



## East African Journal of Health and Science

[eajhs.eanso.org](http://eajhs.eanso.org)

Volume 8 Issue 2, 2025

Print ISSN: 2707-3912 | Online ISSN: 2707-3920

Title DOI: <https://doi.org/10.37284/2707-3920>



EAST AFRICAN  
NATURE &  
SCIENCE  
ORGANIZATION

Original Article

### Perceptions of Healthcare Providers on Quality of Services and Their Satisfaction During Implementation of Free Maternity Services Policy in a National Referral Hospital, Kenya

Dr. Christine Mwikali Musee, PhD<sup>1</sup>\*, Judith Mutindi Mweu<sup>1</sup> & Dr. Lydia Okutoyi<sup>1</sup>

<sup>1</sup> Kenyatta National Hospital, P. O. Box 20723-00202, Nairobi, Kenya.

\* Author for Correspondence Email: [christinemusee@gmail.com](mailto:christinemusee@gmail.com)

Article DOI: <https://doi.org/10.37284/eajhs.8.2.3306>

Date Published: **ABSTRACT**

10 July 2025

**Keywords:**

Free Maternity  
Services,  
Mothers,  
Policy,  
Quality,  
Satisfaction.

In Kenya, the Ministry of Health policies shape healthcare affordability and access. A free maternity policy was announced with executive directives for immediate implementation without considering hospital human resource capacities, processes and financial requirements. Subsequently, the study site experienced a 100% increase in hospital deliveries under constrained human resources, supplies, infrastructure and other resources. Thus, objectives assessed the perceptions of healthcare providers on the quality of services and their satisfaction during the implementation of the free maternity services policy in a national referral hospital, Kenya. Through a cross-sectional design, this survey purposively collected data from 50 doctors and nurses using questionnaires, with quantitative and qualitative aspects, and 20 Key informants, being managers and/or team leaders (till saturation was achieved). Quantitative data was analysed using Stata version 12 to yield frequencies and percentages, and qualitative data was thematically coded and analysed using NVivo version 15. Some opinions have been quoted directly. Findings obtained showed response rate of 50(100%); skills, personal preparedness, deployment, support-supervision (p value 0.05), workload, job satisfaction, capacity to cope with increased patients, availability of various resources, cleaning agents, cleanliness (p value 0.003), and quality of care were rated between excellent-poor. Key informants said, "...the workload is very high. We are doing our best and living one day at a time...access to healthcare has increased...it is not sustainable...with overstretched infrastructure, no supplies...mothers are sharing beds, confidentiality and privacy is remarkably reduced...litigations...complaints may increase..." In conclusion, there was a mismatch between the increased number of clients and the already existing strains in staffing, resources, and infrastructure. Although the majority of healthcare providers faced a myriad of challenges during this period, they identified the capacity to provide quality services and expressed satisfaction.

#### APA CITATION

Musee, C. M., Mweu, J. M. & Okutoyi, L. (2025). Perceptions of Healthcare Providers on Quality of Services and Their Satisfaction During Implementation of Free Maternity Services Policy in a National Referral Hospital, Kenya. *East African Journal of Health and Science*, 8(2), 134-148. <https://doi.org/10.37284/eajhs.8.2.3306>

#### CHICAGO CITATION

Musee, Christine Mwikali, Judith Mutindi Mweu and Lydia Okutoyi. 2025. "Perceptions of Healthcare Providers on Quality of Services and Their Satisfaction During Implementation of Free Maternity Services Policy in a National Referral Hospital, Kenya". *East African Journal of Health and Science* 8 (2), 134-148. <https://doi.org/10.37284/eajhs.8.2.3306>

#### HARVARD CITATION

Musee, C. M., Mweu, J. M. & Okutoyi, L. (2025). "Perceptions of Healthcare Providers on Quality of Services and Their Satisfaction During Implementation of Free Maternity Services Policy in a National Referral Hospital, Kenya", *East African Journal of Health and Science*, 8(2), pp. 134-148. doi: 10.37284/eajhs.8.2.3306

#### IEEE CITATION

C. M., Musee, J. M., Mweu & L., Okutoyi "Perceptions of Healthcare Providers on Quality of Services and Their Satisfaction During Implementation of Free Maternity Services Policy in a National Referral Hospital, Kenya", *EAJHS*, vol. 8, no. 2, pp. 134-148, Jul. 2025.

#### MLA CITATION

Musee, Christine Mwikali, Judith Mutindi Mweu & Lydia Okutoyi. "Perceptions of Healthcare Providers on Quality of Services and Their Satisfaction During Implementation of Free Maternity Services Policy in a National Referral Hospital, Kenya". *East African Journal of Health and Science*, Vol. 8, no. 2, Jul. 2025, pp. 134-148, doi:10.37284/eajhs.8.2.3306.

## INTRODUCTION

Healthcare policies remove hurdles, set boundaries, and shape direction to access healthcare services. Nevertheless, free maternity policies (FMP) often fashion utilisation inequities and inequalities between populations. Access to skilled maternity health (MH) improves service quality, patients' experiences, screening, referrals, and reduces delays, morbidities, and mortalities [1]. The experiences and satisfaction of healthcare providers (HCPs) is tied to healthcare coordination mechanisms, organisational practices, and infrastructure [2], which were all affected by the introduction of FMP in Kenya [3]. Other aspects of HCP experiences and job satisfaction were related to recognition, professionalism, supervisor commitment, experience, communication, job autonomy, fairness, stress, communication, routinization, age, locus of control, and education [4], many of which were affected by the introduction of FMP. Thus, the need to assess experiences (quality and satisfaction) of providers of maternity healthcare services in Kenya, where a free maternity policy had been precipitately introduced.

In Kenya, the hasty implementation of FMP resulted in insufficient stakeholder involvement, incomplete service coverage, although hospital deliveries and antenatal clinic attendances increased despite insufficient staffing, poor reimbursement, stockouts, and inconsistent data collection plans. Workloads enlarged, and myriads of challenges were experienced [5]. One hospital recorded higher health-seeking behaviour from maternity mothers, service quality, and perinatal results, but increased staffing, resourcing, and creation of awareness were recommended [6]. Evidence exposed that appropriate, timely information and informed improvements would empower clinic attendance, hospital deliveries, and live births [7]. In the current study site, the experiences of healthcare providers had not been assessed thus this study. The study sought to assess the perceptions of healthcare providers (nurses and doctors) on quality and satisfaction during the implementation of the free maternity services (FMS) policy in a national referral hospital, Kenya.

## MATERIALS AND METHODS

This cross-sectional survey employed questionnaires with qualitative and quantitative aspects in the maternity health department of a

national referral tertiary hospital in Kenya. In-depth key interviews were also conducted, recorded, transcribed, themes created, coded, and analysed alongside study objectives.

**Study Design:** A cross-sectional study

**Study Location:** A national referral hospital in Kenya, Nairobi County. Data collection was done in antenatal/postnatal (AN/PN) wards, antenatal clinic (ANC), and labour ward (L/W).

**Study Duration:** February 2015 to February 2016

**Sample Size:** 50 healthcare professionals, 9(18%) doctors, and 41(82%) nurses. The aim was to get the critical 30 individuals as a minimal sample because satisficing was being experienced related to increased workloads [8; 9]. Additionally, having a minimum of 30 participants is considered necessary to yield reliable results [10].

**Sample Size Calculation:** A target minimum of 30 nurses and doctors was set, and 50 were realised.

**Data Collection Tools:** Open-ended questionnaires were used to ensure quantitative and qualitative aspects. Key Informant (KII) interviews were

conducted on team leaders and managers using key informant (KI) interview schedules.

**Pilot testing:** Pilot testing was done to ensure the validity and reliability of data collection tools. The average Cronbach's Alpha was 0.81 and Principal Component Analysis was 0.78. Thus, reliability and reliability ascertained before data collection. Pilot testing findings were not included in the overall study findings.

**Data Collection:** After ethical approval, voluntarily consenting doctors and nurses participated in the survey. Ethical principles were upheld.

**Data Analysis:** Qualitative data was analysed using STATA software version 12, and qualitative data were coded thematically and analysed using N-Vivo version 15. Descriptive values are in frequency tables, and cross-tabulation was done using chi-square to identify associations. A cutoff of  $\geq 0.05$  was used to determine significance.

## RESULTS

This section represents the findings obtained from the nurses and doctors who were interviewed in this research.

**Table 1: Demographic Data and Some Characteristics of the Healthcare Providers**

VARIABLE	Frequency (n)	Percent (%)
<b>Health Provider Cadre</b>		
Doctors	9	18
Nurses	41	82
<b>Duration of Service in Hospital</b>		
0-9 years	23	46
10-19 years	9	18
20 years and above	18	36
<b>Providers Felt Appropriately Deployed</b>		
Yes	44	88
No	6	12
<b>Providers Felt they Received Adequate Support-Supervision and Supervision to Effectively Discharge Their Duties</b>		
Yes	27	55.1
No	22	44.9

A total of 50 health providers working in the maternity health department (MHD) voluntarily participated in the research. They comprised of

41(82%) nurses and 9(18%) doctors. Most had worked in the hospital for 0-9 years, 23(46%), 10-19 years, 9(18%), and more than 20 years, 18(36%).

Eighty-eight percent felt that they were appropriately deployed, and 27 (55.1%) received adequate support-supervision to effectively discharge duties, as displayed in Table 1.

## QUALITY OF SERVICES

### Availability of Cleaning Resources

Figure 1 shows the availability of resources to maintain cleanliness in the maternity healthcare

department. Running water was reported to be available always by 49 (98%) HCPs and disinfectant by 46 (82%). Most 34 (68%) HCP reported that they always received other supplies to discharge their duties of quality MHS. This availability may determine the cleanliness and to level of quality of healthcare services and satisfaction of HCPs with the work environment.

**Figure 1: Health Provider Responses on Resource Availability, Maternity Healthcare Department**

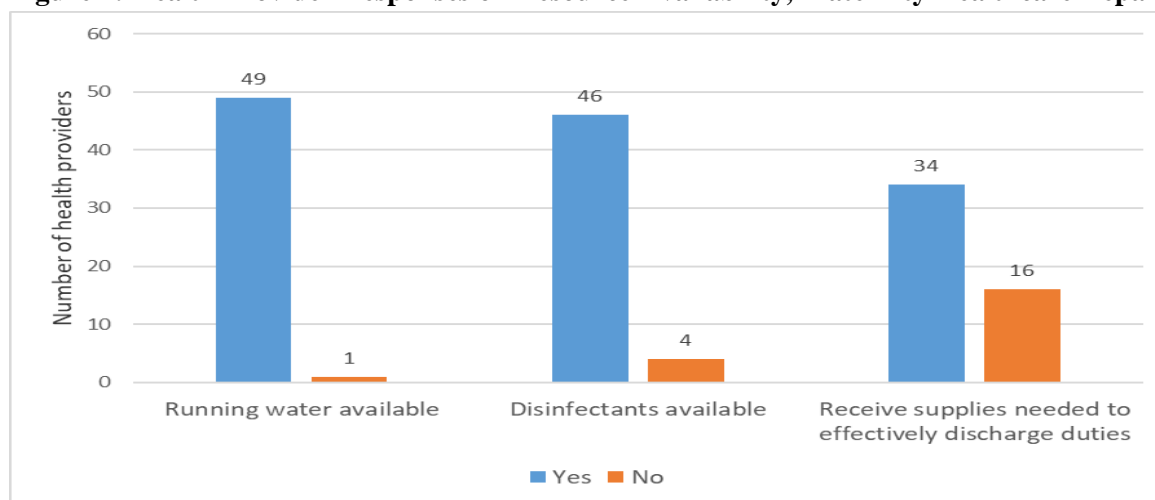
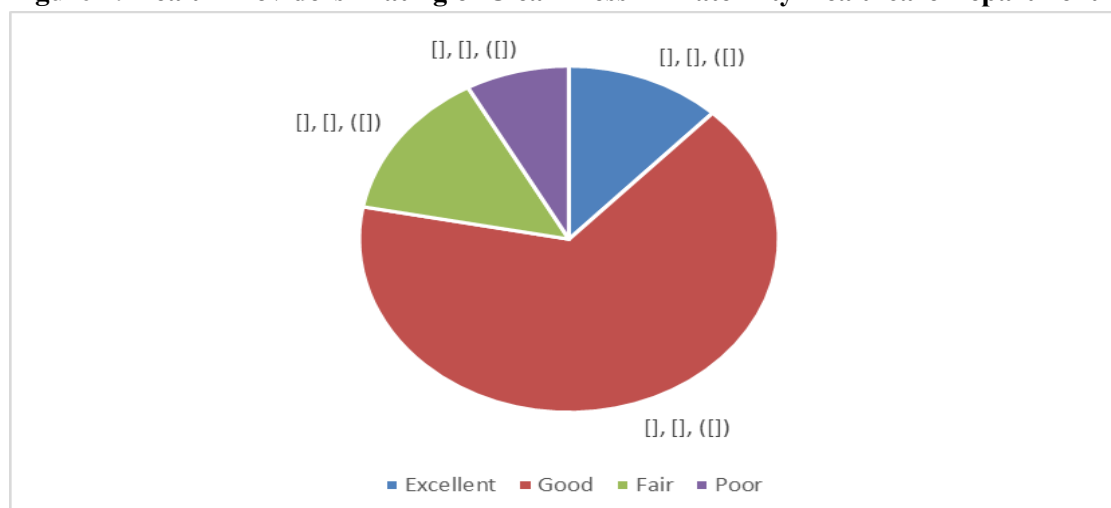


Figure 2 shows that about two-thirds (66%) of HCPs rated the cleanliness of the maternity healthcare department as good. The remaining providers either rated cleanliness as excellent 6 (12%), fair 7 (14%), or poor 4 (8%).

A key informant said, “...the place is clean except for the high patient traffic...it is a bit heavy for the cleaner, but they are doing their best... KI 1”

**Figure 2: Health Providers' Rating of Cleanliness in Maternity Healthcare Department**



There was a significant association between the availability of disinfectant and cleanliness ( $p = 0.003$ ). Nurses and doctors who reported that disinfectants were available were also more likely to rate cleanliness as excellent (Table 2). Providers reported level of support-supervision ( $p = 0.05$ ) was statistically significant, but availability of running water ( $p = 0.099$ ) and always having supplies in ( $p$

$= 0.314$ ) were not statistically significantly associated with cleanliness. A key informant commented, “...*this place cannot do without detergents, soap, and water...they are available...specifically the chlorine-based detergents are not only good cleaning agents, but disinfecting the blood product contaminated surfaces in this time and error... KI 1*”

**Table 2: Comparison of Providers' Rating of Cleanliness and Availability of Disinfectants**

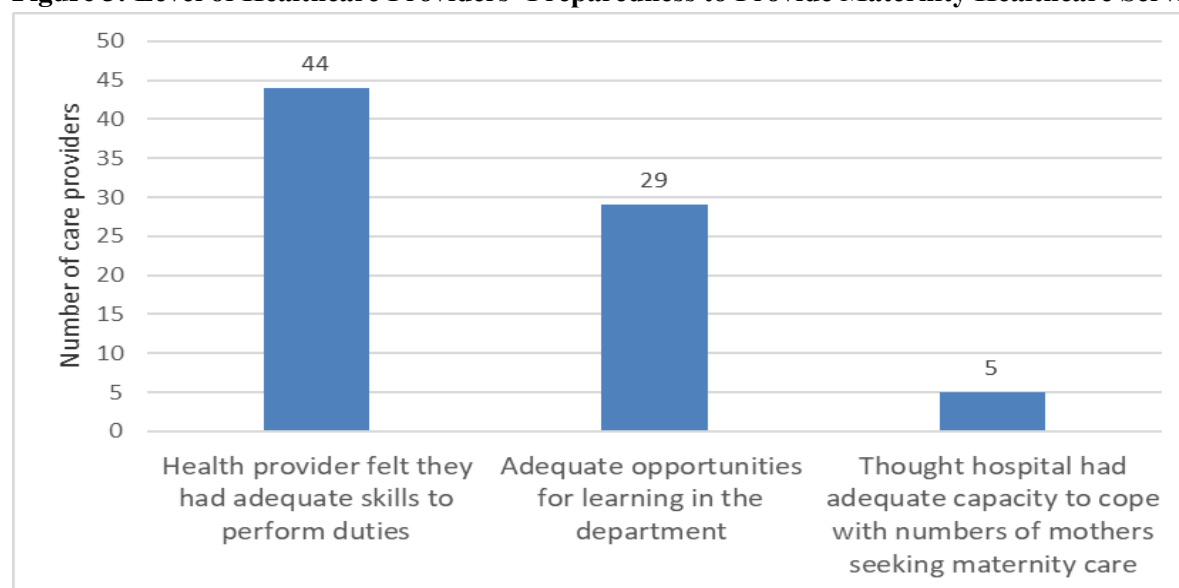
VARIABLE	Rating of Cleanliness in the Working Area				P-value
	Excellent	Good	Fair	Poor	
Support-Supervision Received	5(83.3)	19(57.6)	3(42.9)	0(0.0)	0.05*
Running Water Always Available	6(100.0)	33(100.0)	6(85.7)	4(100.0)	0.099
Disinfectants Always Available	6(100.0)	32(97.0)	6(85.7)	2(50.0)	0.003*
Supplies always available					
Yes	4(66.7)	25(75.8)	4(57.1)	1(25.0)	0.314
No	2(33.3)	7(21.2)	3(42.9)	2(50.0)	

### Health Provider Preparedness and Support-Supervision in Providing Maternity Healthcare Services

Figure 3 shows that 44 (88%) HCPs said they had adequate skills to perform their duties, while 29 (58%) reported adequate opportunities to learn. There were 5 (10%) HCPs who felt that the hospital had adequate capacity to cope with the influx of

mothers seeking maternity healthcare services. They recommended training through formal short course packages as an essential part for maternity health providers, and KIs reported high coverage of more than 90% of midwives. Support supervision may determine the quality of services and HCP satisfaction even in hard times.

**Figure 3: Level of Healthcare Providers' Preparedness to Provide Maternity Healthcare Services**

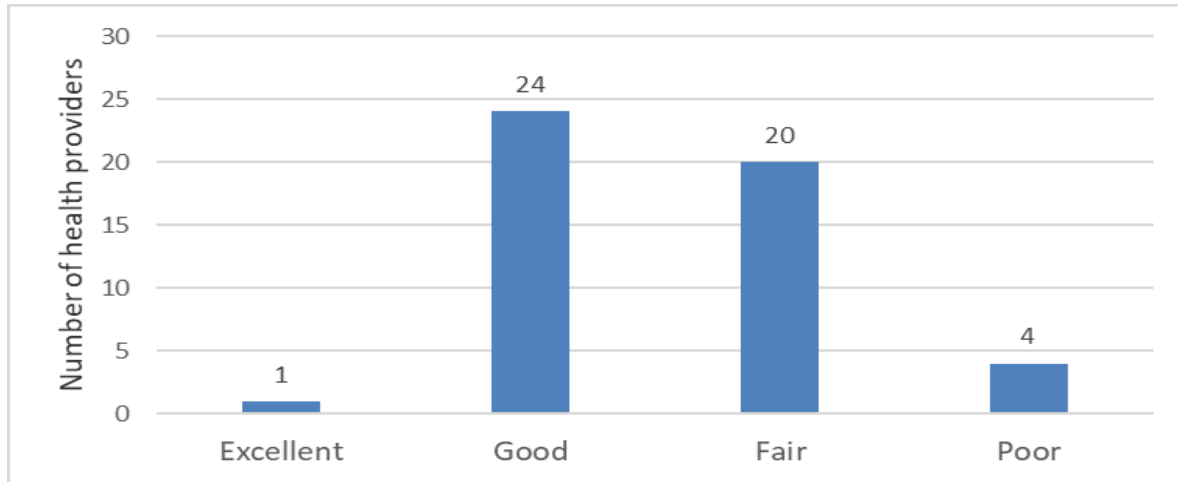


Regarding adequacy of skills for quality performance, a KI said, “... even before implementation of FHP...we realised that a midwife manages a lot of critical cases, ...these midwives here are a very learned crop, I can say almost 95% have done EMONC ... some have done PRONTO... Some have done [both] ... and that has boosted their

morale and confidence even during this patient influx....” KI 7.

As shown in Figure 4, most health HCPs rated the overall quality of maternity healthcare services as good 24 (48%), fair 20 (40%), or excellent 1 (2%).

**Figure 4: Quality of Free Maternity Healthcare Services Provided in the MH Department**



A key informant said, “...here we are committed to quality maternity healthcare at all costs, the suppliers are trying, and our managers are helping a lot, although staffing is short... KI 6”

Table 3 shows that the HCPs’ overall rating of quality of care was not significantly associated with their cadre, deployment, preparedness, resource availability, deployment, or opportunities to train.

**Table 3: Quality of Maternity Healthcare Services and Provider Attributes**

Quality of Maternity Healthcare Services					
VARIABLE	Excellent	Good	Fair	Poor	P-value
Health provider cadre					
Doctors	0(0.0)	3(12.5)	4(20.0)	2(50.0)	0.323
Nurses	1(100.0)	21(87.5)	16(80.0)	2(50.0)	
Appropriate deployment					
Yes	1(100.0)	20(83.3)	19(95.0)	3(75.0)	0.54
No	0(0.0)	4(16.7)	1(5.0)	1(25.0)	
Availability of supplies					
Yes	0(0.0)	18(75.0)	13(65.0)	2(50.0)	0.275
No	1(100.0)	5(20.8)	6(30.0)	2(50.0)	
Skills to perform duties					
Yes	1(100.0)	21(87.5)	18(90.0)	3(75.0)	0.84
No	0(0.0)	3(12.5)	2(10.0)	1(25.0)	
Adequate opportunities to learn					
Yes	1(100.0)	17(70.8)	10(50.0)	1(25.0)	0.198
No	0(0.0)	7(29.2)	10(50.0)	3(75.0)	



### Quality Healthcare is Tagged to Access

Key informants said that maternity health services were tied to maternity healthcare access. An informant said,

*“...for me, quality is accessibility first and foremost... so the affordability comes with accessibility and good outcomes for the patients... Also, still on the side of the patients the duration of staying in the hospital is optimal which means if somebody has been discharged then they go home the same day as opposed to the past where you will find somebody has been discharged but because of lack of funds they would stay in the hospital for a very long time...”* KI 2. Another KI said, *“... more patients have access, which ... resulting from, less bureaucracy for the patient, admissions are quick, the discharges are quick and we can release the patients in time they go home because they are not retained in the ward waiting to clear the bills and that’s a big plus for the project on the side of the patient. Even for us [health providers], in a way it’s easier to attend to those patients, though there are very many, but since they can come, we can intervene a bit earlier, getting more satisfactory results in mothers and babies...”*

### Access was Viewed as Good, but was Causing Overwork, and Quality Compromise was a Threat

Although access was viewed to be good, they expressed fears of overwork that might compromise the quality of services. A KI said,

*“...I think on the flip side is that large numbers of patients have come, almost 200% so because the numbers are high it has overwhelmed the HealthCare workers and so most likely it is going to compromise the quality or the timeliness of the service delivery; for instance delays in surgery and caesarean-sections, so from the patients’ point of view there is delay of providing timely services because the numbers*

*are increased and this jeopardizes quality. The numbers also cause overcrowding, and this means they share beds in the wards... infection prevalence becomes a challenge...”* KI 4.

### Fears of Increased Numbers of Litigations Following Overwork and Burnout

Increased chances of litigation were expressed as a possibility. ... A KI said, “

*...The healthcare givers are being overworked with the number of patients, and are getting burned out...quality and outcomes may be bad, and this exposes the hospital to litigation. We have seen complaints from the patients, and some of them are going to court...”* KI 6. It was noted that the hospital had adopted minimal locum slots in an attempt to reduce staff shortage and sustain the quality of care. A Key informant said, *“... the number of caregivers is short, against the big numbers of the patients. However, the management has supported us with locum for midwives to some extent...”* KI 1.

### Strained Resources Might Become a Hurdle to the Quality of Services

Respondents felt resources might become a hurdle to quality. A KII said,

*“...The resources do not match the patients. The numbers are high and the resources are limited, for example, the infrastructure and the number of beds are too few for the patients. They are sharing beds, making it uncomfortable to them and the confidentiality and privacy are remarkably reduced...again with the large numbers, human resource is strained...and already there were existing staff shortages ...this causes long delays in getting essential services, especially those who need operations...”* KI 10.

### Further Improvement, Infrastructure, and Reimbursement

While linking previous findings on customer satisfaction, a respondent connected the quality of services with HCP satisfaction. A KI said,

*“...quality can be defined in patient/staff satisfaction ... I cannot remember the last satisfaction survey we did... around maternity services before this policy. What I remember is that they were satisfied with the services, around 78%... however, they had a lot of recommendations around quality, saying it needs improvement... issues on infrastructure, supplies and timeliness of services.... free maternity care policy has overstretched the infrastructure, supplies... and right now the reimbursement is very slow so those are the major issues...”* KI 4.

### Quality Improvement Projects may Uphold and Sustain Quality of Services During Influx.

Respondents associated the quality of services with seamless service flows despite high numbers of patients. A quality improvement project was put in place during the period to maintain the quality of services. A KI said,

*“...To mitigate on probable delay ..delay of caesarean-sections forced us to put remedy, like now having two theatres to work 24 hours. It had an impact on the delay of caesarean-section in time, and that has been mitigated by having additional staff; we just have approval for locum for doctors, actually registrars over the weekend for them to run that.... So, delays caused some problems with the quality and outcomes, but now they are being addressed as they emerge...”* KI 4.

### Stakeholder Engagement May Increase the Quality of Services.

Respondents said varied stakeholders needed to be given information to have sustained quality of MHS ... A KI said,

*“... we still need to do a little bit of health education, ...what has been a challenge is the patients; ...when the policy was there were no guidelines, ... several patients who would probably benefit from service at the primary care level are being treated in tertiary level as self-referrals without complication at all...”* KI 9.

A KI indicated that the quality of services would only be realised and sustained based on the timeliness of reimbursement of funds. A KI said,

*“...if only there would be reimbursement as promptly as we require expenditure, ... we have been eating into budgets for other departments.... If this does not improve, at some point, we are going to get stuck...”* KI 7. A KI said, *“...The reimbursement is ...not in consideration of the complications we manage here, they are only reimbursing deliveries.... Referred complications after delivery are not covered even when the mother or baby lands in critical care areas.... Some mothers in critical care have not been paid for...”* KI 4.

### Sustainability and Quality of Services

Quality was pegged on being able to sustain FMS. A key informant said that the sustainability of quality FMHS would depend on healthcare financial funding. A KI said,

*“...It is sustainable with support from the government, including availability of resources, both human and materials...”* KI 1.

Someone else said,

*“...it is not sustainable, and if it is going to be sustainable, the government will have to look for ways and means of getting more funding and increasing budgetary allocation to the health sector guided by the Abuja declaration; the 15% allocation to the health sector...”* KI 2”



## SATISFACTION OF NURSES AND DOCTORS

### Working and Service Environment and HCP Satisfaction

Most HCPs reported dissatisfaction with the hospital reward system, 34(70.8%). Employee morale was either good 23(46.9%) or fair 16(32.7%). Most 40(81.6%) HCPs said that despite

this, they would still recommend getting employment within MHD to others. Approximately two-thirds felt that they got adequate support-supervision shown in Table 4. Support-supervision was statistically significant (p value 0.05). Existing satisfaction with deployment may affect satisfaction when the work environment terrain changes.

**Table 4: Providers' Evaluation of Working Environment**

VARIABLE	Frequency (n)	Percent (%)
<b>Providers' satisfaction with the Hospital's Reward System</b>		
Yes	13	27.1
No	34	70.8
<b>Provider rating of Employee Morale</b>		
Excellent	3	6.1
Good	23	46.9
Fair	16	32.7
Poor	7	14.3
<b>Providers Would Recommend Deployment to the MH Department to an Acquaintance.</b>		
Yes	40	81.6
No	8	16.3
<b>Rating of Support-Supervision Provided</b>		
Yes	31	68.9
No	13	28.9

More than one-half (n = 28) HCPs were satisfied with their job within MHD (Table 6). They felt that the workload was high, 23 (46.9%) or moderate, 21 (42.9%), and 22 (44.9%) manageable and 23 (47.9) felt that their work was moderately related to their job descriptions. A key informant said,

*"... The maternity healthcare department is one of the best places I have worked and would confidently recommend it to others anytime. The management and teamwork are awesome..."*

**Table 5: Overall Job Satisfaction and Rating of Level of Satisfaction with Various Aspects of the Job**

VARIABLE	Health Provider Responses on Satisfaction				
	Very satisfied	Satisfied	Neutral	Very dissatisfied	
<b>Rating of satisfaction with the job</b>	2(4.1)	28(57.1)	15(30.6)	4(8.2)	
	<b>High</b>	<b>Moderate - high</b>	<b>Moderate</b>	<b>Least-moderate</b>	<b>Least</b>
<b>The degree to which workload affected the quality of care</b>	23(46.9)	4(8.2)	21(42.9)	0(0.0)	1(2.0)
<b>The degree to which the workload was manageable</b>	5(10.2)	4(8.2)	22(44.9)	5(10.2)	13(26.5)
<b>The degree to which the work was related to the job description</b>	18(37.5)	3(6.3)	23(47.9)	2(4.2)	2(4.2)

Some Key informants gave comments,

*“...the workload is very high. We are doing our best and living one day at a time. The management is addressing the staff shortage through locums, and a quality Improvement project is addressing the caesarean sections... KI 5.”*

*“...we have a colleague counsellor in the ward...every week we hold a debriefing session, but I have a friend whose back is already affected and she is having physiotherapy sessions... KI 3”*

*“...my work is related to my job description, although sometimes we do task-shifting just to ensure every patient's need is addressed... our work is quality... KI 8.”*

## DISCUSSIONS

Among the health care providers, the majority comprised nurses. Similarly, evidence shows that globally, 50% of the healthcare workforce are nurses, and their representation in research has improved tremendously [11-12]. On the one hand, response rates among doctors have been riddled with lower rates due to satisficing [9], and therefore, there is a need to encourage doctors to commit time to participate in research whenever an opportunity arises, to have their voices represented. As service users, both cadres are expected to actively get involved in their improvement [13] and thus the need to create awareness. Influences of participation in research previously identified include protected research time, mentorship, hospital policies, funding and incentives, leadership, and peer support [14]. Thus, despite competing engagements, healthcare staff and patients need to be mentored to participate in large numbers to increase population representation, reliability, validity, precision of influence, and reduction of margin error.

Regarding staff deployment, most staff felt appropriately deployed and were getting support-supervision to discharge their duties, and

subsequently were satisfied with their jobs. Evidence shows that deployment ought to consider needs, future changes in health and staff interests, capacity, and training. This way, retention is eased with additional incentives [15]. In regard to the working environment, cleanliness and running water were always available, and cleanliness was rated fair to excellent. In addition, the availability of cleaning supplies was shown to be associated with health provider reports of the hospital being clean, pointing to the need to provide cleaning supplies to the maternity healthcare department. In this breath, evidence highlights the core function of cleanliness, supplies including equipment, infection prevention and control, training of cleaning staff for better performance and clinical outcomes [16].

Regarding the capacity of the hospital to cope with the implementation of free maternity services, most providers expressed concerns about the large numbers of mothers but said the facility would cope. A key informant said that there was a main advantage of increased access for mothers to skilled facility-based maternity care. This led to early presentation with timely identification of complications and timely interventions. Early presentation was related to health care quality through relatively low complications, common in late presentations. In a previous study, although overcrowding was reported, improved health-seeking behaviour and improved perinatal outcomes were reported [6]. Elsewhere, patient influxes were associated with poor quality of care, delays in service delivery, and inefficiencies, which in turn affected triaging and emergency care outcomes [17].

Regarding healthcare access and health-seeking behaviour, key informants also reiterated that the introduction of free maternity healthcare services led to the adoption of positive health-seeking behaviour by clients and promoted equity in accessing care, whereby mothers from very low socioeconomic groups were able to access services in a national referral hospital. There were also direct

benefits related to the reduction in administrative bottlenecks during the admission and discharge of maternity clients. However, access was shown to often lead to higher turnouts than expected, which may result in poor prioritisation of care and triaging challenges [18].

On quality of care, while staff felt that resources and infrastructure were constrained, most rated quality of care as good-fair. They felt that the quality of care was also tied to the level of staffing. Concerns from KIs were related to the influx of clients attending care and resource constraints, with negative implications on the quality of care. They expressed fears that the sharing of beds by patients would result in the acquisition of nosocomial infections and dissatisfaction. Healthcare providers would be overworked and stressed. Although there are researchers who show that high patient numbers may result in reduced quality of care, overwork and staff burnout, others indicate that there is no difference in quality [2; 17; 19].

Concerns on staff shortages and levels of supplies featured a lot as a mismatch between the increased numbers of patients and the already existing strains in both financial and human resources, and infrastructure. Similar experiences were reported during the COVID-19 pandemic, including staff shortage, which led to early retirement, psychological and physical stresses and strain, and subsequent burnouts and further insufficient staffing rates [20]. In the current study, debriefing sessions and locum employment were employed as stopgap measures to address these.

Respondents feared workloads that may lead to staff burnout. Key informants reported that the patient workload significantly impacted health providers' productivity and wellbeing, resulting in burnout and decline in quality of care in some areas/aspects. Previous research identified higher burnout prevalence among physicians and nurses than in paramedics and other medical and non-medical staff, but a few of the affected used psychological support [21] as an intervention. Thus, healthcare

providers were at increased risk of overwork and its consequences. Effective interventions recommended included protecting and valuing providers, reducing administrative burdens, increasing access to mental health, increasing investment in workers, and improving the culture of supportive supervision and well-being [22].

The implementation of the free maternity policy had small increases in staffing numbers, increased administrative focus on maternity healthcare. Nonetheless, healthcare providers felt inadequate staffing was biting deep, despite managerial efforts in employing staff on locum, psychological and supplies increases were put in place. Previously, despite assumptions that locum workers pose safety and undermine quality of work in healthcare, evidence shows their performance is professional [23] and they give relief during labour shortages, leave days, holidays, bereavement, illness, and allow for agility in the recruitment terrain [24].

Healthcare providers were passionate about other aspects of the quality of maternity healthcare being given. They were aware of the potential impact of patient influx at the facility on the provision of quality maternity care. This was evident in the reported continuing efforts to define and continuously monitor indicators of quality of care, identified through the key informants. The perception of quality adopted focused on the processes of care and, more importantly, incorporated patient satisfaction. Evidence shows that customer satisfaction often determines healthcare financial performance and effectiveness. It has been shown that quality drives satisfaction, and satisfaction displays healthcare quality. Leadership, innovations, efficiency, network centrality, logistics, physical environment, and competition are antecedents to quality and satisfaction [25]. However, healthcare providers' burnout was associated with missed care, lower patient satisfaction, lower safety culture/climate, patient abuses, adverse effects and patient incidences, nosocomial infections, patient falls,

medication errors, patient complaints, and lower quality of care [26]

Apart from patient satisfaction, health providers used several process measures to demonstrate the impact of free maternity care regarding quality, including delays in receiving required care and human resources issues. There were reports of ongoing quality improvement projects focusing both on process (time taken to undergo a Caesarean-section) and structure (number of staff) of care domains. Researchers show that, although quality improvement projects may not be transferable elsewhere, they have been identified to fast-track the caesarean section pathway and have positive impacts on the mother/baby hospital stay period and reduce caesarean section rates [27-28].

In this spirit, KIs suggested remedies to streamline the implementation of free maternity healthcare policy through a better-informed public, by providing information on the organisation of health systems and referral pathways to decongest tertiary hospitals from treating minor ailments. This would be in line with the World Health Organisation (WHO) guidelines regarding the referral pathway within and outside pandemics [29], although many countries are still struggling with implementation. Knowledge, complexity of disease, distance, and communication were factors influencing referral [30]. Regarding training to have the necessary knowledge and skill as indicated by key informants, this has been reiterated by WHO [29] and Wanja, Njoroge, and Osoro [30].

On the financing of healthcare, several KI felt that they were not well informed about the financial issues, but needed to comment on them. They had concerns about reimbursement delays and uncertainties, and the amount allotted per patient or procedure, and the timings of reimbursements were not clear. There were complaints of delays lasting up to eight months between the provision of care and reimbursement of costs incurred. Healthcare financing has been echoed by WHO [29] because health financing drives every pillar in quality

healthcare planning, implementation, monitoring and evaluation, and improvement. However, the key informants identified the need to revise the rates of reimbursable charges to cover normal and complicated deliveries. This would ensure that the hospital would recover the costs used for the provision of complicated free maternity care. Evidence shows that delayed reimbursement was reported in previous studies with continued levying of services [30]. Additionally, free maternity healthcare services were not free. Clients paid out-of-pocket costs to top up, transport, drinks, water, food, clothes, and unavailable medicines for mothers and babies [32].

Regarding the sustainability of free maternity healthcare services, there were varied views from the respondents. While most informants were positive regarding sustainability, there were strong feelings that it would depend on the ability of the government to raise funds and develop robust financial systems for payment, staffing, leadership, integrity, and resource availability. It had been shown that, in the early moments of free maternity healthcare implementation, mothers and their relatives had substantial financial burdens to bear. Thus, inception was turbulent, and the process did not settle at all. Therefore, sustainability was not possible. A previous study shows that mothers and their significant others still bore the burden of costs for transport and some informal payments despite the connotation of healthcare being 'free' [33]. Overall, free maternity healthcare policy implementation was very useful with positive outputs, outcomes, and impact on healthcare providers, patients, and institutions, but not without a myriad of challenges and mixed perceptions.

## CONCLUSIONS

The quality of healthcare services was mainly positively rated. Cleanliness (p value 0.003) and support-supervision (0.05) were statistically associated with quality. Job deployment, availability of clean water, disinfectants, supplies and staff skills were rated well. Despite being ill-

prepared, having constrained resources, overstretched infrastructure, inadequate staffing, overwork, burnout, inconsistent financial reimbursement, and fear of increased litigations, patient complaints with reduced satisfaction, quality was rated positively by most providers. The satisfaction of nurses and doctors was associated with job deployment, reward system, work environment, workload and support-supervision. Suggestions to improve included better stakeholder engagement, reimbursement, addressing employee morale and creating awareness.

### Recommendations

- Policy makers and leaders need to put measures in place to sustain gains in free maternity healthcare policy implementation.
- Employers and the salaries and remuneration commission need to implement measures to increase staffing objective ratios, monitor and address the physical and psychological well-being of healthcare providers.
- Healthcare institutions ought to have regular customer satisfaction surveys (targeting internal and external customers) to draw from and continuously improve from the lessons and recommendations made.
- Further research needs to be done to cover the experiences of the cleaners and the other healthcare providers and paramedics.

### Study Limitations

This study lacks causal inferences and metric measures for the quality of maternity healthcare services and satisfaction levels of healthcare providers.

### Acknowledgements

Special acknowledgement to the funding institution and research site, study volunteers, and colleagues for all forms of support provided.

**Funding:** Institutional funding

### REFERENCES

1. LeBlanc ME, Testa C, Waterman PD, Reisner SL, Chen JT, Breedlove ER, et al. Contextualizing response rates during the COVID-19 pandemic: Experiences from a Boston-based community health center study. *J Public Health Manag Pract.* 2023;29(6):882–91.
2. Cantarelli P, Vainieri M, Seghieri C. The management of healthcare employees' job satisfaction: optimization analyses from a series of large-scale surveys. *BMC Health Serv Res.* 2023;23(1):428.
3. Orangi S, Kairu A, Malla L, Ondera J, Mbuthia B, Ravishankar N, et al. Impact of free maternity policies in Kenya: an interrupted time-series analysis. *BMJ Glob Health.* 2021;6(6):e003649.
4. Saha S, Saha SK, Jha A, Kumar S. Job satisfaction among health-care practitioners: A bibliometric analysis. *J Radiol Nurs.* 2025;44(1):68–77.
5. Tama E, Molyneux S, Waweru E, Tsofa B, Chuma J, Barasa E. Examining the implementation of the free maternity services policy in Kenya: A mixed methods process evaluation. *Int J Health Policy Manag.* 2017;7(7):603–13.
6. Kainde M, Adela MM. Perinatal outcomes of free maternity services in Mama Lucy Kibaki Hospital, Nairobi County, Kenya. *Int J Community Med Public Health.* 2020;7(10):3860.
7. Lang'at E, Mwanri L, Temmerman M. Effects of implementing free maternity service policy in Kenya: an interrupted time series analysis. *BMC Health Serv Res.* 2019;19(1):495.
8. Teame K, Debie A, Tullu M. Healthcare leadership effectiveness among managers in Public Health institutions of Addis Ababa,



- Central Ethiopia: a mixed methods study. *BMC Health Serv Res.* 2022;22(1):540.
9. Weaver L, Beebe TJ, Rockwood T. The impact of survey mode on the response rate in a survey of the factors that influence Minnesota physicians' disclosure practices. *BMC Med Res Methodol.* 2019;19(1):73.
10. Memon M, Ting H, Cheah J, Thurasamy R, Chuah F, Cham T. Sample size for survey research: Review and recommendations. *J Adv Sci Eng Manag.* 2020;4(1):1–10.
11. Arshabayeva GA, Kumar AB, Yessirkepov M, Zimba O, Kocyigit BF. Advancing research, writing, and publishing in nursing: Addressing challenges and improving standards. *J Korean Med Sci.* 2024;39(38):e297.
12. Smythe A, Carter V, Dube A, Cannaby A-M. A better understanding of nursing research roles may help to embed research into clinical structures. *Br J Nurs.* 2022;31(21):1108–10.
13. Sy MP, Panotes A, Cho D, Pineda RC, Martin P. A rapid review of the factors that influence service user involvement in interprofessional education, practice, and research. *Int J Environ Res Public Health.* 2022;19(24):16826.
14. Chen Y-S, Liao K-C, Yau S-Y. From hesitation to participation: a narrative review of facilitators and barriers for healthcare professionals' engagement in medical education research. *BMC Med Educ.* 2025;25(1):302.
15. Technical Advisory. Augmentation programs towards improved health outcomes [Internet]. Washington (DC): HRH2030 Program; [cited 2025 Jun 9]. Available from: [https://hrh2030program.org/wp-content/uploads/2020/08/3.2\\_HRH2030PH\\_Development-Program-Study-Technical-Advisory](https://hrh2030program.org/wp-content/uploads/2020/08/3.2_HRH2030PH_Development-Program-Study-Technical-Advisory).
16. Cross S, Gon G, Morrison E, Afsana K, Ali SM, Manjang T, et al. An invisible workforce: the neglected role of cleaners in patient safety on maternity units. *Glob Health Action.* 2019;12(1):1480085.
17. Rasouli HR, Esfahani AA, Nobakht M, Eskandari M, Mahmoodi S, Goodarzi H, et al. Outcomes of crowding in emergency departments: A systematic review. *Arch Acad Emerg Med.* 2019;7(1):e52.
18. Francetic I, Meacock R, Sutton M. Free-for-all: Does crowding impact outcomes because hospital emergency departments do not prioritise effectively? *J Health Econ.* 2024;95:102881.
19. Wolfgang F, Glaser F, Pruckner G. Hospital crowding and patient outcomes [Internet]. Econstor.eu; 2024. Available from: <https://www.econstor.eu/bitstream/10419/308786/1/1914650778.pdf>
20. Butler CR, Webster LB, Diekema DS. Staffing crisis capacity: a different approach to healthcare resource allocation for a different type of scarce resource. *J Med Ethics.* 2024;50(9):647–9.
21. Izdebski Z, Kozakiewicz A, Białorudzki M, Dec-Pietrowska J, Mazur J. Occupational burnout in healthcare workers, stress and other symptoms of work overload during the COVID-19 pandemic in Poland. *Int J Environ Res Public Health.* 2023;20(3):2428.
22. Murthy VH. Confronting health worker burnout and well-being. *N Engl J Med.* 2022;387(7):577–9.
23. Ferguson J, Walshe K. The quality and safety of locum doctors: a narrative review. *J R Soc Med.* 2019;112(11):462–71.
24. Weyn T. A fresh outlook: Workforce management with locum tenens. *Physician Leadersh J.* 2023;10(3):49–51.

25. Peral PO, Rambaud SC, García JS. Quality of care and patient satisfaction: Future trends and economic implications for the healthcare system. *J Econ Surv*. 2024 Aug 14; [Epub ahead of print].
26. Li LZ, Yang P, Singer SJ, Pfeiffer J, Mathur MB, Shanafelt T. Nurse Burnout and Patient Safety, Satisfaction, and Quality of Care: A Systematic Review and Meta-Analysis. *JAMA Netw Open*. 2024;7(11):e2443059.
27. Javernick JA, Dempsey A. Reducing the Primary Cesarean Birth Rate: A Quality Improvement Project. *J Midwifery Womens Health*. 2017 Jul;62(4):477–83.
28. Bowden SJ, Dooley W, Hanrahan J, Kanu C, Halder S, Cormack C, et al. Fast-track pathway for elective caesarean section: a quality improvement initiative to promote day 1 discharge. *BMJ Open Quality*. 2019 Jun;8(2):e000465.
29. High-value referrals: learning from challenges and opportunities of the COVID-19 pandemic. Concept paper. Copenhagen: WHO Regional Office for Europe; 2023.
30. Wanja T, Njoroge K, Osoro EN. Factors influencing the upward referral system of patients in Nairobi County. *Int J Community Med Public Health*. 2021 Sep 27;8(10):4759.
31. Pyone T, Smith H, van den Broek N. Implementation of the free maternity services policy and its implications for health system governance in Kenya. *BMJ Glob Health*. 2017 Nov;2(4):e000249.
32. Acharya J. Are Free Maternity Services Completely Free of Costs? *Osong Public Health Res Perspect*. 2016 Feb;7(1):26–31.
33. Oyugi B, Kendall S, Peckham S. Effects of free maternal policies on quality and cost of care and outcomes: An integrative review. *Prim Health Care Res Dev*. 2021;22:e32.