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Book Reviews

Millennium Development Goals - Kenya: Sustaining the Gains for Maternal and Child Health

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Abstract

As the 2015 Millennium Development Goals (MDGs) deadline approaches, Kenya will not be able to meet all the MDGs targets. Despite good progress, evidence shows that MDGs 4 and 5 (reduce child mortality and improve maternal health) are among the MDGs off track, not only in Kenya but also in other developing countries. Poverty, unequal development and lack of equitable access to health services are some of the factors that affect the ability to achieve the MDGs 4 and 5. Although the targets seem elusive given the deadline, every effort should be made to get resources to maintain the MDGs momentum and sustain the gains made by making health services more accessible, affordable and acceptable. Use of innovative technology such as *m-Health* and *e-Health* in government owned health facilities can increase women's access to information as well as health services.

Introduction

Although Kenya will not meet all the MDGs by the 2015 deadline, impressive progress has been made (United Nations Development Programme [UNDP], 2012 p. 7). However, sustaining the gains made is important so as to avoid regression as has happened with MDG 5 (Improve maternal health). It is high time there was political will and commitment to improve maternal health and reduce child mortality (MDG 4). Kenya has the 35th highest child mortality rate globally as both women and children continue to die from preventable deaths (United Nations International Children Education Fund [UNICEF] 2012, p. 10). The government can change this by making maternal child health services more accessible, available, affordable, and acceptable to all women of child bearing age.

MDGs 4 and 5 - off track

Like most of Sub Saharan Africa, Kenya has major challenges in improving maternal health and reducing child mortality. Although infant mortality rate dropped from 78 per 1,000 in 2003 to 58 per 1,000 in 2009, and the under five mortality rate dropped from 120 per 1,000 in 2003 to 74 per 1000 in 2009, the overall two thirds reduction MDG target has not been met (UNDP, 2012, p. 10). One in every nine children dies before the age of five years (United Nations, 2013, p. 24). While 41 percent of child deaths result from pneumonia, diarrhoea, meningitis, tetanus, Human Immune deficiency Virus (HIV), measles and under nutrition, evidence shows that they are more concentrated in the poorest of regions as a result of unequal development and urban-rural gaps (Africa Development Bank [ADB], 2013 p.51; UN, 2013, p. 26; World Health Organization [WHO], 2011 p. 2). It is therefore necessary to address the social determinants that affect health such as inequalities in education and economic empowerment between rural and urban communities, the urban poor, the marginalized and hard to reach communities (ADB, 2013, p.55).

In contrast to child mortality, maternal mortality rate (MMR) has increased. Previously at 414 per 100,000 live births, MMR rose to 488 per 100,000 live births in 2011, and then to 495 by 2013 (UNDP, 2012, p.10; MDP, 2013, para 10). Other maternal health indicators such as deliveries by skilled attendants and the unmet need for family planning (FP) are 44 percent and 25 percent respectively (WHO, 2011, p. 2). A community approach and research that addresses issues relating to knowledge, attitudes, beliefs and practices that hinder women from accessing these services would be appropriate. According to the United States Agency for International Development (USAID), meeting the need for FP could avert 434,306 child deaths and 14,040 maternal deaths between 2005 and 2015 (USAID, 2006, p. 43).

Sustaining the Achievements

To sustain the gains made, economic and regional variations that affect equitable access to health services need to be addressed. As a step towards this direction, the government scrapped maternity fees in government facilities (MDP, 2013, para 13). While this move addresses affordability, it does not get rid of geographical barriers to access such as distance and cost of transport. Opening up the facilities built by Constituency Development Funds (CDF) will increase the population within the World Health Organization recommended 5km distance to a health facility (MDP, 2013, para11). Some operating health centres do

not provide maternity services despite having maternity units due to the lack of equipment and staff. These require governmental and non-governmental partnerships for funding.

The withdrawal of donor funding for basic reproductive health services and anti-retroviral drugs (ARVS) for the prevention of mother to child transmission of human immune deficiency virus (PMCTC) is also thought to contribute to the increase in MMR (Population Action International, 2006 p. 4; Medecins Sans Frontieres [MSF], 2010, p. 5). Donor support is still very essential although the government should allocate more funds to health service delivery for the sustainability of started programs.

The use of technology and innovations such as *m-Health and e-Health* as part of health care service delivery system can increase women's access to information and enable consultations with qualified health care workers such as doctors, nurses and midwives (WHO, 2011, p. 2; Kilwake, Matoke, Waliaro, Wanyembi & Ogao, 2012, p.51; Deshmukh & Mechael, 2013, p.9-10). Such models have been implemented in other low and middle income countries such as Nigeria, India and Bangladesh (mHealth Alliance, 2014, para 3; Rajan & Labrique, 2014; Mobile Alliance for Maternal Action [MAMA]-MAMA India, 2014).

Developing a patient recall data base that allows patient/client tracking and communication systems can be instrumental in communicating with or sending reminders to patients who are due or past due dates for important return visits such as immunizations, cervical cancer screening, antenatal visits or treatment such as tuberculosis and ARVs (Deshmukh & Mechael, 2013, p.13). It can also be used for follow ups, tracking treatment outcomes and referrals. This would certainly reduce defaulter rates and the associated morbidity and mortality. Collaboration with mobile phone service providers can make this a reality as 93 percent of Kenyans own mobile phones (Demombyness, & Thegeya, 2012, p.3).

Conclusion

While Kenya has certainly achieved a great deal in the MDGs, collaboration from all stake holders to win the fight against maternal (MDG 5) and child (MDG4) mortality is needed. Political will and commitment from the government will be necessary to maintain the MDGs momentum post the 2015 deadline. At the same time, support from donors to be able to maintain essential services such as ARVs for PMCTC and thus sustain the gains made so far will be critical.

Innovative approaches such as *m-Health* and *e-Health* can increase women's access to services and information thus empowering them to take charge of their health and that of their children. To make the life of every woman count, every effort should be made to obtain adequate resources which in turn should be focused on people and health as opposed to disease.

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