REPORT ON THE STAKEHOLDERS DIALOGUE ON MATERNAL HEALTH IN KENYA HELD AT THE SERENA HOTEL NAIROBI KENYA JULY 12-13

INTRODUCTION

The fight against maternal mortality in Kenya and the critical new insights contained in research on maternal health were the focus of a two-day dialogue organized by the African Population and Health Research Center (APHRC) in conjunction with the Woodrow Wilson International Center for Scholars (WWICS).

The meeting was meant to reflect on the findings of new research on maternal health in Kenya and was attended by stakeholders and experts in the field from both the public and private sector.

DAY I

OPENING

The dialogue was opened by the Executive Director of APHRC Dr Alex Ezeh who observed that the state of maternal health in Kenya was unacceptable with national estimates of about 488 deaths per 100,000 live births and up to possibly 700 deaths in some areas such as slums.

Dr Ezeh noted that causes of maternal health challenges and those who are most affected are well known. He observed that half of women in the country deliver children with assistance of untrained delivery workers.

Dr Ezeh proposed a break from the strategies of the past arguing that Kenya could not continue doing what it did for the last 20 years and expect to make progress. He urged the meeting to crystallize the issues and identify the opportunities for progress and if possible deliver action points that could be shared with the government and policy makers.

Calyn Ostrowski of the WWICS expressed delight at having the opportunity to hold the dialogue in Kenya with in-country experts on the issue of maternal health. The Center observed that it was proud to partner with APHRC to build on the ground momentum and energize the state of maternal health care in Kenya.

PRESENTATIONS

Mumia Osaaji, the moderator noted that there exists a misperception in Kenya that maternal health is a women’s issue; maternal health, he emphasized, has a bearing on the health of the new-borns as well.

It was further noted that there are many life threatening pregnancy related complications and subsequent poor outcomes for women and new-borns that can be prevented or managed through early detection and appropriate and timely interventions.
Kenya, the meeting was told, was one of the countries that endorsed the resolution of the International Conference on Population and Development (ICPD) in Cairo, Egypt in 1994. As a follow up of the recommendations, the government drew up the *National Reproductive Health Strategy* (NRHS) 1997-2010 to focus on access to quality maternal and child care; utilization of quality and cost effective maternal child health (MCH) services; effective referral systems; clean/safe delivery and emergency obstetric care; adequately equipped health services to provide quality, effective management of complications of pregnancy and post-abortion care; and establishment of district audit systems on maternal and neonatal deaths.

Despite this, the meeting was told there is urgent need for more evidence on best practices related to preventing maternal morbidity and mortality. Such evidence has, in the recent past, forced a re-examination of the place of traditional maternal health practices and interventions.

It was observed that the health of a mother and the new-born is heavily dependent upon the quality of Antenatal Care (ANC), Delivery Care, Postnatal Care (PNC), Newborns Care as well as Emergency Obstetric Care (EmOC).

It was observed that maternal health impacts directly on the attainment of Millennium Development Goals and specifically MDG 4 (Reduce child mortality) and MDG 5 (Improve maternal health) and indirectly on MDG 6 (Combat HIV/AIDS, Malaria, TB and other diseases).

Dr. Lawrence Ikamari revealed that Kenya is a rural country with 75% of the population living in rural areas with women making up slightly over half the population.

It was further revealed that childbearing starts early, some as early as twelve, and ends as late as 55 and marriage is universal.

It was also revealed that Kenya’s maternal mortality ratio is high with the best estimates from the Kenya Demographic and Health Survey (KDHS) of 2008-09 estimating 488 deaths per 100,000 births.

Despite the lack of precise data, best estimates available in terms of figures, the meeting heard, suggest 14,700 women and girls die every year due to pregnancy related complications.

Additionally, another 294,000 to 441,000 women and girls suffer from disabilities caused by complications during pregnancy and childbirth each year.

It was observed that 80% of women live in rural areas which means that most of these deaths occur among rural women. It was also observed that most women fail to adequately space their births which is a contributing factor in rural areas to poor maternal health.

It was revealed that high fertility directly increases risk of maternal health. Kenya’s total fertility, it was shown, has remained relatively high over the last
decade at around 5 children per woman. In 2008-9 KDHS, Kenya’s total fertility rate was estimated at 4.6 children. Rural women have higher fertility rate (5.2) than urban women (2.9).

It was also shown that rural women experience high early childhood mortality. The 2008-09 KDHS estimated infant mortality in rural areas as 52 per 1,000 live births compared to 49 per 1,000 live births in urban areas. Child mortality is 25 per 1,000 live births in rural areas compared to 16 per 1,000 in urban areas.

It was noted that timely access to antenatal care is critical for ensuring safe pregnancy. Antenatal coverage is high in rural Kenya. Most women (90%) receive antenatal care from a skilled provider. 85% of them receive antenatal care from the public sector.

It was also noted that the majority of rural women seek antenatal care during the second trimester, and make the recommended number of visits.

The key question posed then was how to make sure rural women go for antenatal care in their first trimester?

It was noted that the presence of a skilled attendant at birth is closely associated with better delivery outcomes and reduced maternal and neonatal mortality. According to Dr. Ikamari, 63% of births occur in rural Kenya, and only 37% of women deliver in a health facility.

The reasons why women choose not to deliver at a health facility were also presented. When asked 42% of women said the health facility was too far; 21% said it was not necessary, while the rest said delivery happened too fast and or identified cost as a hindrance.

Culture was identified as a possible reason for making woman shy away from health facilities with the perception that delivery at a health facility was meant for weak women.

It was noted that there is no data available for emergency obstetric care services at the rural level but most rural facilities are generally weak in emergency obstetric care.

With regard to family planning as an intervention, it was revealed that the use of family planning is modest in Kenya. Rural women are less likely to use modern family planning than urban women. Use of modern family planning methods among rural married women is 37.3% compared to 46.6% among married women in urban areas.

It was presented that HIV/AIDS prevalence in rural areas is estimated at 7% compared to 8% in urban areas. Women age 15-49 in urban areas have a higher HIV prevalence than those in rural areas (10.4 and 7.2 percent respectively).

Although HIV prevalence in rural areas was slightly lower than in urban areas, the greatest burden of disease is still in the rural areas, where three-quarters of the population live.
Dr. Catherine Kyobutungi of APHRC gave a presentation on the state of maternal health in the urban context. She revealed that MDG 5 is the least likely one to be met by African countries and that over 50% of all maternal deaths occur in Africa. In sub-Saharan Africa, the meeting was told, a woman has a 1 in 16 chance of dying during childbirth.

The meeting heard that in the last 10 years the rate of skilled delivery has fallen by % from 44-43%.

Key interventions presented as a way of overcoming maternal health challenges include: access to family planning and safe abortion simply because women who do not get pregnant cannot die from childbirth. Others are care from skilled professionals, access to health facilities and good referral systems.

It was revealed that Kenya’s unmet need for contraceptives stands at 26% and that 40% of unplanned pregnancies end in abortion; begging the question how safe is abortion?

It was also revealed that there exists a low physician population ratio. For instance, there are 260 pediatricians in Kenya 160: of whom operate in Nairobi. This places high expectations on midwives.

In terms of the urban context it was revealed that 78% of the poorest women deliver at home while only 17% at a health facility. 74% of the richest urban women in Kenya deliver at a health facility while only 22% deliver at home.

54% of the 78% of poorest women who deliver at home are unattended by anyone and 41% are attended to by a Traditional Birth Attendant (TBA).

Of the 22% of the richest women who deliver at home 40% of them are unattended while 31% are attended to by a TBA.

It was revealed that 68% of the poorest women who deliver unattended and 66% of those attended by a TBA gave “not necessary” as the reason for non facility-based delivery.

The respective figures for the richest women were as follows: those who delivered unattended 75% and those who delivered with a TBA 70%.

Cost was only a factor in 4-7% (richest - poorest respectively) while access was a factor in 18-27% (richest - poorest).

It was noted that the use of contraceptives is higher in urban Kenya and that the urban poor were doing as well as the urban rich in this regard.

It was observed that the urban context to maternal health was critical because of expected population growth. In the next 40 years the global population is expected to grow by 2.5 billion and most of that growth will be urban. Sub-Saharan Africa is expected to grow its population by 900 million people, 730 million of whom will be urban residents. Urban growth is higher than the overall population growth.
In Kenya, the urban population is between 22-32% of the national population, the urbanization rate is 4.0 while the population growth rate is 2.6. It was also revealed that 60% of urban residents live in slums or slum like conditions creating what the meeting was told is the urban-urban divide between the urban rich and the urban poor.

With regard to fertility it was shown that fertility among the urban poor at 4.2 was not far off from rural levels.

Still on the urban divide the meeting was also shown data on timing and frequency of Antenatal care. The data showed that only 7.5% of slum women had their first ANC visit during their first trimester of pregnancy. (17% in urban Kenya and 11% in rural Kenya).

The data also suggested that only 54% of slum women had 4+ ANC visits during their entire pregnancy (71% in urban Kenya and 54% in rural Kenya).

The meeting was taken through uniquely urban barriers to maternal health in Kenya. These are transport and security, particularly for women who go into labor at night and live in slum or slum like conditions. For them, travelling to the health facility is a problem and getting vehicles to come to the slum to is hard because of the security situation

The meeting was informed that there are measures being taken to improve maternal health in the urban areas. It was revealed that there is Bill and Melinda Gates-funded Urban Reproductive Health Initiative (URHI) particularly for the urban poor in existence. Slum upgrading is also in progress across the city while the road infrastructure is being renovated across the city and primary health care facilities are also being revitalized in communities.

Dr. Margaret Meme then explored maternal health in Kenya from a human rights perspective. It was suggested that the Kenyan society and policy-makers did not appear to grasp the magnitude of maternal mortality.

It was revealed that 8,000 women die every year in Kenya during childbirth and from delivery related complications. The meeting was told the deaths are comparable to 10,000 deaths in Somalia which is a war zone.

It was suggested that maternal health challenges would only be met when the public and policy-makers fully grasp the magnitude and tragedy that is maternal mortality.

The meeting was told that there was need to deliberately include men in the maternal and reproductive health process. Their support (particularly financial since most men control the purse strings in the home) and understanding of the issues involved would help achieve better outcomes for both mother and child. Currently, most men are only involved in maternal health at conception and sadly after the death of the woman and or child with everything else in between falling on the shoulders of the women, the meeting was told.
It was observed that this gender imbalance requires rectifying through deliberate programs targeted at men in order to overcome the challenges of maternal health in Kenya. If men are involved in the entire reproductive health debate and they are sufficiently informed on what the stakes really are they will certainly have to dig fewer graves.

It was revealed that Kenya’s new constitution recognizes health as a human right. However, the linkages between health and legal frameworks are either nonexistent or grossly insufficient.

It was noted that a rights based approach to maternal health has two main players: women who are the right holders and policymakers who are the duty bearers.

The governments who are the duty bearers must respect and protect mothers from third party violations and fulfill rights via allocation of resources as well as other appropriate measures to ensure the right to health is fully enjoyed particularly through resource allocation.

It was also noted that there are other rights linked to maternal health such as the right to information and against discrimination particularly with respect to men and reproductive health.

The meeting was apprised of the four elements of the right to health as set out by the World Health Organization including:

- **Availability:** That functioning public health and health care facilities, goods and services, and programs shall be available in sufficient quantity.
- **Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the state party.**
  - Accessibility has 4 dimensions:
    1. Non-discrimination
    2. Physical accessibility
    3. Economic accessibility (affordability)
    4. Information accessibility
- **Acceptability:** That all health facilities, goods and services must be respectful of medical ethics, sensitive to culture and gender and the life-cycle. They must also be designed to respect confidentiality and privacy.
- **Quality:** Skilled personnel, supplies equipment, and scientifically approved medicine.

**GROUP WORK**

The meeting then broke up into groups of three to reflect on various questions and come up with ideas and solutions. Each group was to be guided by a set of questions.
Group 1

Q1. What are the knowledge and capacity gaps to improve maternal health in urban and rural settings in Kenya?

The following factors were highlighted by participants in the group:

- Lack of awareness of delivering in a health facility; low levels of education among women and girls
- Low level of information among men on safe motherhood
- Low level of information among policymakers
- Negative cultural practices and perceptions, for instance, women who deliver at home are more valued than those who deliver at the health facility.
- On Capacity: Lack of trained personnel, security, transport in most rural areas
- High cost of delivering at private maternity homes
- Lack of health facilities in close proximity particularly in rural areas.

Q2. How can policymakers, NGO’s, donors, etc better coordinate and improve human resources for maternal health in Kenya?

Members proposed the following interventions:

- Employment and retention of midwives and health professionals
- Distribution of health workers
- Pre-service and in-service training to ensure health workers are up-to-date on emerging guidelines
- Competency-based training

Q3. What populations should be involved in setting priorities for maternal health? What maternal health priorities should be set in Kenya?

Participants identified the following constituencies and priorities:

- Adolescents
- Women
- Health workers
- Men
- Policymakers
- NGOs and faith based organization.

Priorities:

- Investment in reproductive health services particularly family planning, ANC and PNC
- Increase in health facilities that can offer EMoC
- Networking within stakeholders

Group 2:
Q1: What are the policies and funding priorities that are required to increase the uptake of antenatal and postnatal care?

- It was observed that Kenya does not necessarily need new policies but comprehensive implementation of existing policies.
- It was noted that there was non-clarity of user fees particularly at public health facilities and that there should be clear communication on the same.
- Political will: It was noted that Kenyan politicians carry great sway with the people and they can help greatly to spread the gospel of ANC and PNC if they were to get involved.
- Improve level 2 and 3 health facilities – only 5% of facilities can do caesarean sections.
- Male involvement: Sensitize and bring men into the reproductive health process.

Q2: And on human resources?

- Motivation: Develop and implement employee motivation programs particularly for health workers in rural areas where they operate under hardship conditions.
- Recruitment and deployment: Putting health workers on performance contracts.
- Boost retention of health workers.
- It was noted there was a need to break down the silos in the health industry and integrate services particularly HIV/AIDS and maternal health care.
- It was also noted that there was an urgent need to strengthen public supply systems to ensure key family planning commodities and drugs required at health facilities are available countrywide.
- Active involvement and partnership of stakeholders can help increase the provision of maternal care.

Q3. Which development sectors should be involved? (e.g. transportation, communications/technology, etc).

- Maternal health is not a ministry of health issue alone. There’s need for a multi-sector approach involving multiple ministries and departments like Ministry of Finance.
- Agriculture: To address the nutrition aspect by ensuring there is access to enough food across the country for pregnant mothers and in the right diet combinations so as to prevent low birth weight.
- Legal: To develop frameworks for the rights-based approach and for enhancing accountability. Civic education for women on their rights and obligations.
• Education: To provide adolescents with information on reproductive health.
• Integration.

Group 3:
Q1. What is needed to increase education and dissemination of midwives?
The members of Group Three felt the following points were critical in this regard:
• Pre-service training should be done more often to have many health workers access the training.
• Train and recruit more midwives
• Incorporate new guidelines in the curriculum
• Increase funding to add capacity for training of nurses and midwives

Q2. How can variables such as training, recruitment, retention, and remuneration be addressed?
Members highlighted the following points:
• Incentives: Adopting performance based allocation of resources so that resources go to those workers and facilities that do the most work.
• Addressing the disparities in distribution of health workers and equipment
• Harmonizing pay for rural health workers with those of their urban counterparts
• Consistently evaluating training needs in the health sector

Q3: What are the policies and funding priorities that are required to increase the uptake of antenatal and postnatal care?
On this question participants put forward the following ideas:
• Parliament take action to ensure compliance with the Abuja declaration to raise allocation for health to 15% of the National Budget from the current 6%.
• Parliament provide a budget line for maternal health
• There be increased advocacy for maternal health
• Parliament employ gender responsive budgeting.
• Government support a voucher scheme to make antenatal and postnatal care more affordable
• A program for providing mobile postnatal clinics particularly in rural Kenya be developed to boost postnatal care.
• A maternal health bill be prepared and submitted to parliament for debate.

PLENARY
The meeting then went into a vibrant plenary session where participants gave their questions and reflections on the presentations and group work.

The first point in plenary was the need for a sector-wide approach in not only handling maternal health challenges but in improving the entire health system as a whole. Effective health policies and interventions can only work when they are the fruit of multiple expert perspectives such as finance, gender and research.

A question on the efficacy of short-term family planning methods was also raised and most participants agreed that long-term family planning methods were indeed the more effective, but their use was hampered by a weak supply system and a lack of education particularly among rural Kenyans on how to use them.

The subject of maternity/waiting shelters was mooted as a possible solution to raising the number of health facility deliveries in rural areas where mothers may live far from the health facility. The shelter provides a space close to the hospital where the mother can stay until she goes into labor and then travels to the health facility.

It was revealed that waiting shelters are already in use in the country in parts of North Eastern Province and the Coast. It was subsequently proposed that the intervention be scaled up to cover a wider area and serve more women.

The plenary was, however, dominated by the question of Traditional Birth Attendants and their role.

The key questions raised about TBA’s were:

- How to improve TBA’s to serve more effectively?
- How to ensure they refer clients to hospitals?

It was noted that culture was a hindrance in terms of getting women, particularly rural women, to distrust TBA’s and go to the health facility instead. It was brought to the meeting’s attention that in some areas there exists perfectly good harmony between TBA’s and health workers and that should be the way to go particularly where health workers are too few to effectively reach out and do their work at the same time.

A physician in the plenary suggested that doctors and health workers also needed to change their perception of TBA’s and consider them as partners and work with them to help pregnant women achieve positive outcomes during delivery.

It was also revealed that the problem with TBA’s is not handling normal delivery because some even receive training on how to handle that. It is the handling of complications that is the problem with TBA’s since 15% of all deliveries have complications that TBA’s are not equipped to handle.
It was noted that TBA’s do not necessarily get it wrong all the time and emphasis should be placed on having strong referral mechanisms in place so that when things go wrong the mother can be rushed to the health care facility.

It was also noted that it is not possible to completely wipe out home delivery; there will always be women who want to deliver at home and TBA’s can assist them to do that, but with strong referral mechanisms in place for when complications arise.

On factors that hinder referral such as transport it was proposed that innovation be employed for instance the use of motorbikes and/or tractors.

It was underscored that home delivery cannot be eradicated completely and therefore the need for concerted efforts to educate women.

It was proposed that the Ministry of Culture should come in to help clear up and or eradicate cultural issues around health facilities. It was also proposed that TBA’s should be registered by the Ministry of Health not Culture.

The plenary also observed that the best policy interventions cannot work without community acceptance or involvement.

**VIDEO CONFERENCE**

After the plenary, the meeting went into a live videoconference with a similar meeting in Washington D.C, USA, at WWICS to exchange and share views and ideas on maternal health.

Jane Harman President of the Woodrow Wilson Center for Scholars kicked off the video conference by noting once again the numbers: 350,000 women die every year from pregnancy related conditions when pregnancy is not a disease.

She noted the need to scale up family planning initiatives and improve health systems. The WWICS pledged to focus its programming on maternal health on key issues and relevant policy debates in the world.

The Washington panel was made up of Dr Nahid Mata, Senior Maternal and Newborn Advisor USAID, and John Townsend, Vice President and Director of the Reproductive Health Program at Population Council.

It was noted in the ensuing discussion that lack of skilled birth attendants and institutional capacity at local levels are massive impediments towards beating the challenge of maternal health in Kenya. It was revealed that 60% of registered doctors and nurses are based in Nairobi and therefore there is an urgent need to address the equitable deployment of health workers across the country.

It was noted that pre-service training is a long-term investment that can provide sustainability and greatly improve quality of delivery care.

Cross sector cooperation between health and other sectors such as communication, agriculture and education was noted as a key intervention.
It was also noted that it is critical that newborns are not forgotten in the maternal health debate.

Integration was without question the highlight focus area of the video link discussion. It was proposed that Kenya should aggressively pursue integration in the health sector so that a pregnant woman, for instance, does not need to make multiple visits to different locations for ANC, family planning and nutrition advice. If these services are integrated the mother can have all of them at one convenient location.

In a rejoinder on the issue of integration it was observed that integration could end up over-burdening the health worker at the rural facility who may have to provide multiple services at the same resource levels as providing one service.

It was consequently observed that what should be pursued then is smart integration that starts at the policy level, resource allocation level and then trickles down. That way integration will have a higher chance of success.

It was also observed that it was important not to overlook the role of the private sector, including religious groups, that provides 40% of health services. It was further noted that rigorous accreditation and continuous medical assessment programs are required to keep health care standards at the required levels.

The preference of women to deliver away from the health facility brought the issue of community mobilization into the debate and it was suggested that discrimination and poor care in health facilities was perhaps a factor in contributing to that state.

It was also noted that research devoid of context is not of much help in policy formulation. It was observed that because of population growth, Kenya cannot plan for the short-term. With 42% of the population under 15, education about reproductive health is vital. It was further observed that Kenya should be planning for 2025-2050 with a proposed population growth of 25%.

It was also proposed that the policy debate in Kenya be sufficiently broad since only half of all health services come from the public while the rest come from the private sector, NGO’s and faith- based organizations.

With regard to the disconnect between prevalence of contraceptives and the high birth rate it was suggested that there is not enough information on how to use contraceptives.

It was observed that abortion is high and will get higher as demand for children falls. It was also observed that there is need to drastically improve the participation of men in reproductive health.

It was noted that financing is a critical element in meeting Kenya’s health challenges. With the country facing a food crisis, a decline in food production, what are the priority areas?
It was emphasized that it is not enough to understand the evidence but it is vital to go from that understanding to action.

After the plenary session there was a Q&A session between the Washington based audience and the Nairobi participants.

There was a question on research prioritization and how research priorities are selected. The answer was that research in Kenya normally follows the financing. Where the money is the research follows.

There was a question on the integration of TBA’s. It was revealed that the government does not recognize TBA’s. The government tried to train them but it did not work as expected so the current strategy is to encourage referral by giving them incentives to refer their clients to health facilities.

There was also a question on barriers to integration: and the biggest barrier was identified as the capacity the commensurate levels of health workers needed are just not there.

There was a question on what US policy changes might help boost the maternal health fight in Kenya. It was noted that there are a lot of good intentions and a lot of talk about system strengthening but in silos – systems for children, systems strengthening for HIV, system strengthening for women. It was noted that a broader one system approach should be employed.

There was a question on the effect of the new constitution and what the devolution provided for in the new constitution means for health systems. It was observed in reply that decentralization is still a work in progress, the funding mechanisms and oversight mechanisms are not yet fully defined.

It was observed in conclusion that maternal mortality has been reduced in the last 10 years because there is political will and good data and that political will is a result of good and persistent advocacy.

It was also observed that the search for interventions must be influenced by cost for the purposes of sustainability.

**DAY II**

Day II was a recap of Day I’s discussions for a wider local audience, including policymakers. At hand to do the recap were Mumia Osaaji, the moderator, Catherine Kyobutungi and Lawrence Ikamari.

Three Members of Parliament – Hon. Sofia Abdi, Hon. Ekwe Ethuro and Hon. Jackson Kiptanui joined other participants. The three sit in key parliamentary committees such as Health, Budget and Women Affairs.

Dr. Alex Ezeh told the meeting that it was possible to meet MDG 5 as Egypt had already done so and it was not an impossible task.
He said the first step was preventing unwanted pregnancies that end up in unsafe abortions. Dr. Ezeh told the meeting that no woman need die from childbirth.

It was recommended that strengthening health systems through increasing health staff and retaining them was crucial to check mortality rates. Ensuring an efficient supply chain and investing in adequate facilities were also emphasized.

It was observed that an investment be made in management training for health workers and integration.

It was recommended that there was need for strong referral systems that work.

It was noted that reliance on occasional national surveys was unhelpful and there was need for more focused research on interventions that work and at what cost.

PLENARY

The meeting then went into plenary.

It was brought to the attention of the meeting that North Eastern Province had for the first time been included in the DHS survey registering a contraceptive prevalence rate of 4%.

It was noted that there was a need to emphasize postnatal care and particularly family planning during postnatal care.

It was also noted that women chose to deliver at home to avoid disrespect, abuse, deplorable labor wards and terrible service and there was need for data in that regard.

It was recommended that the community be involved in all voucher and/or maternity shelter interventions to make their management easier.

It was noted that there was need for education on long-term contraception methods.

In his address Hon. Jackson Kiptanui lauded the dialogue as a meaningful forum. He told the forum that the Kenyan budget process had changed dramatically and parliament was now heavily involved in the process and had the power to affect the direction of funds and priorities. He said it is meetings like these that would provide perspective when making decisions on the budget.

He revealed that under the Economic Stimulus Package the government was trying to address the capacity gap in the health sector by hiring 15 nurses per constituency in the last financial year and 25 in the current financial year.

CLOSING

In his closing remarks, the chairman of Parliament’s Network on Population and Development Hon. Ekwe Ethuro, thanked the organizers for inviting him to this important meeting whose theme is ‘Maternal Health Challenges in Kenya: What New Evidence Shows’.
He noted it was one of the few dedicated to maternal health this year. He lauded the partnership between WWICS and APHRC, which resulted in this meeting coming to Kenya.

He regretted that MDG 5 was unlikely to be met in Africa. He said he’d work hard as a policymaker to bridge the gap in Kenya and Africa as no mother should die while giving life.

He praised Kenya's active participation in the Campaign for Accelerated Reduction in Maternal Mortality in Africa (CARMMA), noting his personal support of it. He added that he was personally proud of the 2007 Kenya National Reproductive Health Policy. It was developed to enhance equitable, efficient and effective delivery of quality reproductive health services, and through this mechanism special attention has been given to the inclusion of vulnerable and marginalized populations. This policy includes a comprehensive approach to improving maternal health services and encourages inter-sectoral implementation through private sector and public-private partnerships. Additionally, the policy serves as a guide to the planning, standardization and implementation of maternal health services provided by the private sector, faith-based organizations, community-based organizations and Kenyan government.

Despite these initiatives, he noted, there was urgent need for more evidence on best practices related to preventing maternal morbidity and mortality. He thanked research institutions such as APHRC for tirelessly working to present research evidence to take forward parliament’s work in regard.

He emphasized that failure by researchers to communicate research was “perhaps” the biggest impediment to research use in policy formulation.

He said the detention of mothers for failure to pay maternity fees was a scandal and should not happen anywhere. He expressed hope that the recruitment of 20 nurses per constituency would improve maternal health outcomes.

He said he would keep the pressure on government to live up to the Abuja Declaration.

Concluding, he said that health was too important to be managed from two ministries as currently obtains in Kenya. He said he would campaign to have it as a single ministry.

He invited foreign participants to enjoy Kenya – Maasai Mara, Mombasa, and Nairobi National Park – outside the hotel.

**SUMMARY OF KEY RECOMMENDATIONS**

- Integration was highlighted as one of the main action points from the meeting and not just haphazard integration but smart integration across multiple levels and sectors. It was recommended that research on the best ways to achieve integration be conducted as a priority.
• Human resources for health: It was revealed that out of the 251 obstetricians in Kenya 160 practice in Nairobi. The same pattern applies for pediatricians and most health workers. The dialogue identified this capacity gap as a key action to be addressed through the equitable hiring and deployment of workers across the republic.

• Scaling up of family planning interventions: It was recommended that family planning is scaled up as an intervention with an emphasis on education and efficient supply particularly on modern long-term methods.

• Advocacy and Finance: It was recommended that advocacy be scaled up to ensure the government implements the Abuja Declaration on allocation of 15% of national budget to health.

• Research: there is still a massive opportunity for more research not only on maternal health and interventions related to health but across the entire health system.

• Education: to young people on reproductive health issues to enable prevent unwanted pregnancies and improve maternal outcomes through smarter choices by mothers.

• Facility upgrades: It was recommended that Level 2 and 3 facilities be upgraded to handle emergency obstetric care and offer caesarean sections.

• Legislation: A maternal health bill be prepared and within it be embedded the creation of a National Council on Women’s and Children’s health.

• Design of strong referral mechanisms to supplement work of Traditional Birth Attendants.

• Promotion of ANC and PNC

CONCLUSION

The meeting was well organized and attended. The videoconference was a novelty as it brought United States experts in maternal health with their Kenyan counterparts to share ideas.