Policy Brief

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Maternal Deaths on the Rise in Kenya: A Call to Save Women's Lives

Recent estimates indicate a significant drop worldwide in the number of women dying from pregnancy related causes, from an estimated 422 in 1980 to 251 per 100,000 live births in 2008. A combination of factors can be credited for the decline, including better care during delivery, lower birth rates and increased educational attainment for women. These declines may also be attributed to the international commitment to maternal health spelled out in the Millennium Development Goals (Goal 5: Improve maternal health). This is encouraging news to motivate countries to continue investing more to reduce a problem that has long been seen as intractable.

While the global news about maternal health is positive, Kenya is not only lagging behind the world, it is experiencing an increase in maternal mortality: More women are dying from pregnancy related causes today than they did five years ago. In 2003, the number of women dying from pregnancy related causes was 414 deaths per 100,000 pregnancies. By 2009, the number had increased to 488, representing about 15% of all deaths of women aged 15–49.

This Policy Brief intends to provide appropriate information on priority areas that require action and more resources in order to reverse the trend.

In Kenya, however, the recent trend has tragically been in the other direction. The 2008-09 Kenya Demographic and Health Survey (KDHS; KNBS and ICF Macro, 2010) found that more women are dying of pregnancy and childbirth related causes than was the case in 2003 (CBS et al., 2004) – 488 versus 412 per 100,000 live births. This is a matter of great concern, as these deaths arise from well-known preventable causes – obstructed labour, complications of unsafe abortion, infections, haemorrhage and high blood pressure. All are treatable (see Figure 1).

With skilled health care during pregnancy and delivery, provided in an adequately supplied and equipped health facility, these premature deaths can be prevented. Although the government has an obligation to provide these services, many women in Kenya have no or only limited access to appropriate care and in cases where it is available it is often of poor quality.

Kenya has endorsed international conventions and calls to action as a commitment to development and the allocation of resources to

health and development interventions. These commitments include the International Conference on Population and Development (ICPD), which spells out the rights of women to be informed and to have access to maternal health care services, and the Millennium Development Goals articulated in the Millennium Declaration. Nationally, Kenya's own Vision 2030 emphasizes women's health and the reduction of maternal deaths (GOK, 2007).

Despite these endorsements, financial and political commitment to maternal health is lacking and as a result there is no progress on maternal mortality. The low priority afforded to women's needs means that women continue to die and their families to suffer.

MDG 5, for example, sets the target for reducing maternal deaths from 414 per 100,000 live births in 2003 to 147 per 100,000 live births by 2015 and to achieve universal access to reproductive health care. Kenya is well off target on this goal and going backwards. At this critical point in the countdown to 2015, political commitment and more resources for maternal health care services are required to accelerate progress.

Areas of Concern

Skilled attendance at delivery, postnatal care, obstetric care and family planning are important interventions for reducing maternal deaths. Unfortunately, Kenyan women do not have access to these services, do not understand their value, cannot afford them or do not use them because of cultural reasons.

Skilled Care Inadequate

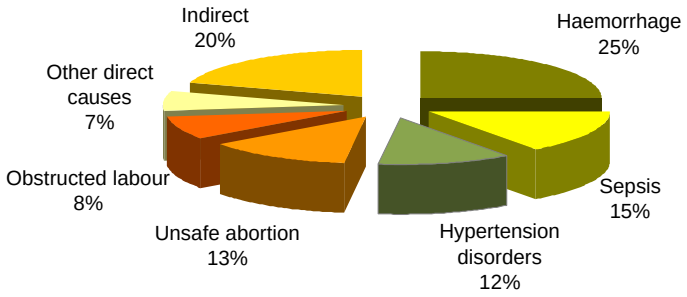
The presence of a skilled attendant at birth reduces the likelihood of maternal death as complications that require urgent medical attention can be identified and referred. Skilled attendants include doctors, clinical officers, nurse and midwives who have been trained to manage normal deliveries, recognize complications and refer women to a more advanced level of care.

Only 44% of Kenyan births are assisted by these skilled personnel. In fact, 28% of women deliver at home assisted by traditional birth attendants, 21% by untrained relatives or friends, and 7% with no assistance from anyone (KNBS and ICF Macro, 2010).

Traditional birth attendants (TBAs) are not regarded as skilled birth attendants because they generally do not have the necessary skills to recognize, manage and prevent pregnancy-related complications; this puts the life of the mother and the child at risk. According to recent estimates, only about 2 in 10 Kenyan TBAs have undergone any type of formal training in birth assistance (Tawiah, 2007). Unfortunately, even in cases where the TBAs have formal training, they still practise traditional ways of managing births – often with disastrous consequences for the women who use their services (Kamal, 1998).

Most women (42%) have little choice but to give birth at home because of lack of transport and long distances to health centres. The problem is particularly common in arid and semi-arid lands, where health facilities are poorly equipped and are far from homes with no passable road or transport available. Some women (21%) do not think it is necessary to deliver at a health facility

Figure 1: Causes of maternal deaths



Maternal death refers to the death of a woman while pregnant or within 42 days of the end of pregnancy from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (WHO, 2004). The maternal mortality ratio (MMR) is the number of maternal deaths per 100,000 live births. The MMR is used as a measure of the quality of a health care system.

It is estimated that skilled attendance at birth, backed by emergency obstetric care when needed, would reduce maternal deaths by 75% (UNFPA and Guttmacher, 2009).

(KNBS and ICF Macro, 2010). Low education levels, coupled with low awareness of the existence of or the need for skilled birth attendants, further reduce demand for delivery services. For there to be a significant reduction in maternal deaths, the immediate goal is to have a skilled attendant present during every delivery.

Emergency Obstetric Care Is Inadequate

In general, 15% of all pregnant women are at risk of serious obstetric complications. All pregnant women should therefore have access to quality basic or comprehensive emergency obstetric care.

Obstetric care in Kenya is limited, especially in rural areas where the majority of women live. The services that are available, whether provided by the government or private medical practitioners, are mainly concentrated in urban areas, and are thus inaccessible to the majority of women. Maternal health facilities in Kenya are also often poorly equipped and lack important components of maternal health, i.e., normal delivery, postnatal care and emergency services (NCAPD et al., 2004). This means that even in cases where the mother gets to the health centre, there is no guarantee she will get the services she needs.

Many Women Do Not Go for Postnatal Care

The risk of death for mothers is highest immediately after delivery (the 48 hours after delivery). Postnatal care is therefore essential to prevent complications after childbirth. Only 42% of women receive postnatal checkups within two days of delivery, and more than half of women who give birth do not seek postnatal care. These figures are worrying, given that pre- and postnatal care are critical to women's health. The mothers mostly affected are those in the lowest wealth quintile, those with low levels of education and those in remote areas like North Eastern Province where 79% of women do not receive postnatal care. Targeting services to such areas would potentially have a great impact on mortality levels.

High Unmet Need for Family Planning

The risk of maternal death increases with each pregnancy, and with pregnancies that are too close together. Satisfying women's unmet need for family planning, that is, ensuring access to contraceptives by women who want to space or avoid pregnancies but are currently not using contraception, could reduce unintended pregnancies, unsafe abortions and maternal deaths.

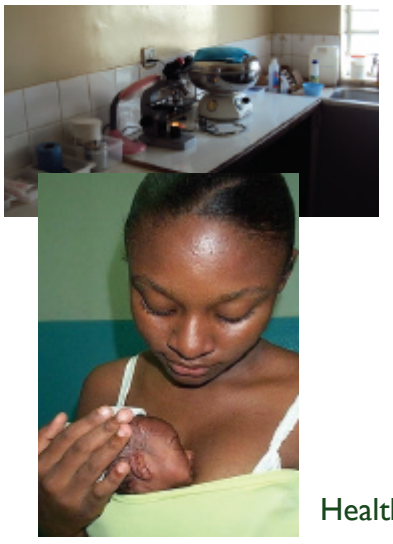
Kenya continues to have a high unmet need for family planning. About a quarter of currently married women who want to space or limit their births are not using any form of contraception. Access to modern contraceptives would enable women to avoid unwanted and too many pregnancies, which can lead to unsafe abortions and complications associated with too many births. It could also reduce maternal deaths by more than one-third (UNFPA and Guttmacher, 2009).

Some 28% of women deliver at home assisted by traditional birth attendants, 21% by untrained relatives or friends, and 7% with no assistance from anyone.

Quality of Staff Is a Key Concern

Antenatal, delivery, postnatal and other obstetric care services provided in public health facilities are substandard. Service provider harassment and mistreatment of women in public health facilities in Kenya is reportedly rife (NCAPD and ORC Macro, 2006). Providers are not only frequently unfriendly to women, but also regularly fail to answer their questions, ask them for important routine information or counsel them during antenatal care consultations.

Many if not most service providers also lack more advanced skill, for example recognizing and treating life threatening complications. It is important to improve the performance of health care



Health facility equipped to save lives

providers by increasing training opportunities and making them accountable to the public.

Public Health Sector Is Under-Financed and Characterized by Shortages of Most Basic Essentials

Kenya's public health sector capacity to respond to the needs of women is limited. The sector is under-financed and characterized by shortages of most basic essentials. It frequently suffers stock-outs of medications and basic supplies including contraceptives, shortage of personnel and a lack of key equipment.

For example, complications related to unsafe induced abortions are a major cause of maternal deaths (NCAPD et al., 2004) and although one of the priorities of the Kenyan National Reproductive Health Strategy is to extend the coverage of post-abortion care, so far such services remain scarce (NCAPD and ORC Macro, 2006). Many health facilities lack basic supplies for complicated deliveries, including blood transfusion services, and kits for post-abortion care. Investing in health systems is critical to the improvement in maternal health and achievement of the MDGs. Perhaps more to the point, as indicated above, if adequate family planning services were available there would be fewer unintended pregnancies and thus much less demand for induced abortions.

FGM puts mothers and their babies in substantial danger during childbirth. Death rates are higher for infants born to girls and women who have undergone this practice.

Traditional Harmful Practices Affect Maternal Health Outcomes

Some Kenyan communities persist with traditional practices even though they have been found to be harmful to the health and wellbeing of women and girls. Two of the most detrimental are early marriage and female genital mutilation (FGM), often euphemistically referred to as female circumcision or female genital cutting.

Early Marriage

Marriage before the age of 18 is a reality to many Kenyan girls. This is in spite of the practice being illegal. Early marriage results in early childbearing, which carries health risks to the mother and child. Babies born to young mothers are more likely to die in their first year of life than those born to older mothers aged 20–29 years (KNBS and ICF Macro, 2009).

The adverse effects of early marriages extend beyond the immediate health risks. Girls who marry early are often forced to drop out of school and this has negative consequences in life including lack of employment opportunities and impaired personal growth, which can lead to poverty.

"We must fight for women's health with all our resources all the time".

– Ban Ki-Moon, UN General Secretary

Female Genital Cutting

Female genital cutting (FGM) is generally performed on young girls below 10 years. This practice has grave consequences during childbirth, especially for women who have undergone extreme forms of the procedure. According to the World Health Organization, the practice is linked to increased complications in childbirth and maternal deaths. Other side effects are severe pain, heavy bleeding, infection, infertility, urinary incontinence, and psychological and sexual problems.

FGM also puts babies in substantial danger during childbirth. Death rates are higher for infants born to girls and women who have undergone this practice (UNICEF, 2008).

Although the practice is a violation of children's rights and is outlawed by the Children Act of 2001, it is still practised in many Kenyan communities among young girls. Current estimates indicate that 27% of women are circumcised. The practice is more prevalent among the Somali (98%), the Kisii (96%) and the Maasai (73%). Supporting the right of girls and women to lead healthy lives and eliminating harmful practices can improve maternal health.

Moving Forward

It is possible to reduce maternal deaths if women have access to skilled attendance at delivery, emergency obstetric

care when needed and family planning. This would go a long way in reducing mortality and improving the health of women, and as a result move Kenya closer to achieving the MDG 5 targets on maternal health and the goals of Vision 2030.

There have been efforts by the ministries of health to reverse poor health indicators. The Kenya Essential Package for Health (KEPH), for example, aims to improve the health and well being of all Kenyans (MOH, 2007). It defines six phases of the human life cycle and sets target for improving the health of each one. It also defines six levels of care, from the community to the national referral hospitals.

There is a strong emphasis on service delivery to the wider public and a focus on communities as the foundation of affordable, equitable and effective health care as proposed in the second National Health Sector Strategic Plan (NHSSP II). The overall goal of the Community Strategy is to enhance community access to health care, which includes maternal and obstetric care (MOH, 2006).

The Reproductive Health Output-Based Approach currently being implemented by the Ministry of State for Planning, National Development and Vision 2030 and the Ministries of Health is an attempt to make selected services available and affordable to poor women.

The output-based approach concept entails financing for agreed outputs rather than for predefined inputs by selling vouchers for reproductive health and family planning services at subsidized prices to poor patients. The programme aims to improve the delivery of reproductive health services in the short run, thus contributing directly to MDG 5.

Delivery at a well-equipped facility, with a trained birth attendant, saves lives of both mothers and babies.

Access to modern contraceptives could reduce maternal deaths by more than one-third.

Other initiatives to address maternal health include the development of the National Reproductive Health Policy, which has highlighted maternal health priorities, updated standards and national guidelines for maternal care, and provided for the promotion of community midwifery.

Much more can be done with political and financial commitment to ensure maternal health is protected. Strengthening health systems to ensure the country can deliver proven interventions effectively is critical. NCAPD recommends the following actions:

For ministry officials and policy makers:

- Increase government allocation for contraceptives to ensure that women who want to space or avoid pregnancy have access to modern contraceptives.
- Provide adequate and sustained government funding for maternal health.
- Mainstream the output-based approach project piloted in Nairobi, Nyanza and elsewhere.
- Train health workers appropriately to improve client relations and quality of care.
- Make health providers more accountable to the public in order to improve their performance, e.g., through enforcement of Citizen Service Charters and individual performance contracts with the government.
- Enforce existing laws and policies against early

Government action in educating the community on the dangers of female circumcision and early marriages and enforcing existing laws forbidding such harmful practices is critical.

marriages and female circumcision.

For programme managers:

- Provide information and encourage more frequent antenatal and postnatal visits – Pregnant women need care during this critical period for their health and that of the baby.
- Promote preventive knowledge among community members – Most maternal deaths are avoidable, and the health care solutions to prevent or manage the complications are well-known.

No woman should die while giving life!

– Slogan of The Campaign on Accelerated Reduction of Maternal Mortality (CARMMA) launched by the 4th Session of the AU Conference of Ministers of Health, held in Addis Ababa in May 2009 (UNFPA, 2010)

- Involve men to join in the responsibility for the health of their wives and children.
- Educate communities on the dangers of early marriage and pregnancy, as well as of female genital mutilation, as these are among the contributors to such problems as obstructed labour.

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NCAPD is a semi-autonomous government agency that formulates and promotes population policy and coordinates related activities for sustainable development in Kenya.