

Women's Reproductive Healthcare in Kenya

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Introduction

You wake up and your body is weak, you are exhausted, your head is spinning and you are feeling pains in your stomach. You have been pregnant before and know that this is what it feels like when the baby is ready to be born. You try and stand, but your body is tired and you feel achy, nauseas, and have the chills. What you do not know is that you are anemic and that you were bit by a malarial fly yesterday. Pregnancy exacerbates anemia and the malaria is able to spread quickly through your body. You must get a midwife by your side to help you deliver this baby, because you are too weak to travel the 9 miles to the nearest clinic on foot. Your family is poor and there are no other modes of transportation, the midwife has been called, your baby is coming, and both of your lives are in danger.

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No matter where you are in Kenya, if you are unable to pay for private practice health care then just like this woman you would also face this dangerous, often deadly practice of reproduction. Three quarters of the Kenyan population live in rural areas, which lack quality maternal healthcare.¹ This issue inhibits women from reaching needed medical help, forcing them to rely upon traditional midwifery practices. This, in turn, increases the risks associated with childbearing for both the mother and child due to a lack of modern medical resources and training. With the mean number of children per woman in Kenya being between 4 and 5 in 2011, it is common for women to experience a high number of miscarriages, abortions, and neonatal deaths. Sadly, this is a systematic reality that is likely to continue without holistic policy reform.

¹ "Financing Reproductive Health in Kenya: Recommendations for Donors." *Www.eurongos.org*. EuroNGOs, Policy Brief 2012.

In Kenya, women's reproductive healthcare is far from reaching the development standards of the western world, and every day women face this reality in a number of ways. The leading cause of death for women of childbearing age in Kenya is maternal mortality.² It is estimated that approximately 14,700 women and girls die each year due to complications related to pregnancy. Additionally, up to 441,000 women annually will experience disabilities caused by complications during pregnancy and childbirth.³ The maternal mortality ratio has in fact worsened over the last two decades, increasing from 365 deaths in 1994 to 414 deaths per 100,000 live births in 2003. This is due in large part to the disease burden the country faces and the government's failure to mitigate this burden.⁴ This insufficient response by government is also seen in the failure of current policy to improve the dismal status of women's reproductive healthcare; and yet, "the tragedy—and opportunity—is that most of these deaths can be prevented with cost-effective health care services."⁵

In an effort to shed light on the health related barriers that women in Kenya are exposed to on a regular basis, this paper aims to promote a new sense of fairness and understanding for how to reform Kenya's reproductive healthcare system and how to do so in a way that works to ensure improved safety for mothers and children. By offering a comprehensive look at the number of issues that play into maternal healthcare, we can become aware of the inefficiencies, inequities and utter injustices for women in the current Kenyan health care system.

² "Country Cooperation Strategy: Kenya." *World Health Organization*. May 2009. Web. <<http://www.who.int/countries/ken/en/>>.

³ "Maternal and Neonatal Program Effort Index (MNPI): Kenya." Policy Project, USAID, 2002.

⁴ "Country Cooperation Strategy: Kenya." *World Health Organization*. May 2009. Web. <<http://www.who.int/countries/ken/en/>>.

⁵ "Maternal and Neonatal Program Effort Index (MNPI): Kenya." Policy Project, USAID, 2002.

The Kenya National Reproductive Health Policy (2007)

As of 2011, about 50% of the Kenyan population still lives in poverty. In addition, seventy five percent of the population lives in rural areas that are plagued by droughts, lack of food security, transportation, basic necessities and infrastructure.⁶ Women's maternal health in childbirth is only one of the many improvements to be made in regards to human development in Kenya. Kenya was ranked 145th out of 187 countries and territories on the Human Development Index (HDI), which situates it in the low human development category.⁷ In an already poor country, Kenyan women are also a marginalized group due to the traditional patriarchal society. This places the development of women's rights and healthcare low on the list of improvements to be made in a country that lacks significant human development. The nation has come nowhere near achieving the United Nations Millennium Development Goals (MDG), specifically MDG 5 which focuses on improving maternal and reproductive healthcare in developing countries, as set by the United Nations (UN) back in 2000 (see Appendix A).

The World Health Organization (WHO) claims that "poor infrastructure, weak institutions and poor regulatory enforcement are key development challenges" that make Kenya's overall progress towards meeting the MDGs in all areas slow and uncertain.⁸ However, Kenya has made strong efforts to improve policy on some of the issues which the country previously ignored. In accordance with this, in 2007 the Kenya National

⁶ "The State of the World's Midwifery: Kenya, 2011." *Wwww.unfpa.org*. UNFPA, 2011. <http://www.unfpa.org/sowmy/resources/en/country_info.htm>.

⁷ "Kenya GDP Purchasing Power 2010: 66 Billion". *Imf.org*. 14 September 2006.

⁸ "Country Cooperation Strategy: Kenya." *World Health Organization*. N.p., May 2009. Web. <<http://www.who.int/countries/ken/en/>>.

Reproductive Health Policy was developed by the Kenyan global health partnership, a tri-party collaboration between the government of Kenya, and a team of implementation and development partners.

Two-thousand seven marked the first policy that Kenya ever enacted to address reproductive health, and it was put in place with the “framework for equitable, efficient, and effective delivery of high-quality reproductive health (RH) services.”⁹ The policy was meant to reach those who faced the greatest risk and therefore were in the greatest need.¹⁰ Evidently, Kenya understood the strong correlation between reproductive health and the Nation’s aggregate development.

The goal of the policy was to achieve an enhanced reproductive healthcare system for all Kenyans by addressing up to date issues, all sectors of the population, and aligning itself with other international policies and improvements.¹¹ Some of the main aspects of the policy include, but are not limited to:¹²

- Improved reproductive health resources
- Prevention of transmission of HIV from mother to child
- Improved access to RH emergency care
- Increased awareness of RH issues for adolescents
- Decreased violence against women and children
- Promoting awareness of sexual and reproductive health issues
- Strong midwifery practices in communities

⁹ USAID: Health Policy Initiative. “Stories From the Field: Kenya Adopts First National Reproductive Health Policy” (2007).

¹⁰ USAID: Health Policy Initiative. “Stories From the Field: Kenya Adopts First National Reproductive Health Policy” (2007).

¹¹ EBIT.

¹² “Kenya Adopts First National Reproductive Health Policy.” *Www.healthpolicyinitiative.com*. USAID, Oct. 2007.

Further the policy established a National Reproductive Health Strategy to help guide the implementation of these changes.¹³ While the policy was successful in naming the critical factors for improving reproductive healthcare, it fell short in terms of implementation. Thus leading to a mixed record of successes and failures.

Policy Achievements

The USAID report on the new health policy initiatives projected that the “policy’s focus on strengthening community midwifery practice and helping traditional birth attendants become advocates of safe motherhood will contribute to enhanced maternal health. Its integration of reproductive healthcare and HIV services will conserve vital resources while continuing to provide patients with comprehensive care.”¹⁴ Additionally, the public sector has increased its proportion of the overall financing of reproductive health services from 34% in 2005/2006, to 40% in 2009/2010, all in all lowering the private out of pocket payments by 3%; and in absolute values the public sector increased its financing by 55 percent, in addition to an increase of 23% and 21% respectively from private and donor funding since 2005/2006 as measured in 2009/2010.¹⁵

Furthermore some of this increased financing in reproductive healthcare has resulted in slight improvements in reproductive health indicators when compared to 1998.¹⁶ These slight improvements include an increase in the contraceptive prevalence

¹³ "The State of the World’s Midwifery: Kenya, 2011." *Www.unfpa.org*. UNFPA, 2011. <http://www.unfpa.org/sowmy/resources/en/country_info.htm>.

¹⁴ USAID: Health Policy Initiative. “Stories From the Field: Kenya Adopts First National Reproductive Health Policy” (2007).

¹⁵ "Country Cooperation Strategy: Kenya." *World Health Organization*. N.p., May 2009. Web. <<http://www.who.int/countries/ken/en/>>.

¹⁶ This was used as a benchmark year because of thoroughness of the data available from that year from the Kenya National Bureau of Statistics through the use of a Demographic and Health Survey.

rate from 39% to 46%, a majority of the population (92%) receiving some sort of antenatal care and a small decline in the total fertility rate from 4.7 to 4.6.¹⁷ The achievements of the policy prove to be minute and progress to be modest.

Policy Failures

Although the public sector has increased its financing of the reproductive healthcare services as noted above in absolute terms, the government's overall health expenditures as a percentage of total government expenditures has decreased significantly from 8.6% in year end 2002 to 4.6% in year end 2011. This has had serious implications for the health system as a whole and a severe effect on reproductive health service provision.¹⁸ A lack of funding has posed a major problem for Kenya, and has become relatively more pronounced in recent years as the divide between the health sector policies and the corresponding outcomes has grown.¹⁹ With limited financing and systematic inefficiencies plaguing the healthcare sector, the pledge made in the 2001 Abuja Declaration of allocating at least 15% of Kenya's national budget to healthcare has not been achieved and remains out of reach.²⁰ In total, reproductive healthcare expenditure captures only 0.8% of GDP and 13.9% of the overall health expenditures in Kenya.²¹ The lack of financial resources allocated to reproductive healthcare makes it difficult for the health sector to make a significant amount of changes and have an impact on a majority of women's lives. This being said, the

¹⁷ "Financing Reproductive Health in Kenya: Recommendations for Donors." *Www.eurongos.org*. EuroNGOs, Policy Brief 2012.

¹⁸ "Financing Reproductive Health in Kenya: Recommendations for Donors." *Www.eurongos.org*. EuroNGOs, Policy Brief 2012.

¹⁹ EBIT.

²⁰ Abuja Declaration: "In April 2001, African Union countries meeting in Abuja, Nigeria, pledged to increase government funding for health to at least 15%, and urged donor countries to scale up support." – World Health Organization

²¹ "The Abuja Declaration: Ten Years On." World Health Organization, 25 Mar. 2011.

policy has the intended purpose of achieving better reproductive care for all but a number of issues still persist for those in poverty both in urban and rural areas. These specific barriers will be expanded upon to highlight some of the key discrepancies of distribution of services and reforms in women's reproductive healthcare throughout Kenya.

Overall, Healthcare policy in Kenya, including the 2007 Reproductive Health Policy, is developed by a global health partnership amongst three key actors. These actors are the government of Kenya; implementing partners, private for-profits and not-for-profits that provide health services to Kenyan; and, development partners, that consist of international agencies that support the Kenyan health sector.²² With a number of different backgrounds and goals in mind, the combination of different global agencies in decision-making can be a detriment to the ability of public health reform to be decided on, sustainable, equitable for the population at hand, and effective in a specific nation. All in all, these factors most likely play a role in the failure of the 2007 policy to achieve its stated goals and to maintain any policies that are implemented. Even within one facet of the global health partnership, the government of Kenya alone faces problems with multiple decision-making parties and varying goals amongst them. A policy brief on the reproductive health environment in Kenya stated the problem well²³:

Despite having an enabling policy environment to promote universal access to reproductive health, 'there still exists disconnect between the policies and action, which often leaves a gap that must be filled'. Different government ministries and agencies have contributed to the development and are charged with implementation of these policies and guidelines. Besides the

²² "Country Cooperation Strategy: Kenya." *World Health Organization*. N.p., May 2009. Web. <<http://www.who.int/countries/ken/en/>>.

²³ "Financing Reproductive Health in Kenya: Recommendations for Donors." *Www.eurongos.org*. EuroNGOs, Policy Brief 2012.

two ministries of health, the Ministry of Planning, National Development & Vision 2030, Ministry of Gender Affairs and Children, Ministry of Youth Affairs and Sports, and Office of the President have been implement SRH (sexual and reproductive health) related interventions. Consequently, managing and monitoring resources allocated to RH programs has been difficult. In addition, lack of priority setting and costing makes it complex to use the existing policies as a basis for planning strategic interventions and support.

Furthermore, the policy implementation lacks a structured way to set various objectives, measure the efforts towards the set objectives, and evaluate what more needs to be done. Such inefficiencies have made it extremely difficult to deliver evidence-based care and determine the most effective and efficient ways to improve maternal and newborn health. As noted by Harvard University Ethics and Populations Health scholar, Norman Daniels, the decision making process in healthcare reform and the key decision makers are the most important factors in equitable and just healthcare reform. Through his accountability for reasonableness standards, Daniels has creates an equitable and transparent way to initiate and enact just reforms (See Appendix C). Addressing reproductive healthcare problems through Daniels' accountability model could help to improve the efficiency, effectiveness and fairness of the reform at hand.²⁴

Due in part to some of the financial failures and decision making problems described, Kenya's reproductive health (RH) indicators still show that when it comes to reaching MDG 5 after the implementation of the new policy in 2007, Kenya is still far behind the projected goals and they will certainly be unattainable by 2015. The maternal mortality ratio remains high and the number of births attended by skilled health care

²⁴ Daniels, Norman. *Just Health: Meeting Health Needs Fairly*. Cambridge: Cambridge UP, 2008. Print.

personnel is only at 44%, while it should have increased to 90% by 2015.²⁵ Moreover, the need for family planning is large and unmet, “despite the recognition of the need to increase access to family planning which is irrefutably linked to poverty reduction and commonly regarded as one of the most cost-efficient methods to improve maternal health and child health.”²⁶ To highlight the issue at hand, currently 1.8 million married women still have unplanned births every year and this number is higher for unmarried women and adolescents (15-19 year old). Further reproductive health problems stem from unintended pregnancies such as miscarriages, stillbirths, unsafe abortion and other complications that increase maternal and newborn mortality.²⁷ Although some family planning is available, cultural beliefs pose barriers to the rate of usage of contraception, young women receiving care and women’s freedom to choose to receive care as a whole.

The Kenyan policy fails to address and make substantial changes in limiting the barriers to better reproductive healthcare for women across the country. Although different infrastructure is in place in urban and rural areas, pregnant women in both face a number of challenges. Not only do women face cultural challenges that hinder their ability to improve their health; they also face structural issues such as the lack of adequate resources and the absence of nearby clinics with trained professionals. For the few resources available, women have trouble getting to them due to lack of transportation and high costs. Transportation and costs disproportionately hinder women who are poor from receiving reproductive health care, because those who have more money are most likely to see the improvements in facilities nearest them and have the ability to get to and pay for

²⁵"Financing Reproductive Health in Kenya: Recommendations for Donors." *Www.eurongos.org*. EuroNGOs, Policy Brief 2012.

²⁶ EBIT.

²⁷ EBIT.

private practice care. Additionally, the disease burden that plagues much of the country plays a significant role in the decline in maternal health. Many of the diseases are both preventable and treatable. Medical improvements have led to both a decline in HIV and a quick cure for malaria. However, both of these diseases still take the lives of women and children in Kenya daily. Preventable measures can be taken to decrease the susceptibility of women to worm infections through antihelminthic treatment, and iron supplements can treat anemia. All of these remedies can be addressed and distributed through good antenatal care. Access to care, as mentioned above, is a bigger barrier for impoverished women in Kenya and must be addressed if any improvements are to be seen.

All in all, reproduction for women, and specifically poor women, in Kenya can lead to premature morbidity for both the mother and the child. This is a severe injustice to Kenyan women because in large part these deaths are preventable. The policy at hand fails to remove the barriers that impede women's access to good maternal health and changes need to be made to improve this.

Barriers to Improved Reproductive Healthcare for Women

Cultural Barriers

Patriarchal Society

It is known that "women's low status in society, lack of access to and control over resources, limited educational opportunities, poor nutrition, and lack of decision-making power contribute significantly to adverse pregnancy outcomes."²⁸ Women and girls are the

²⁸ "Maternal and Neonatal Program Effort Index (MNPI): Kenya." Policy Project, USAID, 2002.

majority of the world's poor, the world's illiterates, those children not in school, and those affected by HIV. Of the enrollment in 700 secondary schools in Kenya, the male to female ratio was 92%.

Furthermore, almost half of women report having experienced physical and sexual violence, a likely conservative estimate as acquiring records is difficult.²⁹ These gender inequalities are reflected in Kenya's human development ranking, gender-related development index. Of 157 countries, Kenya ranks 127.³⁰

Lack of education and rights hinders women's health by limiting their knowledge of necessary healthcare practices and their rights to maternal healthcare. In Kenya, "laws and policies, such as those that require a woman to first obtain permission from her husband or parents, may also discourage women and girls from seeking needed health care services—particularly if they are of a sensitive nature, such as family planning, abortion services, or treatment of STIs."³¹ Therefore, specifically women's reproductive health is greatly deteriorated by these laws and policies.

The World Bank notes that empowering women and improving gender equality will be important obstacles for Kenya to overcome in order to improve reproductive health. Better reproductive health outcomes are associated with women's education, increased wages, improved societal status, autonomy, and participation in the labor market.³² In order to do this, changes in the laws and policies in place must be made to improve equality amongst men and women in Kenya.

²⁹ "Reproductive Health at a Glance: Kenya." The World Bank, Apr. 2011.

³⁰ EBIT.

³¹ "Maternal and Neonatal Program Effort Index (MNPI): Kenya." Policy Project, USAID, 2002.

³² "Reproductive Health at a Glance: Kenya." The World Bank, Apr. 2011.

Early Marriage

Although Kenyan law prohibits child marriages (under the age of 18), they still run rampant. A report released in December 2012 on health care in rural areas exemplifies the problem, and that it is heightened in rural areas. In the report, “43% of girls interviewed and 11.6% of boys were married before 18. Both rates are higher than Kenya’s national rate, which stands at 34% for females and 1.4% for males.” Many reasons account for the persistent high rates of young marriages that include: monetary reasons, stigmas against teen pregnancies, children being born out of wedlock, and parents’ traditional views of marrying off their daughters.³³ The increased rate of early marriage in rural areas is most likely due to the traditional agrarian society. Women are sold for a bride cost which often consists of cattle or other important farming tools, and this increases the incentive for parents to marry off their daughters.

Decreasing young marriage is important for a number of reasons. One proven factor is that young marriage has been linked to gender based violence. Additionally, “pregnancies in adolescent girls, whose bodies are still growing and developing, put both the mothers and their babies at risk for negative health consequences.”³⁴ More specifically some of these negative health consequences can be unintended pregnancy, pregnancy-related complications, preterm delivery, delivery of low-birth-weight babies, fetal mortality, a heightened risk for the spread of HIV, and neonatal mortality.³⁵

³³Aisi, Anthony. "Illegal Underage Marriages High in Rural Kenya, Report Finds." *Www.keycorrespondents.org*. International HIV/AIDS Alliance, 11 Dec. 2012.

³⁴ "Maternal and Neonatal Program Effort Index (MNPI): Kenya." Policy Project, USAID, 2002.

³⁵ KG, Santhya. "Early Marriage and Sexual and Reproductive Health Vulnerabilities of Young Women: A Synthesis of Recent Evidence from Developing Countries." National Center for Biotechnology Information, U.S. National Library of Medicine, Oct. 2011.

While working at the City of Hope orphanage in Tanzania, one of my “little sisters,” was a single parent orphan from AIDS, and a double parent orphan by being sold. She arrived at the gate of the City of Hope after the death of her mother from AIDS left the family economically damaged. Women are the main laborers in many Tanzanian tribal cultures and so to account for the loss of resources, the father and two brothers of this young lady decided to sell her to a village elder as his wife for a hefty bride price. This young woman had heard of the City of Hope from other villagers who had to send children they couldn’t afford there or the children of their deceased family members. She decided it sounded like a safe place, at a distance far enough from her village, to run away to. With nothing but the beat up shoes on her feet made out of old tires and the torn clothes on her back she ran away the night before her marriage was supposed to pass through (no ceremony was scheduled because it was not a celebration, but rather a business transaction). She made it safely to City of Hope after a number of hours trekking on dirt roads and asking for directions from different women in villages along the way. A year later, I met her. Had she been married off she would likely have been the victim of abuse, neglect, and pregnancy complications due to her age, and in the worst case, death; whereas, now she is flourishing in academics and hoping to become a nurse.

A major change in the educational attainment of young women could have a positive impact on the high rates of young marriage. If women were required to attend school through secondary school, it would decrease the chance that women would be able to be married below the age of 18, and it would also help to improve reproductive health outcomes for women when they are ready to have children.

Female Genital Cutting

Female genital cutting (FGC), also known as female circumcision or female genital mutilation (FGM), is a common problem for women in many parts of Africa. In Kenya the most recent data shows that around 27 percent of women between the ages of 15 and 49 have undergone FGC. Many explanations support the practice including social, cultural, religious, and personal reasons. It has been noted that “some of these reasons include maintaining tradition and custom, promoting hygiene or aesthetics, upholding family honor, controlling women’s sexuality and emotions, and protecting women’s virginity until marriage.”³⁶ FGC is noted to cause many reproductive health problems for women, including hemorrhage, pain, infection, perineal tears, and trauma during childbirth. FGC is a practice that has plagued women for decades and persists even though the Kenyan Government has passed several laws and international conventions condemning FGM.

Some community studies have shown promising results for policies that can decrease the persistence of FGC. As was noted in sections above, improving women’s education can have many positive effects and could also reduce this barrier. Not only will education place the young women in school so that they would not be around during the time that circumcisions are done, but increased education on the harmful consequences of the tradition have shown to decrease the amount of people who think that FGC is acceptable. Therefore, efforts to continue to educate women and men on the negative health implications of this tradition will help these communities to understand why this

³⁶ "Maternal and Neonatal Program Effort Index (MNPI): Kenya." Policy Project, USAID, 2002.

tradition is harmful and in turn decrease the prevalence of circumcision and the complications during pregnancy that result from it.³⁷

Sexual Health of the Young Generation

The current generation of young women in Kenya is extremely vulnerable to sexual abuse, high rates of STIs, HIV, and pregnancy. This vulnerability represents their important need for care, yet young women's reproductive rights and healthcare is still relatively neglected in Kenyan society for a number of reasons.³⁸ The 2003 Kenya Demographic and Health Survey showed that teenage fertility was on an upward trend. Additionally, in 2005 around fifty percent of new HIV infections in Kenya occurred among 15 to 24 year olds.³⁹ And in 2011, even with new regulations put in place in 2003 in the Adolescent Reproductive Health and Department Policy, levels of HIV infections still continue to be high and most prevalent among this young, female generation.⁴⁰

One issue, apart from poor infrastructure, maintenance and regulation of the policies in place, are the disapproving attitudes of nurse-midwives and health care professionals in Kenya on youth sexual activity; therefore, those who should be providing the services are one of the key factors standing in the way of young women receiving healthcare.⁴¹

³⁷ "Female Genital Mutilation in Kenya." *Www.giz.de*. Deutsche Gesellschaft Für Internationale Zusammenarbeit (GIZ) GmbH, Sept. 2011.

³⁸ Lee, Laura. "The Impact of HIV on the Sexual Health of Kenya's Young Generation." Africa Portal, 9 May 2012.

³⁹ EBIT.

⁴⁰ Lee, Laura. "The Impact of HIV on the Sexual Health of Kenya's Young Generation." Africa Portal, 9 May 2012.

⁴¹ EBIT.

Future policy needs to work harder at emphasizing youth-friendly services, and creating “an enabling social environment” for young women to be able to receive care without an associated stigma.⁴² In addition, policy that works to improve the education of the younger generation will be an important tool for decreasing the prevalence of HIV transmission and other STIs. Lastly, through improved gender equality and the empowerment of young women many benefits will be seen in women’s reproductive health as this generation ages.

Contraception

Although, Kenya has one of the highest rates of contraceptive use in sub-Saharan Africa, there is still significant need. The unmet need for contraception for the married female population between the ages of 15-49 is reported to be approximately 25 percent.⁴³ Contraceptives are important measures to help limit unsafe abortions and unplanned pregnancy, which may lead to strained resources for already impoverished families, and poor health of the mothers through the extra stress that pregnancy places on one’s body.⁴⁴ Moving past cultural ideas that using protection is “unmanly” will be an important issue to address in the predominately male led society in Kenya. In addition, distribution and education on how to properly use contraceptive measures will be needed in order to ensure availability and correct use. There is also the potential for increased contraceptive use to lower the number of young marriages due to the stigma of out-of-wedlock children that leads to a number of parents marrying their daughters off as soon as they begin menstruating.

⁴² EBIT.

⁴³ Chankova, Slavea et al. "Rising to the Challenges of Human Resources for Health in Kenya: Developing Empirical Evidence for Policy Making." *USAID*. Republic of Kenya: Ministry of Health, July 2006.

⁴⁴ "Kenya: Boosting Contraceptive Use to Cut Unsafe Abortions." *IRIN Africa*, 3 Oct. 2012.

Common Medical Conditions

HIV/AIDS

HIV/AIDS is a leading cause of death for women. A number of reproductive health issues described in this paper make women particularly susceptible to this debilitating and deadly disease. The traditional patriarchal society leads to a number of views about sex that endanger women's health. The traditional male attitude, as described to me by doctors in Tanzania and noted in a number of sources, is that it is unmanly to use protection, unnecessary, and unworthy of the potential to fend off disease if it ruins their reputation within the small communal societies that are common in Tanzania and Kenya. In addition, the lack of adolescent sexual education leads to a large spread of HIV in young women. This spread is often facilitated by the large incidence of sexual assault and rape, rather than youth promiscuity, although that plays a role as well. Lack of communication and stigmas about discussing protection make this a particularly difficult issue to address in many of the rural societies throughout Kenya.

Female genital cutting also plays a role in the spread of HIV among women. HIV can be spread through sharing razor blades that have been exposed to blood as is common during circumcision ceremonies in villages. Additionally, midwives often use unclean medical instruments during delivery, which increases the spread of HIV, as do untrained nurses in rural and urban poor clinics. Furthermore, these individuals also rarely wear gloves and this is also a problem for the spread of HIV to both pregnant women and those supporting the delivery.

Lastly, early marriage and polygamy play a role in the spread of HIV and its consequential effects on women's reproductive health. Due to the male stigma against protection, especially amongst older individuals, and the large number of sexual partners or previous marriages of these men, HIV is easily spread to young women married off at childbearing age.

Efforts have been made both in the reproductive health policy and in subsequent strategies to improve health in Kenya to decrease the spread of HIV and to increase the availability of Antiretroviral Therapy (ART) to treat HIV. However, implementation and maintenance has been difficult and is expensive. Increased funding towards ART treatment, increased education on safe sex practices and improved family planning services are necessary in order to maintain good reproductive health and decrease HIV/AIDS.

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Anemia

Anemia affects 70% of pregnant women in Kenya.⁴⁵ This estimate is likely low due to the lack of testing and statistics in many rural and urban poor areas.⁴⁶ According to the Kenya National Malaria Strategy 2001-2010, each year an estimated 6,000 women with a first-time pregnancy suffer from malaria-associated anemia and nearly 4,000 infants have low birth weight as a result of maternal anemia.⁴⁷

I discovered the importance of Anemia while working in a women's health and reproductive clinic in the rural village of Ntagatcha, Tanzania that is only an hour south on

⁴⁵ "Kenya: Iron Deficiency Anemia." *Www.tulane.edu*.

⁴⁶ Van Eijk, Anna M. "Reproductive Health Issues in Rural Western Kenya." *Reproductive Health Journal*, 18 Mar. 2008.

⁴⁷ Chankova, Slavea, et al. "Rising to the Challenges of Human Resources for Health in Kenya: Developing Empirical Evidence for Policy Making." *USAID*. Republic of Kenya: Ministry of Health, July 2006.

bumpy, dirt roads from the border between Tanzania and Kenya. Anemia plays a large role in many of the illnesses that plague women. Due to the blood loss during menstruation, delivery, and miscarriages many women have extremely low iron count and a decrease in red blood cells. Although many women in developed countries naturally deal with these issues as well, women in developing countries do not have the same access to fortified foods and vitamins, and deal with exogenous factors such as worm infections from water (worms feed off of the nutrients in blood), higher rates of miscarriages due to disease, heavy work, and domestic violence, and improperly performed abortions. Additionally, ordinary accidents are of high prevalence throughout all of Africa in daily life and the medical attention paid to the patient afterward is often poor, and given a long time after the injury is incurred causing more blood to be lost and infections to be common. Due to the lack of excess blood, when sicknesses such as malaria hit women often are hit harder because the disease spreads quicker through the lower cell count. Moreover, during pregnancy a woman's immune system is lowered so disease is more likely. These issues accentuate the negative effects that the low blood cell count of anemic women can have on health during pregnancy.

In addition, iron deficient anemia is often caused by the lack of iron in the typical African's diet and the increased nutritional needs that pregnant women require places a greater stress on the females' body during their pregnancy years. Anemia leads to easy fatigue, headaches, a lack of energy, and dizziness. In the labor-intensive lifestyle of African women, this has a large effect on their productivity. In addition, especially in rural communities it can play a role in a woman's ability to reach medical help that is far away.

Many of the women coming to the clinic in Tanzania traveled many miles over dirt roads, often with children tied to their backs with kangas and no water or food.

Anemia also has a large effect on newborns and small children. By leaving the umbilical cord connected to the fetus for a few extra minutes more red blood can be transferred to the child but all the while at a cost to the mother.

Anemia should be addressed in the Kenya National Reproductive Health Policy in order to improve the health of mothers and work towards reaching the goals of the policy and the MDG 5.⁴⁸ On paper, all dispensaries are supposed to provide antenatal care (ANC) treatment, which includes providing iron supplements and treating for anemia. However, the high levels of anemia still present shows that the facilitation and maintenance of the mandate has been poor, or that other factors are hindering the spread of treatment for anemia.⁴⁹ Distributing iron and some sort of prenatal vitamin supplement to dispensaries will help to improve anemia in Kenya and the complications that result from it.

Malaria

Malaria is the most common cause of death in Africa. It is spread through female mosquitos that breed in stagnant areas of water throughout much of sub-Saharan Africa. While in Tanzania, I saw many cases of both women and children with malaria. The symptoms consist of headache, diarrhea, fever, sweating, chills, abdominal pain, loss of appetite and nausea. Diarrhea poses a critical issue in and of itself because it can lead to

⁴⁸ Chankova, Slavea, et al. "Rising to the Challenges of Human Resources for Health in Kenya: Developing Empirical Evidence for Policy Making." *USAID*. Republic of Kenya: Ministry of Health, July 2006.

⁴⁹ Chankova, Slavea, et al. "Rising to the Challenges of Human Resources for Health in Kenya: Developing Empirical Evidence for Policy Making." *USAID*. Republic of Kenya: Ministry of Health, July 2006.

severe dehydration, malnutrition, and in some cases premature morbidity. Malaria can affect all people in a society, and therefore addressing it is important to improve healthcare for all individuals and especially for pregnant women, because if not treated quickly it can lead to death of both the mother and unborn infant.

Efforts to increase use of insecticide treated nets (ITNs) have been issued by the government and in a rural case study, the women surveyed “76% reported having a bed net in the house (either purchased or provided by government), 97% of which were treated with insecticide...and 69% of women used an ITN regularly.”⁵⁰ The use proved to be higher for those women who were older and had children. Although the use of ITNs appears to be large in this area, the prevalence of malaria is still considerable (36% of pregnant women surveyed). Policy should work to limit the cases of malaria by increasing the distribution of free ITNs and information packets or radio ads on education for how to use them and why they are so important. Another imperative measure will be to educate women about the early signs of malaria. It is treatable if they can get to a dispensary or clinic to get medicine. Early detection, preventative measures, and decreasing the amount of stagnant water in different areas of the country to help decrease the rate of malarial fly reproduction, are all important measures that should be strengthened in order to decrease the incidence of maternal and infant morbidity due to malaria.

⁵⁰ Van Eijk, Anna M. "Reproductive Health Issues in Rural Western Kenya." *Reproductive Health Journal*, 18 Mar. 2008.

Financial Barriers

One of the greatest barriers for equitable access to services resides in the large income disparities and high rates of poverty in the Kenyan economy.⁵¹ Under the Total Health Expenditure for Reproductive Health (THE_{RH}), households finance 19.3% in out-of-pocket payments.⁵² This places a huge burden on individual households to cover their own reproductive healthcare expenses, and is often one of the key factors in the decision of whether a woman or newborn will be able to receive any healthcare or medical attention. One way to improve the financing of healthcare and decrease the individual burden on payment is by incorporating a three-part system in Kenya to fund healthcare.⁵³ Through tax-based revenues, insurance premiums, and small out-of-pocket payments, progress in Kenya might be feasible; however, Kenya's large reliance on foreign aid is likely to inhibit any progress. To address this issue, foreign aid and donations can be added to the tax-based revenues to account for a large part of the population that is in the informal sector. Although it is a problem in and of itself that so many are in the informal sector, by relying on a few sources for healthcare payments, apart from out-of-pocket payments, women would have more access to affordable reproductive healthcare facilities and preventative measures for common illnesses.

⁵¹ "The State of the World's Midwifery: Kenya, 2011." *Www.unfpa.org*. UNFPA, 2011. <http://www.unfpa.org/sowmy/resources/en/country_info.htm>.

⁵² "Financing Reproductive Health in Kenya: Recommendations for Donors." *Www.eurongos.org*. EuroNGOs, Policy Brief 2012.

⁵³ Norman Daniels' Benchmark for Equitable Reform—Benchmark B5: Equitable Financing, Page 259.

Health System Barriers

Facilities & Health Care Professionals

One morning around 8:00 a.m. I arrived at the medical clinic to find a woman walking around the property. Upon asking the doctor who was there and who the woman was, he informed me that she was the mother of the newborn baby who was wrapped in blankets on the un-made hospital bed in of the exam rooms. I use the terms exam room and clinic loosely. The clinic lacks access to water and does not have electricity. The rooms are barren except for one yellow hospital bed that is never covered in sheets and does not have a pillow or safety bars on either side, as one might imagine. The doctors carry bottled water from the water towers at the City of Hope Orphanage to use to rinse the medical instruments. There is a latrine with a cement structure around it for walls and a tin roof on top out back. There is no toilet paper, and the doctors are extremely resourceful with the towels and medical dressings that they have. Nothing goes to waste, and nothing is used in excess.

With those clarifications in mind, I now learned another fact of life in rural Africa. Hospital beds are used for delivery and emergencies, not rest. The woman walking around the clinic in the crisp morning air had only given birth 4 hours earlier around 4:00 a.m. after walking 7 or so miles on the dirt road to deliver at the nearest clinic. After delivery, she still wore the same clothes she arrived in, and about an hour later after collecting her newborn child on her back she made the trek home in the same clothes, on the same day as her delivery. The baby was weighed, measured, and before leaving the clinic received a written copy of a birth certificate with an immunization chart attached.

My time in Tanzania represents one of the critical issues that plague Kenya, the lack of reproductive health care infrastructure, facilities, resources and trained personnel. Although facilities at every level of the current health care system are supposed to provide maternal health services,⁵⁴ many facilities go unfunded, understaffed, and relatively unnoticed. The Government of Kenya has become increasingly aware of the need for human resource development in the reproductive healthcare system and has started to address this growing need.⁵⁵ One of the primary efforts of the government to alleviate this unmet need is through a midwifery training system in rural communities.⁵⁶ An increase in proper training for midwives can help to alleviate the transportation and cost barriers to reproductive healthcare for women in rural and urban poor areas. This is because it is often difficult for these subsets of women to reach affordable care, so midwives provide an asset that comes to them. Although midwives might not be able to provide all of the services that one would receive at a hospital, they will help to improve antenatal care and home delivery processes that are already taking place around Kenya.⁵⁷ In addition, midwives can also provide staff in clinics and hospitals throughout Kenya. The development of a class of skilled midwives will help Kenya progress towards meeting their policy goals and those of the MDG 5. Furthermore, the rise in midwifery practices will also provide employment opportunities for women, which can lead to increased empowerment and the health improvements that come with it.

⁵⁴ Chankova, Slavea et al. "Rising to the Challenges of Human Resources for Health in Kenya: Developing Empirical Evidence for Policy Making." *USAID*. Republic of Kenya: Ministry of Health, July 2006.

⁵⁵ EBIT.

⁵⁶ "The State of the World's Midwifery: Kenya, 2011." *Wwww.unfpa.org*. UNFPA, 2011. <http://www.unfpa.org/sowmy/resources/en/country_info.htm>.

⁵⁷ "The State of the World's Midwifery: Kenya, 2011." *Wwww.unfpa.org*. UNFPA, 2011. <http://www.unfpa.org/sowmy/resources/en/country_info.htm>.

However, more efforts need to be made to address the lack of healthcare infrastructure in Kenya, especially in poor areas. This will be an important development strategy for Kenya in the future, but less costly changes that have been mentioned throughout this paper may be more viable right now with the resource constraints that the country currently has.

Conclusion

Through addressing and working to alleviate some of the barriers to healthy pregnancies for women and children, as I have outlined above, women, such as the one described in the story at the beginning of this paper, will no longer have to face the dangers and fears associated with pregnancy. A multi-sectoral approach that addresses culture, education, professional care, facilities, and resources available is needed in order to improve maternal and neonatal health in Kenya. Improving the status of women in society will also be a critical element to improving their care and increasing justice in Kenya. Women's reproductive healthcare is one of the many improvements that Kenya needs to make and efforts to embark on these improvements are crucial for the development of the country as a whole.

On my honor, I have neither given nor received any unacknowledged aid on this paper.

Mary E. Galbraith
April 21, 2013

Washington and Lee University

Appendix A: Millennium Development Goal

Millennium Development Goals for Women's Health

GOAL 5: IMPROVE MATERNAL HEALTH

1. Target 5.A: Reduce by three quarters the maternal mortality ratio
 - a. Maternal mortality has nearly halved since 1990. An estimated 287,000 maternal deaths occurred in 2010 worldwide, a decline of 47 per cent from 1990, but levels are far removed from the 2015 target.
 - b. The maternal mortality ratio in developing regions is still 15 times higher than in the developed regions.
 - c. The rural-urban gap in skilled care during childbirth has narrowed.

2. Target 5.B: Achieve universal access to reproductive health
 - a. More women are receiving antenatal care.
 - b. More pregnant women are receiving care with the recommended frequency, but gaps still exist in regions most in need.
 - c. Fewer teens are having children in most developing regions, but progress has slowed.
 - d. The large increase in contraceptive use in the 1990s was not matched in the 2000s.
 - e. The unmet need for family planning remains persistently high in regions with low levels of contraceptive use.
 - f. Official Development Assistance for reproductive health care and family planning remains low.

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"United Nations Millennium Development Goals." *UN News Center*. UN, n.d. Web. 19 Mar. 2013

Appendix B: Accountability for Reasonableness Conditions

1. *Publicity Condition*: Decisions regarding both direct and indirect limits to meeting health needs and their rationales must be publicly accessible.
2. *Relevance Condition*: The rationales for limit-setting decisions should aim to provide a *reasonable* of how the organization seeks to provide “value-for-money” in meeting the varied health needs of a defined population under reasonable resource constraints. Specifically, a rationale will be “reasonable” if it appeals to evidence, reasons and principles that are accepted as relevant by (“fair minded”) people who are disposed to finding mutually justifiable terms of cooperation. Where possible, the relevance of reasons should be vetted by stake-holders in these decisions—a constraint easier to implement in public than in private institutions.
3. *Revision and Appeals Condition*: There must be mechanisms for challenge and dispute resolution regarding limit-setting decisions, and, more broadly, opportunities for revision and improvement of policies in the light of new evidence or arguments.
4. *Regulative Condition*: There is either voluntary or public regulation of the process to ensure that conditions 1-3 are met.

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<http://www.unfpa.org/sowmy/resources/en/country_info.htm>.

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