Tackling High Maternal Deaths in Kenya

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PARLIAMENT OF KENYA

Policy Brief

Introduction

Maternal death is defined by the World Health Organization (WHO) as the death of a woman while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management [1]. Kenya continues to have a high maternal mortality ratio (MMR), despite the commitment from the government to address the issue. Calculations by WHO, UNICEF, UNFPA and the World Bank, based on available national data for Kenya, show that MMR declined minimally (by 26 percent) between 1990 and 2015, from 687 per 100,000 births to 510 and the lifetime risk of a maternal death is 1 in 42 [2].

The 2014 Kenyan Demographic and Health Survey estimated a lower MMR (362 per 100,000 live births) and lifetime risk of a maternal death (1 in 67) and concluded that the decline in MMR between 2008-09 and 2014 was not significant [3]. Parts of Kenya are far more affected than others. The 2008-09 Kenyan Demographic and Health Survey recorded Mandera County's MMR as the highest at 3,795 deaths per 100,000 live births, a rate that surpasses that of wartime Sierra Leone (2000 deaths per 100,000 live births) and far above Kenya's national average in that year (448 deaths per 100,000 live births)[1].

Worldwide, about three quarters (73 percent) of all maternal deaths between 2003 and 2009 are due to direct obstetric causes, which are preventable, and more than a quarter (28 percent) are due to indirect causes [4]. Among the direct obstetric causes of maternal deaths, haemorrhage, hypertensive disorders, and sepsis are responsible for more than half of maternal deaths worldwide and complications of unsafe abortion account for eight percent of the deaths [4]. Similarly, in Kenya, haemorrhage, hypertensive disorders, and sepsis are responsible for more than half of maternal deaths whereas complications of unsafe abortion and obstructed labor account for 13 percent and 8 percent of deaths, respectively [5]. These life-threatening pregnancy-related outcomes are preventable by ensuring that all women have access to proven lifesaving maternal health services including contraceptives for preventing unintended pregnancies and unsafe abortions, and prenatal, delivery and post-natal care for early detection and prompt management of complications related to pregnancy and childbirth [6].

Key Messages

- Deaths of girls and women from child-birth and other pregnancy-related causes remain high in Kenya, at 362 in every 100,000 live births. Between 2016 and 2030, as part of the sustainable development agenda, the target is to reduce the global maternal mortality ratio to less than 70 per 100 000 live births.
- Inadequate resource allocation, which translates to lack of or weak infrastructure and inadequate medical supplies and health care personnel, coupled with poor community education and involvement in maternal health care provision, all contribute to high maternal deaths.
- Increased allocation of resources to health care provision, improved infrastructure and adequate and well trained health care personnel as well as better community education and involvement in health care provision, would bring down maternal deaths.

Policy framework

Reducing maternal mortality has been at the top of the global health agenda for over the last 20 years. To build upon the momentum generated by the 5th Millennium Development Goal (MDG 5), a transformative new agenda for maternal health has been laid out as part of the Sustainable Development Goals (SGAs) to reduce the global MMR to less than 70 per 100,000 live births by 2030 of which Kenya is a signatory [7]. At regional level, Kenya is signatory to several regional mandates promoting health in general and reproductive and maternal health including: the 2001 Abuja Declaration, pledging to commit at least 15 percent of the national budget to health care [8]; and the African Union's Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) launched in November 2010 with the slogan "no woman should die while giving life" [9].

At national level, the Constitution of Kenya (2010) is supportive of reproductive and maternal health. Article 43(1) (a) gives every person the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care [10]. The Constitution also provides that a person has the right to emergency treatment (Article 43(2)). In addition, it provides for a devolved system of governance which gives

the mandate of healthcare provision to county governments, hence providing an opportunity to address historical inequities in access to health services.

Furthermore, in 2013, the Government of Kenya introduced free maternity services in all public health facilities through a declaration made by President Uhuru Kenyatta [11]. Additionally, in January 2014, the Beyond Zero Campaign spearheaded by the First Lady of the Republic, Margaret Kenyatta was launched to promote maternal health. The introduction of free maternity services led to an estimated 10 percent increase in deliveries within health facilities across the country, with increases of 50 percent in certain counties immediately following the announcement [11]. According to representatives of Kenyatta National Hospital, the number of pregnant women seeking maternal care was increasing at the rate of 100 percent per month [11].

Despite the existing political support and an enabling policy environment for maternal health, inadequate access to quality maternal health services, including ante-natal, delivery, and post-natal services continues to be a challenge [11]. Many women still live long distances from health facilities and face other barriers to accessing quality care. Furthermore, access to skilled delivery services is still a persistent challenge [11]. Moreover, public expenditure on health in Kenya accounts for only six percent of the total government expenditure. Not only is this far below the Abuja recommendation of 15 percent, it has stagnated at this level over the past decade [14]. Consequently, only 40-50 percent of women in Kenya do not have access to lifesaving maternal health services including contraceptives to prevent unintended pregnancies, pre- and post-natal and delivery care; levels that are considerably below global recommendations (Table 1).

Table 1. Maternal health indicators in Kenya

Indicator	Current Status	Recommended levels
Antenatal care	Nine in ten mothers reported seeing a skilled provider at least once for antenatal care (ANC) in their most recent birth, while 58 percent of women reported having four or more antenatal visits for their most recent birth.	WHO recommends at least four ANC visits during a woman's pregnancy
Delivery care	62 percent of births in Kenya were overseen by a skilled provider. Of these, 61 percent took place in health facilities.	Against MDG target of 90 percent
Post-natal care	51percent women received a postnatal checkup in the first two days after their last live birth	MDG 5 recommended a "continuum of care" from pre-pregnancy, birth, and post-natal and early childhood.
Trends in use of contraception	58 percent currently married women aged 15-49 were using a modern contraceptive method	Against MDG target of 70 percent

Source: 2014 KDHS; WHO; UN Millennium Project

Women living in rural and hard-to-reach areas, those from poor households and those with little or no education have disproportionately worse access to these life-saving maternal health services [3].

Methodology

The development of this policy brief was based on a review of secondary sources of information and research evidence. These included Internet searches of evidence through such engines such as Google, Google Scholar and Pubmed as well as Kenya government policy documents

Discussion of Policy Options

A recent systematic review by Goldenberg and McClure (2015) revealed that interventions that have been associated with historical reduction in maternal mortality in high-income countries include prenatal care and hospitalisation for delivery, use of antibiotics to treat infection and uterotonics (inducing labour), and blood transfusion [12]. The review also found that management of pre-eclampsia/eclampsia steadily improved with: prenatal care (blood pressure measurements and urine protein determination); hospitalisation to monitor the condition; and a transition from watchful waiting to immediate delivery for severe or progressing disease.

In addition, another systematic review on the effectiveness of maternal health interventions in low-income countries, by Nyamtema et al (2011), revealed that programmes that integrate multiple interventions were more likely to have significant positive impacts on maternal outcomes than those that do not. Training in emergency obstetric care (EmOC), adequate numbers of care providers, refurbishment of existing health facility infrastructure and improved supply of drugs, consumables and equipment for obstetric care were the most frequently integrated interventions in 52-65 percent of all 54 reviewed programmes.

Statistically significant reduction of maternal mortality ratio and case fatality rate were reported in 55 percent and 40 percent of the programmes, respectively. Births in

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EmOC facilities and caesarean section rates increased significantly in 71-75 percent of programmes reporting these indicators [13]. The review further revealed that insufficient implementation of evidence-based interventions was closely linked to a lack of national resources, leadership skills and end-users factors. The review indicated that no single magic bullet intervention exists for reducing maternal deaths and that all intervention programmes should be integrated in order to bring significant changes.

Recommendations

Kenya has made some progress in improving maternal healthcare programmes. However, more work remains to be done to address underlying inefficiencies and inequities to achieve better outcomes. The following recommendations are provided for consideration in the effort to strengthen maternal healthcare policies and programmes:

i.Increase resource allocation to strengthen maternal healthcare programmes and services

While Kenya has strong maternal healthcare policies but implementation of the policies is inadequate due to inadequate resources. Members of Parliament and the Health Committee should persistently advocate for increased resources devoted to health in general and specifically to maternal healthcare. They should strive to attain the Abuja recommendation of 15 percent of total government expenditure on health. They should also ensure that operational barriers to implementation and full financing of maternal healthcare policies, are removed.

ii. Increase access to quality maternal healthcare services

Increase access to skilled delivery care

The Ministry of Health and county governments must promote and ensure there is increased coverage of medical delivery services by increasing the number of skilled staff (trained in EmOC) and service delivery points, improving staff retention and strengthening the supply-chain management system. Additionally, county governments need to create incentives for staff to be present at work during scheduled times and also address knowledge and practice gaps, while ensuring that the required resources are in place to enable good practice.

Provide prompt postpartum care and post abortion care.

The Ministry of Health and the county governments must promote and ensure all maternity wards have the necessary equipment to support cesarean section among women with prolonged labor as well as post abortion care. Focus should be on strengthening the capacity of the health system to detect and immediately manage delivery and abortion complications and provide postpartum care and counseling.

Increase access to high quality antenatal care.

The Ministry of Health and county governments must promote and put in place measures to ensure every pregnant mother attains the WHO recommendation of four antenatal visits throughout the pregnancy. Focus should be on ensuring access to high quality antenatal care which includes screening and treatment for Sexually Transmitted Infections (STIs), anaemia and hypertension and information about appropriate diet and other healthy practices and where to seek care for pregnancy complications.

iii. Reduce demand-side barriers to accessing maternal healthcare

Along with supply-side interventions, the Ministry of Health and county governments must promote and invest in effective interventions for addressing demand-side barriers to accessing maternal healthcare services including enabling families to manage the indirect costs to accessing care such as the cost of transport to health facilities and tackling harmful cultural beliefs about pregnancy and childbirth.

iv. Implement interventions using an integrated approach

The Ministry of Health and the county governments must promote and put in place measures to support the integration of interventions to bring about the most significant change including facilitating integrated planning and implementation among different health units, divisions and directorates.

v. Address inequities in access to and quality of sexual, reproductive, maternal healthcare

The Ministry of Health and the county governments must promote and put in place measures to reach vulnerable populations with high-quality primary and emergency maternal healthcare.

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