REPUBLIC OF KENYA

MINISTRY OF HEALTH

# SAVING MOTHERS LIVES

## Second Confidential Enquiry into Maternal Deaths

### For deaths that occurred in 2015 & 2016

61%

A total of **1334 (61%) maternal death** for mothers who died in **2015 (689)** and **2016 (645)** were assessed for this second CEMD report.

28

The **median age** of women who died was **28yrs**. The **youngest mother** being **14 yrs** while the **eldest** was **51yrs**

9.7%

**9.7% (128)** of women who died were **below 20 yrs old**

**Over 4 out of 10** of the mothers were having their **1st or 2nd pregnancy**.

Over **6 out of 10 deaths** occurred during the postpartum period.

For women dying during postpartum, almost **6 out of 10 died** within 24hrs.

50%

**Over half (50.8%)** of the women entered the health system in a stable condition (i.e. stable, alert, mobile, conscious and with **bp> 90/ 60 mm Hg**)

35.7%

Majority of women died due to **obstetric haemorrhage 35.7% (473)** followed by non-obstetric complications **22.2%(296),** hypertensive disorders **17.9% (239)** and pregnancy related infection **6.6% (88)**

**5 out of 10** of women had **anaemia** as a contributing condition.

Records showed that over **5 out of 10** women received **ANC care**.

There was lack of documentation of ANC attendance for **39% (521)** of the women.

Over **7 out of 10 women** who died had given birth, majority **(88%)** of whom delivered in a **health facility**

34%

Among the women who delivered **34% had stillbirths**

51%

**Over half (51%)** of the women who died were referrals from **sub-county hospitals** and **health centres**.

**4 out 10 (540)** of the women who died received **anaesthesia**.

**Critical care** was only available to **16.0% (213)** of the mothers.

## QUALITY CARE

Over **7 out of 10 (73.2%)** deaths occurred outside working hours; similar to findings of the first **CEMD report** where **73.3%** of death occurred also during out of office hours

**Medical officers** were the highest cadre of health care providers involved in the **management of 65% (866)**

Almost **3 out of 10 women** were managed by a specialist **obstetrician gynaecologist**; an increase from **1 out of 10** reported in the first report.

86%

One or more associated factors related to health worker, administration, patient and community factors were identified in majority **(86%) of maternal deaths**

**Health work force** related factors were identified in **90% (1320) maternal deaths**

Delay in starting treatment **41.3% (549),** prolonged abnormal observation without action **37.5% (499),** incomplete initial assessment **33.6% (446)** and inadequate monitoring **30.9% (411)** were the most frequently identified health **workforce related factors**.

**Infrastructural problems** and lack of availability of **blood transfusion services** were the most **administrative factors** identified. Nearly all women (99%) received **sub-standard care**.

**The first Kenya CEMD report only covered health facility maternal deaths that occurred in 2014 was published in 2017**

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