

MATERNAL AND CHILD HEALTH: KENYA



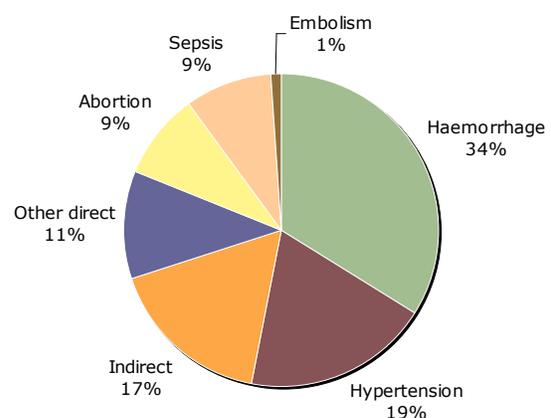
KENYA EXPERIENCES SLOW PROGRESS IN MATERNAL HEALTH

Maternal morbidity and mortality relate to illness or death occurring during pregnancy or childbirth, or within two months of the birth or termination of a pregnancy. The fifth Millennium Development Goal (MDG) aims to reduce the maternal mortality ratio by 75% between 1990 and 2015. In Kenya, maternal mortality remains high at 488 maternal deaths per 100,000 live births.¹ While this is below the Sub-Saharan average of 640 deaths per 100,000, Kenya experiences a very slow progression in maternal health.

Most maternal deaths are due to causes directly related to pregnancy and childbirth unsafe abortion and obstetric complications such as severe bleeding, infection, hypertensive disorders, and obstructed labor.

Others are due to causes such as malaria, diabetes, hepatitis, and anaemia, which are aggravated by pregnancy (Figure 1).

Figure 1: Leading causes of maternal mortality: Regional estimates for sub-Saharan Africa (1997-2007).²



While approximately 92% of women giving birth received some antenatal in 2010, only 47% had the recommended four or more. 56% of Kenyan women deliver at home, with home births being more common in rural areas and only 44% of births were assisted by a health care professional (doctors, nurses and midwives)¹. These rates of antenatal care and skilled birth attendance have declined over the past 10 years, particularly among the poor.³

Maternal morbidity and mortality in Kenya results from the interplay of social, cultural, economic and logistical barriers, coupled with a high fertility rate and inadequate and under-funded health services. Strengthening the health system and improving quality of healthcare delivery is pivotal to reversing the trend of high maternal morbidity and mortality.⁴

Together with income, education also plays a major role in determining maternal health outcomes, including fertility rates, access to family planning, and antenatal coverage. Women with higher education are much more likely to receive antenatal care from a medical doctor than are those with no education (36 vs. 21%). Similarly, the higher the wealth quintile, the more likely a woman is to get antenatal care from a doctor.¹ Restrictive abortion legislation also contributes substantially to maternal mortality and morbidity in Kenya.⁵

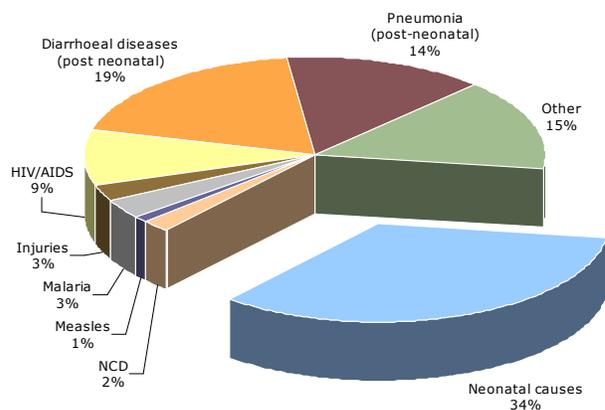
KENYA RANKED 39TH GLOBALLY IN UNDER-5 DEATHS

Over 7 million children under-5 years of age die each year mainly from preventable and treatable conditions. Pneumonia, diarrhoea and malaria remain the leading cause of child mortality, and under nutrition contributes to more than 1/3 of all deaths. Millions of children could be saved each year if proven interventions such as antibiotics for pneumonia, oral rehydration therapy for diarrhoea, and the provision of insecticide treated nets (ITNs) to prevent malaria, were universally available.

While infant and under-5 mortality rates have declined since 1990, mainly due to programs in childhood immunization and malaria prevention, Kenya is still ranked the 39th country with the highest deaths globally.^{1,6} Kenya is not on track to meet MDG 4 to reduce the under-5 mortality by two thirds between 1990 and 2015. Nearly 35% of under-5 deaths occurred during the neonatal period; 1/3 of all neonatal deaths are due

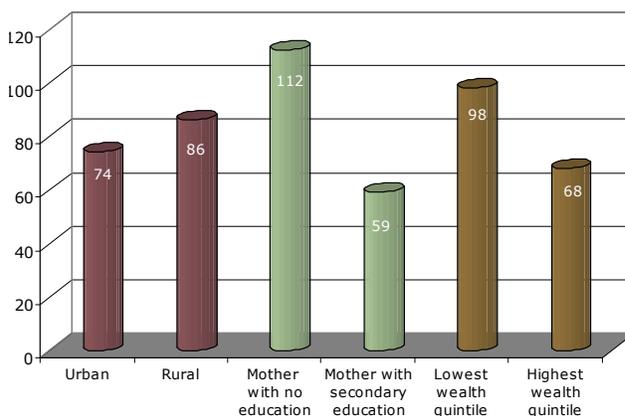
to severe infections, followed by birth asphyxia, preterm births and congenital anomalies (Figure 2). Two-thirds of under-5 deaths are post-neonatal² and leading causes of these deaths are pneumonia and diarrhea. In 2009, Kenya also experienced over 34,000 stillbirths.⁷

Figure 2: Under-5 cause of death in Kenya (2010).⁸



In Kenya one-third of children under-5 is stunted (too short for their age), a sign of chronic malnutrition. Also, 1 in 6 children is underweight or too thin for their age.¹ Years of drought have had a serious impact on Kenya's children, increasing malnutrition rates, morbidity and mortality.^{1,2}

Figure 3: Disaggregated under-5 mortality.¹



Mortality is higher in rural areas, however residents of urban slum settlements exhibit worse health indicators, especially for the under-5 population.⁴ Socioeconomic status is a key determinant of survival, with children in the lowest wealth quintile 44% more likely to die before age 5 than those in the highest quintile.⁸ The coverage of key child survival interventions along the continuum of care shows the richest families are 3 times more likely to receive care than the poorest families.

The biggest differential in the under-5 mortality ratio in Kenya is related to mother's education (Figure 3). Children whose mothers are not educated are 46% more likely to die before age 5 than those whose mothers have higher than secondary level of education.^{9, 10}

WATER SUPPLY, SANITATION AND HYGIENE (WASH) IN KENYA



Over 13 million Kenyans lack access to an improved water supply and 19 million lack access to improved sanitation, and water supply, sanitation and hygiene (WASH)-related diseases and associated conditions (e.g. anemia, dehydration and malnutrition) are the number one cause of under-5 hospitalization

and mortality. Over 50% of hospital visits in Kenya for illnesses are related to WASH.¹ Although Kenya has launched broad reform and stepped up investment, the country still faces considerable challenges in reaching the water and sanitation MDGs.

GOVERNMENT COMMITMENT TO WOMEN AND CHILD HEALTH¹¹

Kenya's new constitution, adopted in 2010, states every citizen has the right to life, and the right to the highest attainable standard of health including reproductive health.

Financing of Health Care is sourced from the public, private households (consumers), and donors. Current estimates of health spending show households remain the largest contributors of health financing (35.9%). The high out of pocket expenditures and the dependency on donors, especially for priority interventions, raises issues of sustaining the investment in the health sector and improved health outcomes. The 2010 Africa Health financing scorecard ranked Kenya number 24 in health investment with the government spending only \$14 US per capita.

Key priorities being pursued to rectify this include a push to increase Government Health Expenditures, a reduction in out of pocket spending through the 20/10 policy, strategies to eliminate fees at point of use, and exploration of pre-payment mechanisms as a future focus of equitable health financing.

The Bill of Rights specifically highlights the rights of Children to basic nutrition and healthcare, as well as more generally states that all Kenyans have a right to the highest **attainable** standard of health, including the right to life, reproductive health, and other attributes of good health.

In 2010, the Global Strategy for Women's and Children's Health was launched by the office of the United Nations Secretary-General. The Initiative calls for a bold, coordinated effort around MDGs 4 and 5, building on what has been achieved so far - locally, nationally, regionally and globally. It calls for all partners to unite and take action – through enhanced financing, strengthened policy and improved service delivery. Kenya has made the following commitments to the Global Strategy:

- Recruit and deploy an additional 20,000 primary care health workers;
- Establish and operationalize 210 primary health facility centers of excellence to provide maternal and child health services to an additional 1.5 million women and 1.5 million children;
- Expand community health care, and decentralize resources.

As of 2011, Kenya is **off track** on these commitments.¹² There are still acute shortages of critical health workers for some staff cadres. Additionally, there is unequal distribution of workers, by urban/rural areas, by regions, and by level of care.

PARLIAMENTARIANS PLAY AN IMPORTANT ROLE IN IMPROVING HEALTH

Parliamentarians are fundamental to the development of issues and critical to improving the health of women and children. Parliamentarians' engagement in MNCH issues not only benefits women and children, but also strengthens the role of parliamentarians in influencing national health and development.

The work of parliamentarians can help to:

- Ensure necessary resources are allocated to the health sector;
- Enhance legal frameworks to address gender inequality and promote reproductive rights;
- Improving access to quality care and medicines among poor and marginalized populations;
- Expand maternity protection for working women;
- Increase the legal age of marriage; ensuring more sexual and reproductive health education for adolescent girls;
- Construct mechanisms and structures to improve accountability and remedial action, including greater collaboration with civil society.



Parliaments have a crucial role to play on Maternal Newborn and Child Health (MNCH) issues within the broader context of the health sector and the overall national development agenda. This has been recognized by the Inter Parliamentary Union (IPU) and “Countdown to 2015 - Tracking Progress in Maternal, Newborn and Child Survival”, which have identified five core actions that parliamentarians can take in positioning, promoting and protecting the health of women and children:

- Representing the voice of women and children
- Advocating for MDGs 4 and 5, nationally and internationally
- Legislating to ensure universal access to essential care
- Budgeting for maternal, newborn and child health
- Holding the government to account for implementing policies.¹³

As representatives of the people, it is the parliamentarians' job to speak on behalf of women and children, to ensure that their voices are heard, and to make sure that their rights and concerns are reflected in national development strategies and budgets.

Spending on women's and children's health is an investment, not just a cost, contributing to the well-being of families and communities, and to a nation's socio-economic development. Estimating costs and raising the required funds, and ensuring efficient and effective use of these resources, are key responsibilities - enabling "more money for health" and "more health for the money".¹⁴

REFERENCES

- ¹ Kenya Demographic and Health Survey (KHDS) 2008-2009
- ² Countdown to 2015 Maternal, Newborn & Child survival: Kenya
- ³ Ziraba, A., et al. (2009). Maternal mortality in the informal settlements of Nairobi city: what do we know? *Reproductive Health*, 6 (6)
- ⁴ Ukachukwu, V. (2009). Maternal morbidity and mortality in per-urban Kenya: assessing progress in improving maternal healthcare. *East African Journal of Public Health*. 6(2)
- ⁵ In harms way: The Impact of Kenya's restrictive Abortion Law (<http://reproductiverights.org>)
- ⁶ UNICEF: KENYA (www.unicef.org/infobycountry/kenya_2621.htm)
- ⁷ <http://chartsbin.com/view/1445>
- ⁸ Kenya: neonatal and child health profile (2011): MCH/WHO
- ⁹ <http://www.who.int/healthinfo/statistics/mortality/en/index.html>
- ¹⁰ Levels and Trends in Child Mortality (2011): Estimates developed by the Interagency Group for Child Mortality Estimation (ICGE)
- ¹¹ Information in this section based on: 'Implementation of the constitution in the health sector' Position Paper.
- ¹² http://www.who.int/pmnch/topics/part_publications/2011_pmnch_report/en/index4.html
- ¹³ PMNCH: Taking the Lead (http://www.who.int/pmnch/topics/part_publications/20100716_takingthelead.pdf)
- ¹⁴ <http://portal.pmnch.org/knowledge-summaries/ks3>