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Antenatal care in Kenya needs improvement

By Patience Afulani

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Maternal and neonatal mortality has remained high in low-resource settings despite progress in recent years. The estimated maternal mortality ratio in Kenya is 342 per 100,000 live births, a startling 18 times the rate in the United States.

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High quality prenatal care can address these high levels of mortality. High quality prenatal care means women receive all the recommended services needed to ensure a successful pregnancy. But it's not just about receiving services; the woman's experience matters. High quality care is person-centred, meaning that it is respectful and responsive to the woman's needs and preferences.

This kind of care can prevent or identify and manage complications or pre-existing conditions that could cause problems during the pregnancy. Receiving quality prenatal care can also make it more likely that women will go to a facility for skilled care during birth, which is critical for managing complications at birth to prevent morbidity and mortality.

Kenya's national guidelines for obstetrics and perinatal care recommend four comprehensive and targeted prenatal care visits. The guidelines also urge providers to treat each visit as though it may be the only one to ensure patients are getting thorough care.

The guidelines say:

> *"Antenatal care should be simpler, safer, friendly and more accessible. Women are more likely to seek and return for services if they feel cared for and respected by their providers."*

A recent Bixby Center study surveyed around 1,000 women in a rural county in western Kenya, to see how the prenatal care they received measured up. It is one of few studies to look at both provision of services and women's experiences of care. The study found gaps in both provision of services and women's experiences of care, indicating that women are not reaping the full benefits of prenatal care.

Gaps in quality care

The study found that most women received basic services like blood pressure monitoring and urine tests at least once

during pregnancy. However, it found that they were not receiving them consistently at every visit as recommended by the guidelines.

The situation is even more dire for advanced services like ultrasounds, which fewer than one in five women received. Women with complications – for whom ultrasound is recommended – were not more likely to have one. Young women 15-19 years old were less likely to get an ultrasound, in addition to being less likely to have a good prenatal care experience. Given that this group has a high risk of complications, poor quality care may be playing a big role in their outcomes as complications may not be identified early or at all.

Women from the wealthiest households and those with college educated partners, however, had about two times higher odds of receiving an ultrasound than women from the poorest households and those with partners with primary education or less.

In the provision of person-centred care, the major gap was in communication. Only around two-thirds of women understood the purposes of tests performed or medicines received most or all of the time. Less than two-thirds felt they were able to ask questions and only half were consistently asked if they had questions. Most women felt respected by providers and felt they were treated in a friendly manner, which was encouraging.

But there is still room for improvement – one in 10 women didn't feel that way. A significant number of women also said they never got the opportunity to discuss issues in private. Prior research shows that women sometimes experience verbal and physical abuse during prenatal care.

As in many areas of health care, the most disadvantaged and disempowered women received the lowest quality care – both in terms of services provided and their experiences of care. Women who received all their prenatal care in lower level facilities, however, had better experiences than those who received some prenatal care in higher level facilities.

Some women may get better treatment because they are able to access facilities that offer higher quality care, are able to pay for higher quality care or have the knowledge and ability to advocate for themselves. Structural factors and provider attitudes could also contribute to the low quality of care. Providers simply aren't able to take weight and blood pressure measures or do blood and urine tests if they don't have the right equipment and laboratories. They can't give out medication if it's not in stock.

The need for supplies and equipment has an obvious connection to providing services, but it can also have an impact on person-centred care if it manifests as frustration in providers' interactions with women. Poor communication could be due to time constraints – it takes less time to just provide services than to talk to women and answer their questions. But that means that women might not adhere to treatment and recommendations for further tests because they don't understand why it's important.

What next

While it's important to get women to health facilities, much more is needed to achieve the full benefits of prenatal care. A lot of work remains to improve both dimensions of quality prenatal care. And the momentum behind improving person-centred care during childbirth should spread to prenatal care.

There must be special attention to disparities based on demographic factors, social status and facility type to move towards the sustainable development goal of "no woman left behind".

As countries like Kenya update their national guidelines, they must consider how to strengthen providers' ability to provide person-centred care to all women in all types of facilities and hold them accountable for providing it.

ABOUT THE AUTHOR

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