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Strengthening Cross-Sector Partnerships in Maternal Health to Achieve Universal Health Coverage: Insights from Health Facility Administrators in Kilifi County, Kenya

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Abstract

Intersectoral collaboration serves as a tool to enhance efficiency by compensating for potential deficiencies in expertise, skills, and competencies within a department through resources from other sectors. In Kenya, there is limited research on intersectoral collaboration within the healthcare system. This study investigates the potential of intersectoral collaboration in maternal healthcare and strategies for leveraging such collaboration to advance universal health coverage (UHC) in Kenya. Free maternity services (FMSs) represent a key primary healthcare initiative driving the country towards UHC. Despite the pivotal role of UHC in shaping contemporary health policy, numerous challenges remain before its objectives can be fully realized. Additionally, competing priorities in health systems require complex, value-laden, and politically sensitive decisions regarding which health interventions and investments to prioritize. Consequently, this study aims to explore the perspectives of health facility administrators on whether intersectoral collaboration can facilitate the achievement of UHC in Kenya. The study focused on Kilifi County, Kenya, and draws on qualitative research conducted between March and July 2016, January to July 2017, and follow-up interviews during the COVID-19 pandemic in 2020–2021. Data were analyzed thematically. Findings suggest that the expanded free maternity services program, Linda Mama, represents a viable pathway to UHC. Participants emphasized the importance of equitable stakeholder representation, distributed leadership, and local participation, highlighting bargaining power as a critical factor in enhancing UHC through intersectoral collaboration under the Linda Mama program. These strategies require a bottom-up approach to foster accountability, ownership, and trust, all of which are crucial for achieving UHC.

Keywords: Maternal health, Intersectoral collaboration, Universal healthcare, Qualitative research, Kilifi County

Introduction

Health is both a prerequisite and a driver of sustainable development goals (SDGs), playing a central role in advancing the 2030 Agenda [1, 2]. Among the SDGs, only SDG 3 explicitly addresses health, though several targets across the remaining 16 goals indirectly influence health outcomes [3]. Major health-related targets, such as reducing preventable child mortality and addressing the HIV epidemic, are too extensive for the health sector to tackle alone and rely on progress under other SDGs. This underscores the importance of intersectoral action to improve health outcomes and highlights the need for collaboration between the health sector and other sectors to achieve the full spectrum of SDG targets, not solely those under SDG 3 [4–6]. Many countries have developed policies explicitly targeting universal health coverage (UHC), while others integrate UHC objectives into broader healthcare strategies, reflecting increasing recognition of UHC's role in improving population health and minimizing catastrophic healthcare expenditures [7, 8].

In Kenya, UHC embodies a novel framework for addressing poverty, social redistribution, state-citizen relations, health, and development, emphasizing innovative approaches to inequality and social justice [9]. UHC introduces fresh perspectives on governance, social

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protection, and the state's role in health [10, 11]. Since independence, Kenya has implemented numerous reforms and policy measures advancing UHC [4, 12], with its core objectives being to enhance financial risk protection and increase access to essential health services for citizens [3, 9]. Achieving these goals necessitates careful government prioritization and budgeting to provide equitable financial protection across socioeconomic and health status groups [13, 14].

Despite the widespread emphasis on healthcare services, the potential for intersectoral collaboration remains largely untapped in many low- and middle-income countries [5]. While prior research has examined health system components that may advance UHC in Kenya and Tanzania, drawing insights from healthcare professionals, patients, and policymakers [12, 15, 16], these studies did not investigate whether intersectoral collaboration itself could drive UHC. Other studies have emphasized stakeholder engagement, including community participation, and advocated bottom-up strategies for health policy reforms in diverse contexts [17–21], yet the potential for structured intersectoral collaboration remains unexplored. Muinde and Prince [9] highlight the need for further research to understand the policy silos that hinder intersectoral health strategies. In Kenya, maternal healthcare policy currently lacks a clear framework for intersectoral collaboration, making it crucial to explore health facility administrators' perspectives on establishing such partnerships to advance UHC.

There is a pressing need to support countries in implementing intersectoral health actions under the SDG framework, positioning health sector engagement as integral to UHC [5, 22, 23]. Existing frameworks, including "Health in All Policies" and the political economy of intersectoral action for health, can guide countries in this endeavor [24]. Intersectoral strategies involve deliberate cooperation among diverse sectors—such as health, economy, and environment—and stakeholders, including government, civil society, and private entities, to collectively achieve policy goals. Leveraging the knowledge, resources, and capacities of multiple sectors can enhance health outcomes, although improving public health remains challenging due to large populations and geographical disparities [25, 26].

Over the past twenty years, Kenya has made notable strides in improving access to healthcare and reducing overall mortality rates [27]. Despite these achievements, persistent inequalities in healthcare availability and health outcomes remain across the country [27]. As part of broader efforts to reform health systems, Kenya has prioritized ensuring equitable and affordable access to essential medical services. For instance, the proportion of births occurring in health facilities increased from 44% in 2008 to 61% in 2015 [28], partly driven by the launch of the free maternity services (FMSs) initiative in June 2013 [29]. However, studies indicate that the rollout of FMSs was rushed for political reasons, with limited engagement from both the public and relevant stakeholders, which hindered effective implementation [30–32].

Healthcare in Kenya is delivered through a combination of public hospitals, private-for-profit providers, and non-governmental organizations. Public facilities operate under a four-tier system comprising community-based services, primary health services, county referral facilities, and national referral hospitals [33, 34]. While user fees are applied in both private and public facilities, services at levels one and two of the public system are subsidized. Private facilities typically charge higher fees, making them more accessible to wealthier populations, whereas lower-income households rely predominantly on public services or lower-quality private providers [35]. The responsibility for delivering services at levels one to three rests with county governments, whereas national referral services and policy oversight are managed by the national government [36]. Devolution has further clarified these roles, with counties overseeing service delivery while the national government focuses on policy formulation, capacity building, and management of national referral hospitals [36].

Kenya's Constitution (2010) guarantees the right to health under Article 43(1)(a), stating that every person is entitled to "the highest attainable standard of health, which includes the right to healthcare services, including reproductive health" [37]. In alignment with this, Vision 2030 emphasizes sexual and reproductive health rights (SRHRs) as integral to improving quality of life, particularly for youth. The Social Pillar of Vision 2030 highlights the importance of equitable, affordable, and high-quality healthcare, including SRHR services, as part of the broader UHC agenda [12, 37].

Evidence suggests that involving stakeholders throughout all stages of policy development and implementation can help address underlying public health challenges and create contextually appropriate, sustainable solutions in sub-Saharan Africa [38]. Muinde and Prince [9] observed that although government

measures—such as free healthcare services and expanded national health insurance coverage—aimed to increase access, perceptions among ordinary citizens (wananchi) varied. Structural inequalities, patronage systems, and historical exclusion continue to shape access to healthcare, with promises of inclusion often masking entrenched inequities. These dynamics raise important questions about trust, accountability, and equity, which are critical considerations for intersectoral collaboration in healthcare. The present study therefore investigates whether such disparities and issues of trust could influence the success of intersectoral collaboration, with a focus on health facility administrators' perspectives regarding the potential role of such collaboration in advancing UHC in Kenya.

Materials and Methods

Study setting

This qualitative study was conducted in Kilifi County, located along Kenya's coast. Kilifi faces semi-arid and arid climatic conditions, with seasonal water shortages affecting over 65% of residents, while flooding and droughts threaten food security and agricultural productivity. Poverty levels are high, with approximately 66.7% of the population living below the poverty line, and about 67% of households experience food insecurity. The county is predominantly rural [28]. The main ethnic group is the Giriama, a sub-tribe of the MijiKenda, whose livelihoods primarily involve subsistence farming, supplemented by activities such as salt mining, small-scale trade, cashew nut processing, palm wine production, and animal husbandry. Kilifi ranks among the top 15 counties in Kenya for maternal and perinatal mortality [21, 39]. The study was carried out at Kilifi County Referral Hospital, the primary referral facility in the region. Additional details on the study setting are documented in previous publications by the author [12, 30, 40, 41].

Study design

This research employed a qualitative design and formed part of a broader multidisciplinary project on inclusive growth through social protection in maternal health programs in Kenya (SPIKE). The overarching aim of SPIKE was to understand community perspectives on social protection initiatives, with particular attention to local participation in policy development [11]. Within this context, the present study specifically investigated the views of health facility administrators on whether intersectoral collaboration could advance the achievement of UHC in Kenya. The study was conducted longitudinally to capture evolving perspectives over time.

Study sample and data collection

Data were collected longitudinally through multiple waves of interviews. The initial rounds of fieldwork were conducted from March to July 2016 and January to July 2017. Follow-up interviews were subsequently conducted during the COVID-19 pandemic in 2020, specifically between June and July and again from September to October. Health administrators were selected purposively based on their key roles in maternal and child health and their responsibilities in managing healthcare operations at both hospital and county levels. Inclusion criteria required participants to have held administrative positions for at least three years prior to the study. Lower-level healthcare staff and personnel without administrative responsibilities were excluded.

A total of 10 key informant interviews were conducted with health administrators whose roles provided critical insight into the implementation of free maternity services and their potential contribution to UHC. In addition, two round-table discussions were held in the county health boardroom, each including four health administrators. Discussions were documented through written notes and audio recordings. Informal conversations with administrators within health facilities were also conducted during the 2016–2017 fieldwork to explore local perceptions of maternal health social protection programs. The five matrons—senior nurse–midwives overseeing departmental operations—were intentionally included in the study, with interviews focusing on the two busiest health facilities in the county. During the COVID-19 follow-up in 2020, these same five matrons constituted the study population [39]. Therefore, the study sample comprised both health administrators and matrons operating at county-level facilities.

Data analysis

Thematic analysis was employed to interpret the qualitative data [42]. Audio recordings were transcribed using the F5 transcription-free software, and handwritten notes from informal conversations were manually coded. Codes were reviewed collaboratively by the researcher and supervisors to identify recurring patterns and overarching themes. Data analysis continued until

thematic saturation was reached, meaning no new themes emerged. Findings are presented in detail and supported with verbatim quotations from participants.

Ethical considerations

Participants were fully informed of the study's objectives and were free to withdraw at any time. Participation was voluntary, and only those who provided consent engaged in the phone interviews; no participants declined involvement. Ethical approval for the study was obtained from the Maseno University Ethical Review Committee (reference number MSU/DRPI/MUERC/00206/015) on 2 March 2017.

Findings

The analysis of this study highlighted several key themes that illuminate health facility administrators' perspectives on how intersectoral collaboration could contribute to achieving UHC in Kenya. The major themes identified were equitable stakeholder representation, the necessity of collaborative and distributed leadership, and active local participation coupled with bargaining power.

Stakeholder representation

During interviews with a nurse from a maternal and child health clinic, as well as in round-table discussions, participants emphasized the importance of ensuring balanced representation in both the formulation and implementation of health policies. They argued that insufficient stakeholder inclusion represented a major limitation of the FMS program as a social protection initiative. A nurse noted:

"FMS is a good social protection program. But, if healthcare providers, especially those responsible for maternal and child health, are not included during policy making, it is challenging to implement. There should be equitable representation, including local communities, local administration, and other social institutions that can support the FMS agenda. We overlooked community health volunteers in this policy, yet they play a crucial role in health outcomes. Achieving UHC remains difficult, and collaboration is essential to advance this agenda" (Interview with health facility nurse).

A round-table participant further observed:

"FMS has a drawback: lack of representation. UHC cannot be realized without intersectoral collaboration. However, these collaborations must include all stakeholders involved in health, ensuring fair representation during policy implementation. Health alone cannot achieve goals such as UHC" (Round-table discussant).

The discussions also revealed the importance of involving relevant institutions continuously to strengthen the UHC agenda. Participants suggested that such ongoing collaboration would increase awareness among local populations and other actors about the relevance and effectiveness of FMS in promoting UHC. A sustained collaborative approach would foster bottom-up engagement, giving institutions and communities more localized control over resources allocated from the national government through meaningful representation.

"With representation and ongoing bottom-up engagement with multiple actors, the UHC agenda will gain legitimacy. When communities and institutions are involved, they develop a sense of ownership over policies and resources meant to support mothers. Community engagement should be continuous and include educational initiatives" (Informal conversation with health facility administrator).

A matron in charge of maternal and child health added:

"If we consistently involve community members—for example, by engaging community health volunteers in maternity health talks—most mothers now understand their rights regarding maternity care and have changed their attitudes toward facility-based delivery, thanks to free maternity services" (Interview, Matron 06, MCH, Kilifi County).

Distributed leadership

Participants emphasized that effective intersectoral collaboration relies heavily on distributed leadership. Developing leadership capacity across different levels of government and sectors, as well as identifying champions in various domains to coordinate shared objectives, was seen as essential. Relying solely on national or county authorities was considered insufficient for sustaining intersectoral initiatives in healthcare. Participants highlighted the value of bringing together leaders with specialized knowledge in different areas of maternal health policy to strengthen collaboration.

"We have various organizations with leadership expertise, including mobilization, community engagement, and policy interpretation. These actors must be brought on board. Even for mothers in rural areas to appreciate the government's FMS initiative, we need leaders and experts from different fields involved" (Interview with Health Administrator).

Another participant noted:

"We can learn from leaders in organizations outside the health sector. By developing a clear implementation plan and strategy, transparency can be enhanced. FMS will continue, but to advance UHC, we must actively ensure that health services are linked with other sectors. The agenda must remain adaptable" (Round-table discussion with county health officials).

Participants stressed that policies aimed at achieving UHC should address the needs of communities by integrating leadership from multiple organizations. They also suggested mechanisms to support county and national authorities in fostering intersectoral collaboration, including knowledge sharing and involving leaders from non-health sectors.

"Mothers say they were never consulted, and even health workers were excluded. I wish the county and national governments had engaged more widely. Beyond politicians, leaders and experts from communities, local NGOs, and other partners should be included to help drive the UHC agenda forward" (FGD participant, April 2017).

Local participation and bargaining power

The findings also highlighted that community engagement is critical for achieving UHC in Kenya. Policy initiatives should view community members as active participants rather than passive beneficiaries, enabling them to take part in organizing, decision-making, and evaluating health programs. The involvement of communities is particularly crucial for initiatives like Linda Mama to meet their objectives. Participants noted that citizen engagement helps design UHC schemes that respond effectively to local priorities, while involving healthcare providers in decision-making enhances their bargaining power.

"Challenges exist with free maternity care, and some community members resist hospital deliveries. Economic hardships make even free maternity services costly because Linda Mama does not cover X-rays, medications, lab tests, or transportation. Nonetheless, ensuring safe births is essential. Health providers had to strike to be heard, which shows that communities must be engaged from the outset" (Round-table discussion with county health authorities).

"Local participation—or public involvement—is vital for successful policy implementation. When communities have a voice, they can advocate for UHC and demand quality services. For example, acceptance of the rubella vaccine improved because local community health volunteers were involved. Such engagement can also yield positive outcomes for FMS" (Interview with an administrator).

"If we could negotiate effectively with the national government, Linda Mama could be an excellent platform for advancing UHC in Kenya. Currently, we have limited room to influence policy; we mainly implement directives. Once health providers are consulted before policy rollout, we gain bargaining power and cannot be coerced" (Interview with health provider).

This section reflects on the key insights derived from the perspectives of health facility administrators and county health officials regarding the potential of intersectoral collaboration in maternal healthcare to advance UHC in Kenya.

Intersectoral or multisectoral health actions are defined as initiatives involving non-health sectors that can positively influence health outcomes [5]. The findings of this study suggest that equitable and inclusive representation of stakeholders is critical for the expanded free maternity services program to drive the UHC agenda. Such representation promotes the establishment of accountable and participatory institutions, ensuring that community voices are integrated into policy discussions. As noted by Pradier *et al*., 2023, and Rifkin, 2014 [43, 44], excluding key stakeholders can compromise the feasibility and community acceptance of interventions. Similarly, this study aligns with prior research [38, 45–47] showing that policies are more likely to succeed when community participation and multi-stakeholder involvement are prioritized. Obi, 2024 [20] further emphasizes that strategic engagement of local actors can enhance utilization of primary healthcare services and expand access to maternal health care, contributing to UHC.

Reports by Pratt, 2018 and 2019 [48, 49] also underscore that inclusive representation strengthens the adoption of health policies. In contrast to the implementation of FMSs without adequate stakeholder input, involving community representatives in policy design can improve understanding and acceptance of such programs. The findings highlight that achieving UHC in Kenya cannot rely solely on the SDGs. Given the interrelated nature of the SDGs across health, education, agriculture, and environmental sustainability, addressing complex challenges requires multi-sectoral approaches. Bennett *et al*., 2020 [50] argue that the interconnectedness of SDGs necessitates innovative thinking, which can be

operationalized through inclusive stakeholder representation from the grassroots level. This study demonstrates that convening representatives from diverse communities, organizations, disciplines, and cultural backgrounds fosters knowledge sharing, deliberation, and the development of solutions to advance UHC via initiatives such as Linda Mama.

The study also revealed that collaborative and distributed leadership provides an alternative pathway for enhancing local accountability and engagement in implementing Linda Mama, promoting transparency, inclusiveness, and active participation. Building people-centered health systems requires addressing power imbalances, fostering trust, and aligning the interests of different actors. Abbas *et al*., 2022; Fourie, 2001; Ombere *et al*., 2023 [17, 51, 52] argue that codifying regulations limits the influence of a small elite, amplifying marginalized voices and ensuring long-term representation. Despite Kenya Vision 2030's emphasis on social development, the study indicates that intersectoral collaboration can make healthcare services both affordable and accessible, regardless of socio-economic status. In this context, distributive, accountable, and collaborative leadership within programs such as Linda Mama can serve as a catalyst for Kenya to achieve UHC and realize the health objectives embedded in Vision 2030.

This study highlights a notable deficiency in local participation during the expansion of free maternity services. Health providers reported limited bargaining power to advocate for certain priorities and emphasized that some objectives could not be realized without appropriate incentives for community members. Previous research also indicates that Kenya's free maternity services program was implemented rapidly, serving both as a pathway toward UHC and as a politically sensitive initiative [12, 30]. This study argues that meaningful stakeholder involvement in program design is essential to ensure the appropriateness, acceptance, and long-term sustainability of interventions; without it, even carefully crafted programs may fail to achieve their intended outcomes. Prior studies have shown that many public health initiatives focus on increasing awareness under the assumption that knowledge alone drives behavior change [43]. Incorporating local participation as part of intersectoral collaboration enhances the likelihood that health strategies are culturally and educationally appropriate, with program structures aligned to community norms and values [12, 45, 47]. Evidence also suggests that applying participatory principles throughout policy development and implementation can address underlying causes of public health challenges in sub-Saharan Africa, yielding long-term, contextually suitable solutions for UHC [20, 38]. Furthermore, this study echoes findings by [52] that building institutions requires "trust," with community respect for health systems linked to both the care provided and contributions to societal well-being [12, 53]. Effective community involvement is contingent upon the relevance and targeting of health activities in which community members are engaged [20].

For UHC to succeed through initiatives such as Linda Mama, it is critical for legislators to understand the primary healthcare needs of local communities, capturing emic perspectives. Allowing communities to monitor and participate in programs strengthens trust in politically neutral or locally owned initiatives. These results support WHO recommendations that active community engagement in the planning and implementation of maternal and child health programs improves health outcomes [13].

Conclusion

Health equity is inherently complex and requires engagement from multiple sectors and stakeholders. Despite the challenges of achieving UHC in Kenya, there is growing recognition of its importance in enhancing healthcare access. This study, a follow-up examination of the expanded free maternity services program Linda Mama, presents insights from health administrators on how the program could facilitate Kenya's progress toward UHC and the potential role of intersectoral collaboration. Using qualitative methods, the study found that Linda Mama is a valuable initiative. Given the interconnected nature of the SDGs, advancing UHC necessitates intersectoral collaboration. Participants emphasized that realizing effective collaboration requires fair stakeholder representation, collaborative and accountable leadership, and active community participation with bargaining power. Such approaches provide a comprehensive and integrated framework for implementing Linda Mama, fostering local ownership and supporting Kenya's sustainable advancement toward UHC.

Limitations

A major strength of this study is that it represents one of the first anthropological investigations focusing on

health administrators' perspectives regarding strategies to enhance intersectoral collaboration within the Linda Mama program for advancing UHC in Kenya. However, a key limitation is that the study relied solely on health administrators' viewpoints, and as policymakers at the county level, their responses may have been subject to exaggeration. To mitigate this, multiple data collection methods were employed to triangulate findings, strengthening the study's reliability. Additionally, perspectives from administrators of other institutions—including NGOs, faith-based organizations, private hospitals, and international agencies involved in maternal healthcare—were not included, representing a potential area for future research. While the findings may not be generalizable beyond Kilifi County due to inter-county variability, the study identifies critical contextual factors that can inform policymakers and guide evidence-based strategies to strengthen the implementation of UHC in Kenya.

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