUNGOMA COUNTY

Lessons on the path to universal health care

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Introduction

The Maternal and New-born Improvement (MANI) project supports Bungoma County to strengthen health service provision, with specific attention on maternal and newborn health. This support addresses all six WHO health system building blocks, including health financing, service delivery, health governance and leadership.[1] Interventions under these building blocks have included support to operationalize the Linda Mama programme, managed by the National Hospital Insurance Fund (NHIF). This case study documents experiences and lessons from Linda Mama implementation in Bungoma County to-date and provides recommendations to further strengthen the programme's management and implementation. While the case study focuses on Bungoma County, findings are applicable to other counties.

Background

In April 2017, the Ministry of Health's Free Maternity Service (FMS) was transferred to the NHIF under the brand name 'Linda Mama: *Boresha Jamii'*. Phase 1 (from April 2017) commenced with the faith-based and private sectors; from July 2017, under Phase 2, the public sector was added. From March 2018, Linda Mama introduced Phase 3 to include antenatal care (ANC) and post-natal care (PNC). For all Linda Mama services, benefits are 'portable' (e.g. mothers do not need to receive services from the same provider/site). Currently, it is estimated that 502 'low cost' private and faith-based facilities are contracted while approximately 4,000 public sector facilities nationally are reported to be accredited as part of the scheme.[2]

Reimbursement rates under Linda Mama are tiered to level of care and by sector. Table 1 presents the tariffs for ANC, delivery (normal and caesarean) and PNC. In comparison, normal delivery under the NHIF national scheme is reimbursed at KES 10,000 (US$97). Public-sector tariffs are lower given that these are additional to line-item budgets such as salaries and consumables.

Table 1 : Linda Mama tarifs

Facility level	Normal delivery	Caesarean section	ANC (per visit)	PNC (per visit)
Level 2 and 3 (private health centres, dispensaries)	Ksh 3,500	N/A	1st visit = Ksh 1,000 2nd - 4th visits = Ksh 500	1st - 4th visits = Ksh 250
Level 2 and 3 (public health centres, dispensaries)	Ksh 2,500	N/A	1st visit = Ksh 600 2nd - 4th visits = Ksh 300	1st - 4th visits = Ksh 250
Level 4 (private hospitals)	Ksh 6,000	Ksh 17,000	1st visit = Ksh 1,000 2nd - 4th visits = Ksh 500	1st - 4th visits = Ksh 250
Level 4 and 5 (public hospitals)	Ksh 5,000	Ksh 5,000	1st visit = Ksh 600 2nd - 4th visits = Ksh 300	1st - 4th visits = Ksh 250

Purpose and Methodology

The purpose of the case study was to generate learning on the implementation of Linda Mama in Bungoma County, since the launch of the programme through the first quarter of 2018. The perspectives of managers and providers in the public, faith-based and private sectors were included to generate recommendations on how to improve performance.

The case study deployed a mixed-methods approach, drawing on primary and secondary data sources. Secondary data included Linda Mama programme documentation as well as published studies on Linda Mama and the FMS. Primary data was collected through observation and key informant interviews

(KIIs) with:

- NHIF offices, both branch and national level
- The county health executive and management team members (county and sub-county level)
- Six public, three faith-based and three private-for-profit providers (for the purposes of the case study, we refer to faith-based and for-profit collectively as 'private providers')
- MANI technical advisors

Semi-structured interview guides were used for the interviews. Observation was used to capture key discussions in a breakfast meeting held on April 11th, 2018 with the county executive and management team members, NHIF personnel from the branch office and national level, the county First Lady's office, and MANI staff. A grounded approach to coding data was used, whereby all data were reviewed, and codes iteratively introduced. Findings have been organised around key themes.

Findings

Operationalization of Linda Mama

Accreditation in Linda Mama

As of March 2018, approximately 40% of the health facilities in Bungoma county were accredited with Linda Mama. The NHIF has a target of accrediting all public health facilities (currently 120 are accredited with 47 pending). For the private sector there is no target, with only 12 private facilities accredited to date (with one in process). Accreditation is simple for public health facilities and entails a written request by the County Director of Health to the NHIF branch office, listing the public health facilities to be included. For private providers, they must be registered with the NHIF and comply with various norms and standards.[3] The need for a 'whole sector' approach to Linda Mama was recognised by the county leadership during the April 2018 breakfast meeting.

> *"A woman should have a choice…we bring in competition to drive quality. It is a fair competition, more women, more money. The end game is that everyone is on NHIF."* (NHIF manager)

> *"Private and faith-based facilities are squarely under sub-counties, [we] need to assist them as well."* (County health manager)

Sensitization on Linda Mama

Health worker sensitization remains limited in the public sector and has relied mainly on individual initiative. The NHIF branch office oriented sub-county health management teams (SCHMTs) on how to register mothers and make claims with the intention that this orientation would be cascaded to public health facilities. However, this was found not to be the case individual initiative rather than systematic cascade of information was the norm. In the breakfast meeting, a senior health manager emphasised that health workers have "*Linda Mama in the house"* (the national Programme Manager was in attendance) and need to *"know all that [Linda Mama] entails."* When one public hospital was singled out as being a Linda Mama exemplar, the medical superintendent responded that *"we are just working, doing our job."*

The private sector has had more experience with Linda Mama but many have not actively engaged. Although several private providers were contracted under Linda Mama from April 2017, many were slow to provide services. In most instances, private providers had only become active in the scheme from January 2018; even then, for many, the number of expectant mothers they are seeing is few. For some private providers this is due to a lack of community awareness, through visible signage or community sensitization to promote their facility in Linda Mama. In other instances, providers had initiated services in 2017 but due to unclear procedural communication, had not been reimbursed and thereafter, shied away.

> *"We attended three deliveries and were not paid so we decided to treat as 'charity'."* (Private provider, Bungoma County)

Health workers are intended to play a pivotal role in sensitizing expectant women on Linda Mama. Given this, health worker knowledge on Linda Mama is critical. At the moment, poor sensitization leads to frustration for mothers and health workers, as many mothers show up at health facilities without identification. In other instances, it is speculated as they may not show up at all for fear of payment.

> *"Women are confused about the registration process, and the fear of a possible payment. If they are assured it is free, they can figure out the transport."* (Private provider)

Health worker sensitization is effective where there is an active community unit, and mobilization of mothers is taking place. This was observed in several of the health facilities visited where a close relationship was in place between the health facility and the community. Community Health Volunteers (CHVs) and other community resource people such as traditional birth attendants (TBAs) and chiefs, are recognised as playing a critical link between families and health facilities. In almost all instances, providers - both public and private - were incentivizing CHVs based on their performance or were planning to do so with Linda Mama reimbursements. Most often incentives were small, between Ksh 100-Ksh 200 per woman registered. In one instance this was significantly more (Box 1).

Box 1. Model Linda Mama health facility

In one private facility, there are eight active CHVs (not a CU). The facility manager pays each CHV KSH 1,500 for each mother that attends ANC and delivers in the health facility. CHVs are paid after the delivery while mothers are given a baby blanket and cloth as a baby's gift. The manager notes that CHVs are solving problems for mothers such as paying for *boda boda* transportation or photocopies. With the income from NHIF capitation, the facility is also paying for *SupaCover* for some households and has 119 on insurance to date. The facility manager sees this as good for business as she does not have to waive fees for services (as often occurred in the past). The health facility is the most active in Linda Mama in Bungoma for services rendered and paid reimbursements.

The facility leadership has embraced Linda Mama from registration through to claims processing. They have a staff member designated to handle both Linda Mama and NHIF revenues. The health facility maintains proper records on revenues at the maternity, a good practice that other facilities could learn from.

In high volume facilities, strategies have been devised to cater for registering expectant women on Linda Mama. This has included the establishment of a receiving desk at the ANC, maternity or the Maternal and Child Health/Family Planning unit, manned by dedicated staff. Some public facilities have taken a business approach to Linda Mama by offering incentives to mothers, such free photocopying to facilitate registration, while one hospital has included free ultrasound as part of its ANC service offer to attract mothers to the facility.

In all health facilities, health workers assist mothers to register for Linda Mama. Mobile phone registration was reported to work well, with a few exceptions. The two-step registration process, which first involves the generation of a unique code by the expectant mother followed by the facility registration once pregnancy is confirmed, is not well understood by providers, or mothers. In all health facilities, there was a challenge with registering girls who were under 18 (many of the Linda Mama clients, given high rates of teenage pregnancy in Bungoma County), or women who did not have identification for other reasons. None of the health workers were aware that women could be registered using their ANC card in lieu of identification.

Linda Mama claims process

While initially slow to grow, claims submission has increased significantly by the end of the first quarter of 2018. As of January 2018, only seven health facilities had submitted claims. By early April 2018, this figure had jumped to 42 health facilities. To facilitate processing, high volume facilities have put in place processes for Linda Mama claims. For example, one hospital had set up a secretariat while most facilities had designated staff to manage Linda Mama reporting requirements.

Slow reimbursement and procedural errors pose real risks for providers. Initially, there were some challenges with Linda Mama claims processing, which resulted in losses to health facilities.[4] Providers recalled not collecting all the documentation required for claims and learned the hard way through claims rejection (Box 2 recounts one such experience). Delays in reimbursement or incomplete reimbursement were also cited. One facility in-charge indicated that she had submitted a claim in August 2017 and was paid in February 2018. When reimbursed, she only received half of what was expected with the NHIF branch office unable to provide a reason to her for the partial payment. Experiences such as these are some of the reasons cited for slow and low engagement with Linda Mama. As noted by one private provider, *"If there is a problem with the claim, then the hospital is vulnerable."*

Box 2. Bitter experience with Linda Mama

In one public PHC facility, Linda Mama claims were submitted in January 2018. However, as the submission did not include a copy of the mothers' identification, the delivery claims were rejected. The facility manager assigned a CHV to trace the mothers but with limited success. Of 29 pregnant women who delivered, the CHV was only able to trace seven and get copies of their identification. The facility in-charge did resubmit the claim. The rural facility has no photocopier, which means that expectant women need to come and go to get copies of their identification and services rendered.

Reimbursement rates are considered low by most providers, particularly those in the private sector. Private providers must consider their 'bottom line', ensuring that there is enough to pay salaries and buy commodities at the end of the month, more so than the public sector which benefits from the Exchequer. This preoccupation was an occurring theme in discussions with private providers. In particular, the reimbursement for normal delivery and caesarean section were flagged as low. Providers in both the public and private sectors also raised concerns about the lack of reimbursement for other complications in delivery or the costs of treating sick expectant mothers and infants.

Service charges, and potentially the service package, varied between private providers. While all were level three (one provider) and four (five providers) facilities, faith-based providers and those in rural areas tended to charge less. Variation in charges may also be reflective of the service offer - in terms of adherence to standard antenatal and post-natal packages - which may vary between providers. None of the providers visited, both in the public and private sectors, had the list of services included in the Linda Mama package. Importantly, none of the providers were aware that post-partum family planning was included as part of the PNC package as it does not come with an additional reimbursement. Table 2 provides an overview of service charges in private providers visited in relation to Linda Mama reimbursements (Table 1).

Table 2 : Private provider service charges

Service	Min (Ksh)	Max (Ksh)	Median
ANC 1st visit	300	1,000	678
ANC 2,3 and 4	50	500	180
Normal delivery	2,500	10,000	
PNC	20	300	142
Long-acting reversible contraception	200 (IUCD) 200 (implant)	1000 (IUCD) 1000 (implant)	680 (IUCD) 560 (implant)

Performance of Linda Mama

Performance-to-date under Linda Mama in Bungoma county has significant potential for growth. It was reported in the April 7th, 2018 breakfast meeting that 9,776 women have registered (as of the end of March 2018), with 4,906 women delivering normally and 639 delivering through cesarean section.

Approximately Ksh 12 million had been paid with Ksh 6.8 million pending. A county manager summed up Linda Mama growth in the breakfast meeting, *"by the look of things [the public sector] have woken up."*

There are no county targets set for Linda Mama on which to benchmark performance. The NHIF branch office confirmed that they did not have targets nor did the County Department of Health (DoH). Health managers in public primary health care (PHC) facilities consider their estimated number of deliveries as their Linda Mama target while estimates at hospital level are more difficult, given their referral function and women by-passing PHC facilities. Private sector providers, with the exception of one, did not have a target.

There is some market segmentation with private providers having more mixed clientele than their public counterparts. The private providers estimated that 75-90% of their patients were on the NHIF SupaCover with the remainder covered through Linda Mama and private insurance, with very few fee-paying. One private provider noted that some women on Linda Mama can afford to be on the NHIF SupaCover and should be directed to do so, *"[we need to] help those people that can pay to realise that they should be paying."* In the public sector the number of NHIF clients was reported to be much less but growing.

Health system weaknesses and bottlenecks in the public sector are recognised as impediments to performance of Linda Mama. County health managers acknowledged human resource shortages and 'erratic' transfers as affecting service delivery in the public sector, including those provided under Linda Mama. Other managers highlighted that vouchers for authority to incur expenditure (AIE) get 'stuck' at the county executive level, which delays their utilisation.

Utilisation of Linda Mama reimbursements

In Bungoma county, all facilities - both public and private - can receive reimbursements directly to their bank account. This is a significant enabler for the programme in the public sector as facilities can benefit directly from the 'fruit' of Linda Mama. Bungoma county is one of the few counties in Kenya to allow for this as, in many other counties, reimbursements from the NHIF and Linda Mama are pooled in the county revenue account (CRF) and may get delayed or diverted. This places Bungoma County at a significant advantage.

While only a few public facilities have received reimbursements to date, several are poised to receive and utilize these. All public facilities outlined clear procedures for decision making on fund utilisation with procedural checks and balances. At PHC facilities, while reimbursements are less, there appears to be greater opportunity for directing these towards Linda Mama services, staff and CHV incentives. It was implied that the smaller sized reimbursement parcels received at individual health facilities are less attractive for capture by higher levels of the system, and therefore less likely to be misappropriated. This was reported as an issue under the former FMS managed through the MoH. While SCHMT members do not hold decision making authority over PHC facilities, they would like to play a role in guiding facilities on procurement from KEMSA as part of due process and accountability.

Public providers acknowledged that the former FMS had less paperwork, however health facilities were less involved. Claims were raised automatically and relied on the DHIS2. There were notable delays with reimbursement and a lack of transparency with reimbursements banked in the CRF. One public facility in-charge recalled that, with the FMS, health facilities got cash but were not sure of the period covered and the reason for the amount. Sometimes the cash was shared with other health facilities as they might not have received anything. The same public provider indicated *"with Linda Mama, we don't know about the goodness"* as he was still awaiting reimbursement. His view is likely to positively change once the facility receives its first reimbursement directly to its account.

In comparison to the FMS, Linda Mama is considered more transparent but requires more paperwork. Currently, this relies upon photocopies of mothers' documentation as well as all services provided, which can create a burden to health workers. As Linda Mama "rides on technology", health

facilities with ICT capacity are better able to manage the claims process. While paper-based at present, in future Linda Mama will move to an e-claims system. Health facilities without internet and computers will be left behind. Health workers like the technology as they can see their projected income and plan accordingly.

"The use of technology allows us to know how much we can expect from NHIF." (Public provider)

Integration of Linda Mama

Cross-functional management

The NHIF branch office does not submit management reports to its headquarters. At present, the only data available is via the NHIF management information system (MIS) which can report on number of women registered, number of services, and claims (submitted, processed, pending). This information is not accompanied by a management report to interpret trends or flag issues.

The NHIF does not submit MIS reports to the County DoH. However, the NHIF does avail MIS data when requested by the county DoH. While there are no regular performance review meetings, a NHIF-DoH committee has been established which is intended to address problems and improve actions. The County Health Administrator on the County Health Management Team (CHMT) has been designated the focal point for NHIF engagement.

Leveraging other Initiatives

Accountability mechanisms are in place, which Linda Mama can leverage. Many public providers have hospital management boards or facility management committees, depending on the facility type. These structures have oversight over budgets and workplans and their endorsement is needed before an AIE can be raised and approved by the County Chief Officer. In one stance, a facility also referred to its Community Health Committee (CHC) which ensured an additional layer of accountability and a conduit for conveying community priorities.

Linda Mama has benefitted from leveraging other initiatives in Bungoma County. This has included a recent CHV training in which modules on Linda Mama and *SupaCover* were included, facilitated by NHIF branch staff. The First Lady's office is working with spouses of the Members of the County Assembly (MCAs) and MCAs themselves as a conduit for communication on Linda Mama. Given her passion for health, she has also taken part in field and radio appearances promoting Linda Mama.

Linda Mama has benefitted from the MANI project in Bungoma County. This has included facility-based performance-based financing (PBF) and transportation vouchers for pregnant women to reach health facilities. Both interventions have laid a solid foundation for Linda Mama as facilities have forged stronger community linkages and health workers have developed skills and experience in autonomous decision making on PBF, channeling reimbursements towards initiatives that promote quality and access to MNH services. While the MANI project plans to exit Bungoma County at the end of the year, supporting community awareness and facility readiness for uptake of Linda Mama is a key part of the programme's exit strategy. As such, the project team sees Linda Mama as *"…the beginning of a journey toward UHC."*

Conclusion and Recommendations

Bungoma County is well poised to deliver on the promise of Linda Mama. Linda Mama represents a tremendous opportunity for expectant mothers, who previously may not have been able to deliver in a facility (one such mother was met as part of the case study). As expectant mothers can designate a facility, healthy competition between providers also represents potential for driving up clinical quality and client-centred care within facilities and across providers. As public providers have some autonomy and authority over how reimbursements are spent, they can benefit from the Linda Mama 'fruit'. As a flagship programme for the county, the DoH leadership is also poised to deliver on the promise of Linda

Mama. The passionate support of the County First Lady has also provided foundation for success. This is bearing results as Bungoma County is reported to be leading on Linda Mama in the country.

While a strong foundation has been laid, there is still much that can be done to deliver on the Linda Mama promise. These are not unique to Bungoma and are of relevance to other counties, the Ministry of Health and the NHIF.

- **Develop strategies to encourage mothers to transit from Linda Mama to NHIF as part of plans for UHC.** Like the Linda Mama model facility (Box 1), this may include subsidy for indigent households while encouraging those who can afford to pay, to get on *SupaCover*.

- **Exploit opportunities to integrate sensitization and procedural orientation on Linda Mama into existing and planned health worker and community engagemen**t. Linda Mama should not be viewed as separate, but integral to other reproductive, maternal and neo-natal initiatives. Consider additional guidance on referrals, treatment of other delivery complications and mother or infant illness which is not currently catered for in the reimbursement schedule.

- **Provide procedural clarity to health workers and mothers on ANC and PNC packages, so that these are delivered consistently and completely.** Reinforce the inclusion of post-partum family planning (PPFP) within the PNC package. Consider a separate reimbursement, or a top up to one of the PNC visits, to cater for this service. The effective inclusion of modern PPFP in Linda Mama would allow Kenya a viable strategy for improving its uptake, which is estimated at only 16% at six months, despite an estimated 64% of women delivering in health facilities.[5] This suggests a missed opportunity for post-partum mothers.

- **Remove or reduce bottlenecks for the utilization of Linda Mama reimbursements in the public sector.** While funds are received directly into public facility back accounts, all AIE must be approved by the Chief Officer. Consider allowing hospital chief executives and sub-county medical officers AIE as a means of reducing reliance on one approval point.

- **Strengthen leadership and management of Linda Mama by the County DoH.** Consider regular Linda Mama management review meetings that include the NHIF, county health managers and the private sector so that problems are identified, and remedial actions implemented. Build county level leadership that seeks to more firmly define the role of Linda Mama and the transition of women from the programme on to *SupeCover* as part of the county's UHC plans.

End Notes

[1] World Health Organisation, 2007. Everybody's Business: strengthening health systems to improve health outcomes (WHO's Framework for Action), WHO, Geneva.

[2] Personal communication (Jan 19th, 2018), NHIF, Dr Fardosa, Manager Programmes and Schemes.

[3] This is a lengthy process and is documented in an Africa Health Markets for Equity (AHME) case study. Appleford, G., Therui, I. and Owino, E. January 2018. Brokering Accreditation in Kenya's AMUA Social Franchise Network, African Health Markets for Equity, Marie Stopes International.

[4] While the NHIF allowed for a "grace period" for July and Aug 2017 where facilities were allowed to claim without supporting identification, those that did not make their claims during this period have lost considerable income.

[5] Avenir Health, 2017. Opportunities for Family Planning Programming in the Post-Partum Period in Kenya. Avenir Health, Connecticut, USA.

For further information on this case study or the MANI project, please contact the MANI Team Leader, Nicole Sijenyi Fulton, n.fulton@manikenya.com The MANI project is a component of the Maternal and Newborn Health Programme funded by UKAid from the UK government.