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Dying to Give Birth: The State's Failure in Maternal Healthcare

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Kenya remains one of Africa's deadliest countries for pregnant women, with 594 maternal deaths per 100,000 live births, a crisis fueled by preventable obstetric emergencies like hemorrhage, sepsis, and unsafe abortion.[1] Despite constitutional guarantees to the highest attainable standard of health under Article 43(1)(a), systemic neglect has deepened disparities in maternal healthcare, particularly in availability of emergency services especially in rural areas.

Emergency treatment is defined as necessary immediate health care that must be administered to prevent death or the worsening of a medical situation.[2] Article 43(2) of the Constitution of Kenya provides that every person has a right not to be denied emergency treatment regardless of their ability to pay.[3] This includes pre-hospital care, stabilizing the health status of the individual, or arranging for referral in cases where the health provider of first call does not have facilities or capability to stabilize the health status

According to the 2023 Kenya Health Facility Census Report by the MoH, emergency care for maternity in Kenya is in a dire state, with only 5.8% of health facilities equipped with accident/ emergency units, 49% lacking ambulances, and 60% unable to provide blood transfusions.

[1]United States Agency for International Development (USAID) Report on Preventing Child and Maternal Deaths 2024

[2]Section 2, Health Act.

[3]Section 7, Health Act.

of the victim. Despite this, the lack of proper obstetric emergency systems is among the leading causes of maternal mortality.

The 2023 Kenya Health Facility Census Report by the Ministry of Health reveals the deplorable state of emergency care for maternity in Kenya. According to the report, only 5.8% of health facilities in the country have accident/ emergency units; 49% lack ambulances, and 60% cannot provide blood transfusions. Notably, less than half of all health facilities in the country offer maternity services, and only a third of those facilities are equipped to offer emergency obstetric care.[4] Many facilities are operating without essential medical supplies. Nearly half (46%) lack oxygen supplies which are vital in managing maternal emergencies and beds are often shared by women as reported at Mama Lucy Kibaki Hospital.

These service gaps are further compounded by staff shortages. In public health facilities, the nurse-to-patient ratio in postnatal wards ranges from 1:16 to 1:67 and 1:7 to 1:2 in labour wards, far exceeding WHO standards of a minimum of 1:4 in postnatal and labor wards. Even more alarming is that despite this shortage, less than 20% of our medical workforce is employed to serve approximately 75% – 80% of our population. This imbalance is made worse by the budget cuts and delayed payments for medical interns.[5]

These figures reflect a systemic failure to provide safe, timely and respectful maternity care to women in Kenya. The lack of emergency response infrastructure, skilled personnel and essential equipment means that women in need of emergency obstetric care often do not receive the care they urgently need leading to increased preventable maternal and neonatal deaths.

WHO IS TO BE BLAMED?

The failure to provide adequate, accessible, and quality maternal healthcare in Kenya is a result of systemic neglect by both the National and County Governments, each of which has distinct but complementary responsibilities in provision of maternal healthcare.

The National Government through the Ministry of Health is mandated to offer technical support at all levels with emphasis on health system strengthening[6] and further to ensure through intergovernmental mechanisms that financial resources are mobilized to ensure uninterrupted access to quality health services country wide.[7]

States have a duty to devote the maximum available resources to sexual and reproductive health and adopt a human rights-based approach to identifying budgetary needs and allocations.[8] The failure of the Stateto dedicate adequate resources to women's specific health needs is a violation of women's right to be free from discrimination.[9] These failuresalsoviolate the State's obligation under Article 21 to ensure progressive realization of rights guaranteed under Article 43 of the Constitution of Kenya.

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[4]Ministry of Health, Kenya Health Facility Census Report (September 2023)

[5]National Library of Medicine- Health budget cuts will be paid for by the most vulnerable

[6]Section 15 (1) (e) of the Health Act.

[7]Section 15 (1) (p) of the Health Act.

[8]Office of the United Nations High Commissioner for Human Rights (OHCHR), Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality, A/HRC/21/22, A/HRC/21/22/Corr.1 and A/HRC/21/22/Corr.2, pp. 4–8

[9]Committee on the Elimination of Discrimination against Women, general Recommendation No. 24, Women and health (article 12 of the Convention) (1999).

The National Government has failed in ensuring adequate resources and budgetary allocations for maternal healthcare. Further, the Ministry of Health has consistently fallen short in providing oversight of maternal healthcare standards and development of policies and guidelines to help prevent cases of obstetric violence. To date, there is no framework that directly addresses the issue of obstetric violence despite the high rate of maternal morbidity and mortality.

Health is a devolved function. The County Government is charged with service delivery, including the maintenance, financing and further development of health services and institutions that have been devolved to it and procuring and managing health supplies for healthcare facilities in the county.[10] This gives counties the responsibility to maintain, equip, and staff health facilities, and to procure essential medical supplies. The widespread shortages as reported by the Ministry of Health, lack of critical equipment and ambulances services point to mismanagement of county funds and a poor prioritization of maternal healthcare.

REGRESSION OR PROGRESSIVE REALIZATION OF RIGHTS?

Despite committing to the Abuja Declaration, Kenya allocates only 7.5% of its budget to health, half the pledged 15% minimum cap. The budget allocation for the State Department for Medical Services in Financial Year 2024-25 was reduced by Sh21 billion.[11] The funding for the free maternal health program, Linda Mama Program, was reduced by half, from 4 billion to 2 billion Kenyan shillings in the National Budget Estimates which started on July 1st, 2024.[12] The healthcare system is regressing at an alarming rate in the country, especially now with the transition from NHIF to SHIF.

In Mitu-Bell Welfare Society v Kenya Airports Authority & 2 others; Initiative for Strategic Litigation in Africa (Amicus Curiae) [2021] KESC 34 (KLR) the Court stated that no provisions of the Constitution are intended to wait until the state feels it is ready to meet its constitutional obligations. The state must be seen to be taking steps towards realization of these rights. There is a constitutional obligation on the State to go

[10]Article 186(1) of the Constitution of Kenya, Section 5 of the County Government Act.

[11]The Star Article- Budget allocation for Medical Services Department

[12]ICJ Kenya- National Budget: Prioritize Funding for Maternal Health Care

beyond the standard objection….Its obligation requires that it assists the court by showing if, and how, it is addressing or intends to address the rights of citizens to the attainment of the socio-economic rights, and what policies, if any it has put in place to ensure that the rights are realized progressively and how the Petitioners in this case fit into its policies and plans."

In the South African case of Government of the Republic of South Africa and Others v Grootboom and Others (CCT11/00) [2000] ZACC 19 ,the Court emphasized that the term progressive realization establishes clear obligations for States parties in respect of the full realization of the rights in question. It thus imposes an obligation to move as expeditiously and effectively as possible towards that goal. Moreover, any deliberately retrogressive measures in that regard would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources"

These two cases are important in emphasizing the constitutional and international obligations of States to progressively realize socio-economic rights, including the right to the highest attainable standard of health. They highlight the fact that the realization of such rights is not a matter of State convenience but a continuous obligation to improve the realization of the rights through actions that can be demonstrated to the public and the Courts and not merely pleading budgetary constraints or future intentions to realize the rights. Further, in Grootbom, the South African Constitutional Court affirmed that any regressive measures such as budget cuts to essential health services would need to be justified.

The State often hides behind the term progressive realization of the right to health, stating that the country does not have the capacity or funding to support healthcare, hence the budget cuts. However, I would like to draw your attention to the Auditor General 2023-2024 report and media reports on allocated expenses of the State that were deemed more important:

- State House Renovations at Kshs 3 billion[13]
- Corruption in County Governments[14] through misallocations, wastage of resources, lack of value for money in project implementation and corruption.
- Undocumented domestic travels, retreats and subsistence in counties[15] such as Nairobi County spent Ksh 200 million on a 3-day staff retreat in Naivasha (2024)
- 800 million shillings for the purchase of cars for the president, his deputy and the prime cabinet secretary.[16]

These choices reflect a discriminatory disregard for the healthcare of the citizens of Kenya and especially women's lives as demonstrated by a 50% budget cut on maternal healthcare.

CALL TO ACTION

To put an end to the ongoing regression of our healthcare systems, especially maternal healthcare, we must seek accountability from our respective county governments and the Ministry of Health on;

- Allocation of funds specifically for emergency obstetric services. Funding will ensure that essential maternal health services such as blood transfusions, emergency obstetric care, ambulance services are accessible to all women. This will reduce delays in maternal healthcare and ensure

[13] KTN News: State House costly renovations, outrage over KSH. 3B renovations

[14] Weekly Vision- Auditor General reveals massive corruption in counties

[15] Auditor General 2023-2024 report

[16] VOA- Kenyan Public frustrated by Excessive Government spending

lifesaving interventions are available.

- Regular assessments and reporting on the quality of emergency obstetric care. This will improve transparency and guide data driven decision making on gaps that exist in maternal healthcare such as infrastructure, personnel or equipment needs for timely corrective action. Public availability of this information will also empower communities to demand better services.
- Regular financial audits of county health budgets to ensure compliance. This is to ensure that resources allocated to healthcare are not misappropriated.
- Mandates for progressive reporting on improvements in maternal health outcomes for marginalized groups. This will promote equity in service delivery requiring the County Governments and Ministry of Health to demonstrate measurable progress in improving care for the vulnerable populations.
- Development of comprehensive policies or legislation on maternal healthcare and obstetric violence. Currently, there is no legal framework in Kenya that specifically addresses obstetric violence and provides redress for violence. Enacting the law or policy would create binding standards for respectful maternal healthcare, clarify institutional responsibilities and establish enforcement mechanisms for both preventive and remedial action.

CONCLUSION

According to WHO, UNICEF, the World Bank and other stakeholders, the majority of maternal deaths could be prevented through access to sufficient care during pregnancy and delivery and effective interventions.[17] The systemic inequalities in maternal healthcare are the leading cause of maternal mortality in our country. A preventable cause that the State refuses to remedy. It is a paradox of our shared humanity that we revere motherhood yet so often fail to safeguard those who create life. Maternal healthcare is not a privilege to be rationed, it is a necessity and the bare minimum. We cannot continue to stay silent as women are denied their constitutional right to safe and dignified care.

[17] United Nations Human Rights Office of the High Commission, 'Preventable Maternal Mortality and Morbidity and Human Rights'