FABRIC OF AFRICA TRENDS REPORT

A Report on Women's Healthcare in Kenya by Philips

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I. Introduction

Philips believes that a Healthy Africa begins with Healthy Women, and that Women are the thread that holds the fabric of Africa together, sustaining healthy families. The Philips Fabric of Africa campaign is a multi-year commitment to improve access to healthcare and deliver appropriate, cost effective technology to the African market, with a particular focus on women's health.

With a presence in Africa for over 100 years, Philips has a unique understanding of the complexities of its diverse healthcare environments and a wealth of experience delivering innovative healthcare solutions across the continent. With the increase in prevalence of NCDs and their anticipated role in the post MDG/2015 landscape, Philips Healthcare believes that health systems strengthening (HSS) initiatives and expanded, sustainable services should be designed to include and meet the increasing needs of women in Africa. The Philips Fabric of Africa Campaign aims to develop meaningful partnerships with local stakeholders to improve healthcare delivery in the areas of maternal and child health as well as Non-Communicable Diseases (NCDs).

The Philips Fabric of Africa Campaign will reflect the post 2015 Millennium Development Goals (MDGs), specifically goals 4[1] and 5[2], focusing on three key areas:

- **Maternal and Child Health**

  In 2010 more women died in pregnancy in Sub-Saharan Africa than anywhere else in the world, with the region accounting for more than half (56%) of the 287,000 deaths recorded globally.[3] Child mortality is also high, with 29% of global neonatal deaths occurring in Africa.[4]

- **Non-Communicable Diseases (specifically breast, cervical & cardiac health)**

  By 2021 more people will die from NCDs in Africa than anywhere else in the world, with an expected death rate of 27% compared to 17% globally.[5] Cervical cancer is the most common form of cancer affecting women in Sub-Saharan Africa, followed by breast cancer.

  Cardiovascular disease is the second most common cause of death in Africa after infectious diseases, accounting for 11% of total deaths. The main causes are smoking, high blood pressure, being overweight and high cholesterol.[6]

[1] United National Millennium Goal 4 target is to reduce the mortality rate of children under five by two-thirds from 1990 to 2015
[2] United National Millennium Goal 5 target is to reduce maternal mortality rate by 75% from 1990 to 2015
[3] United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), World Bank, and World Health Organization (WHO), Trends in Maternal Mortality: 1990 to 2010 – WHO, UNICEF, UNFPA and The World Bank estimates. 2012. http://countryoffice.unfpa.org/uganda/drive/Trends_in_maternal_mortality_A4-1.pdf and United Nations Population Fund (UNFPA). Sub-Saharan Africa's maternal death rate down 41 per cent. New York, United Nations Population Fund. 2012.
[4] World Health Organization (WHO) Regional Office for Africa. The health of the people: the African regional health report. Brazzaville, Republic of Congo: World Health Organization; 2006.
[5] United Nations. *2011 Commitments to advance the Global Strategy for Women's & Children's Health.* New York, United Nations, 2011.
[6] WHO AFRO Commission 2012. Addressing the Challenge of Women's Health in Africa *Report of the Commission on Women's Health in the African Region*

- **Infrastructure Rehabilitation and Caregiver Training**

  Poorly equipped medical facilities, inadequate staff numbers and crumbling infrastructure are a serious concern in many corners of the African continent. Appropriate technology and training are important to delivering appropriate and effective care to patients.

To better understand how healthcare is perceived by women in Kenya, Philips commissioned a one-week qualitative study in Kenya to speak to women[7] and local healthcare workers about healthcare education and real-life experiences of the healthcare system in Kenya. The research team spoke to around 70 women aged between 15 and 45 years, as well as 15 healthcare providers. The study took place in urban, semi-urban and semi-rural living areas.

We plan to use this knowledge to drive collaborative opportunities with stakeholders in the development, business, academic, non-profit and medical communities and work towards improving healthcare delivery for African women and their families.

For further information about the Philips Fabric of Africa campaign, please visit: www.philips.com/FabricofAfrica.

II. Key Recommendations

Kenyan women have a very strong sense of community and are generally a well organized group. They are eager to learn more in order to manage their own health, as well as the health of their families. A lack of knowledge in relation to NCDs is evident, with the women wanting more information on prevention. Lifestyle issues were a key concern, with many women stating that they are worried that the food they are eating and a lack of exercise is impacting on their health. They feel that in the past they were eating fresh food and walking instead of using transport and are concerned about the impact a modern lifestyle will have on their health.

Educating women about NCDs and the importance of early treatment is critically important to help dispel common myths and encourage women to seek regular screening as a large number of patients are diagnosed too late to receive potentially life-saving care. Currently there are no large scale cancer screening programs available to women in Kenya, which would help to raise awareness and increase early detection. African women, particularly the younger age groups, are not aware of the importance of breast cancer screening other than an occasional test during awareness month or a gynecology visit.

The high cost of care is a key concern for women in Africa, value for money is very important and services are often lacking, due to pressure on healthcare workers and inadequate equipment. Healthcare services are often quite stretched, and, as well as dissatisfaction amongst patients, there has been growing unrest with physicians feeling underpaid and unable to provide a quality service to patients due to a lack of resources and equipment.

[7] In the context of this report, 'women' refers to lower-middle and middle class women in the southern part of Kenya.

A need for basic diagnostic equipment is evident to diagnose and treat patients at an early stage. Many public (lower level) facilities lack equipment for screening and early diagnostics, such as ultrasound. The majority of private facilities do not have the funds to employ a full-time technician to operate the available equipment. Radiographers and technicians are scarce, there is no certification program in place and most only have basic training. There is a need for low-cost effective equipment that is easily maintained by a local team.

Due to the high cost of care, providing appropriate and reliable healthcare technology would enable local healthcare professionals to provide better care to patients. Educating staff is also an important factor, so training schemes and ongoing support would also be useful. Partnerships between government, donor organizations and companies that can deliver suitable schemes will be key to improving the health of women and families in Kenya.

III. Kenya's Healthcare System

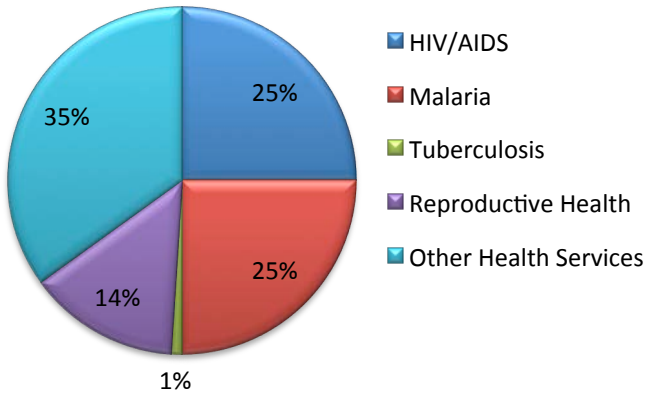
Healthcare in Kenya is mixed between public and private facilities but all is paid mainly out-of-pocket, with extended family often helping to pay for care in case of excessive costs. It is rare for people in Kenya to have healthcare insurance and reimbursement is limited for those who are insured. Most people rely on public healthcare due to subsidized fees/waivers and the system is overcrowded and under-resourced. The women who participated in the study were critical of the system as treatment seemed to be a long and slow process and they didn't feel it delivered value for money. The main complaint was the availability of medicine and tests, sometimes they were prescribed and paid for but not available at the point of care. Medical equipment sometimes does not even meet minimal standards, is broken or sub-optimally maintained.

Private healthcare facilities are on the rise, particularly amongst the growing (upper) middle classes, due to dissatisfaction with public facilities. This group demands more friendly and efficient services, easily accessible care and reliable healthcare information. Due to the long waiting times in public healthcare, people use private facilities for certain diagnostic tests. However, the experiences can be mixed as the private sector is not regulated and can range from one room facilities to specialist practices and large private hospitals.

IV. Overview of Health Expenditure in Kenya

Healthcare funding in Kenya is provided by the government and donor organizations, the main focus is on communicable diseases and general health services.

Total Health Expenditure on Priority Areas (National Health accounts, 2009-2010)[8]



- Expenditure on Child Health (CH) services, which cuts across HIV/AIDS, TB and malaria, sub-accounts & other general health spending.
- HIV/AIDS doubled since 2001/2: 1.3% of GDP
  - 51% Donor contribution (↓70% on 2001/2)
  - 21% Government (↑7% on 2001/2)
  - $^{2}/_{3}$ of HIV expenditure spent on outpatient care [(ART) and preventive health activities]
- Malaria
  - The Private sector incl. households (through OOP spending) financed 52% and the Government 32% of Malaria
- Tuberculosis
  - 42% of resources controlled by Donors
  - Private sector (incl. OOP) and public sector each almost 30%
- Reproductive Health
  - Only a marginal increase of 0.8% vs 2001/2 (Government is the dominant sponsor)

[8] Source: www.who.int/nha/country/ken/**kenya**_nha_**2009-2010**.pdf

V. Kenyan Women's Views on Health

The women who participated in the study are aware of simple measures to stay healthy, mainly to prevent communicable diseases. Staying healthy is mainly important in order to be able to work and take care of their families. As healthcare is so expensive, the women were very aware that being sick meant that the family's money would need to be spent on medical bills.

Education about communicable diseases was evident and the women try to take practical steps to stay healthy. The women also knew about the threat of NCDs and were more fearful of these (compared to communicable diseases) as prevention is not straightforward while the health effects can be severe. The cost of healthcare in relation to NCDs is high and treatment is even not always successful.

'*For example, if it's malaria, we can observe cleanliness by cleaning our drainages and compounds and using a mosquito net at night when sleeping…' '…but there are diseases we cannot avoid, like the cancers because the facilities are expensive; so there's nothing we can do'* [Young mothers, semi-rural]

'Of course first of all cancer because right now in Kenya has become number one because there are so many people being affected with cancer, there is also diabetes and of course still HIV and AIDS.' [Pregnant woman, urban area]

VI. Women's Experience of Healthcare in Kenya

Cost was the biggest factor in any decision regarding healthcare. As care is expensive, women often spoke of delaying seeking care until it was absolutely necessary. Quality of care was consistently front-of-mind and often negative experiences meant that women who were not happy with the value for money provided by healthcare services would stop treatment.

'They told me to take her [stroke patient] *for physiotherapy, someone told me that this private hospital is good, so I took her there about four times but then I felt that it was too expensive so I stopped and started doing therapy for her myself the way I used to see the physiotherapists doing it.'* [Partner of stroke patient, urban area]

'Women feel intimidated if you ask them to go for a test which they can't afford, there is a big chance that she won't come back again.' [Dr. Moses Owinourban area]

Accessibility and lack of appropriate equipment were also mentioned as key concerns for the women interviewed.

'They [the government] *should increase the number of public hospitals and employ more doctors; so that when you go to the hospital you are not referred to a private facility; the reason why people go to public hospitals is because they are cheap.'* [Young mother, semi-rural area]

'*Our hospitals don't have enough ways to treat us because if I go to the hospital I'm sent to buy the injections and medication myself, they don't have it.*' [Mother, semi-rural area]

'*In Kenya we have some other diseases; when one has cancer he/she is not healthy; but in Kenya we have some other diseases that can be prevented by the availability of facilities; but we are not well equipped, especially in the rural areas; so some diseases are not detected early enough to be stopped; so it persists and that is why you find people losing their lives; because we lack those facilities for treating them in advance..*' [Young mother, semi-rural area]

VII. Awareness and Care in Relation to NCDs

VII.a – Maternal, Newborn and Child Health

Despite numerous strategic plans, Kenya has made little progress on maternal health, and is considered by the UN to be making "insufficient progress" toward MDG 5[9]. The country's MMR has remained at 488 deaths per 100,000 live births. The percentage of skilled birth attendance has declined over the past 10 years, with only 44% of total births being assisted by a doctor, nurse or midwife[10]. Accordingly, it is widely considered that special attention is required to address the worsening maternal mortality rates. In October 2011, Kenya, in partnership with the U.S. Global Health Initiative (GHI) (recently reorganized and renamed to the Office of Global Health Diplomacy[11]), kicked off a campaign called "Let's Live" which aimed to reduce preventable maternal deaths in Kenya by 50% by December 2012. The campaign sought to accomplish its objectives by delivering sustainable outcomes in HIV/AIDS and associated illnesses, high-mortality cancers, maternal health issues, and child health issues. Methods included improving the quality and efficiency of community-based health services, increasing access to health facilities, supporting the Kenyan Government's pro-poor policy, establishing comprehensive training programs, developing innovative processes, protocols, and technical applications, and addressing leading causes of mortality in a comprehensive and integrated manner [13].

While insufficient progress has been made on reducing MMR, the United Nations Development Programme (UNDP) Kenya has noted an increase in contraceptive use, from 39% of married women using any method in 2003, to 46% in 2008-09.

Of all deaths of children under five in Kenya, close to 35% are infant deaths. The country's neonatal mortality rate remains static at 31 deaths per 1,000 live births, although this is better than the African average of 45 deaths per live births [13]. Achieving the MDG 4 targets for the Under 5 Mortality Rate (U5MR) and Infant Mortality Rate (IMR) by 2015 will be a challenge for Kenya unless neonatal care – which is closely linked to maternal care – receives more attention [54].

[9] United Nations Millennium Development Goals Report 2012
[10] United Nations Development Programme (UNDP) Kenya. *The State of MDGs in Kenya.* 2012. http://www.ke.undp.org/index.php/the-s
[11] http://www.ghi.gov/newsroom/blogs/2012/194472.htm

The qualitative study showed that there was a large difference in relation to childbirth experiences between the middle and lower classes. Family planning seemed to be on the rise in the urban middle class as this group wanted to be able to provide a good standard of education for children, which is quite expensive. This group was also most likely to receive antenatal care, whilst their lower income, rural counterparts were more likely to only visit a health center if they had a problem during pregnancy.

The general experience of the women interviewed was that antenatal care is a very basic clinical examination where they obtain a pregnancy booklet that allows them to deliver in a public hospital, but that women would only seek care again if they experienced problems during pregnancy.

Due to lack of money, a lot of women in Kenya choose to give birth at home. *'Costs for delivery are three thousand. The reason I feared to go is because I had to pay three thousand for maternity. I had five hundred that day.'* [Young mother, semi-rural area]

Next to costs access to care is an important factor: *'Distance to your home is important because you can get labor pains at night and if the hospital is too far away you will give birth on the way.'* [pregnant woman, urban area]

If costs and transport are less of a concern the quality of the facility comes into play: 'Why did you choose this private facility for these classes and for the visits?' '*Because they have modern equipment for delivery and also the doctors and nurses are friendly and the environment itself is welcoming.'* [pregnant woman, urban area]

VII.b – Breast Cancer

The Nairobi Cancer Registry (NCR) has noted that breast cancer is the number one killer of women aged 35 to 55 in Kenya.

According to the NCR, breast cancer has been the most diagnosed cancer among women in Nairobi since 2000 and 51% of cases were in women below the age of 50. Although Kenya's breast cancer incidence rate has remained relatively low in comparison to that of developed countries, its breast cancer mortality rate is higher. Screening utilizing mammography has not been widespread in the country[12]. As with other African countries, awareness of early detection measures has proven to be a key issue. The Kenya Breast Health Program, aimed at promoting breast cancer awareness, estimated that some 95% of women in Kenya have never had a clinical breast examination.

During the interviews it was evident that media coverage about the disease had ensured that a lot of women were aware of breast cancer, but still at only a very basic level. The women interviewed were unsure of the causes of cancer so felt powerless to prevent it, and also feared the cost of treatment.

[12] Kabura, Stella. *Breast angels aims to curb Kenya's top women killer.* African Laughter. http://www.webaraza.com/webaraza2/about-us/141-breast-angels-aims-to-curb-kenyas-top-women-killer

'I fear the cancer diseases because you can't even know the causes of cancer, it's everywhere. You hear of breast cancer but understanding it is hard, there should be education so that if you get it, you know what you are suffering from. It brings about so much worry.' [Mother, semi-rural]

'I fear cancer; because if you contract HIV, there's free medication for that and you can still be healthy; but when you have cancer, it kills; so that is the disease I fear most.' [Young mother, semi rural]

'You fear because in the first place when you get breast cancer maybe you won't be able to afford to get treatment.' [Pregnant woman, urban area]

Awareness of screening was mixed and some of the women who had heard of it were concerned about the impact of a positive diagnosis, particularly because of the cost of care.

'Sometimes we hear announcements that such and such a place will be conducting free cancer screening; I feel that is not enough they should do the screening and counsel women and give medication…There's no need if I come to a clinic, they only screen and they tell me you have this problem and they leave me like that; you see now they don't give medication they only screen; if they have not counseled you or given medication the chances of going down into depression is very high; so I feel they should do the screening and be ready to start you on medication; even if they'll refer you to another hospital but they should start on this medication.' [Older woman, urban area]

Interviews with cancer patients and their partners showed the response to the high cost of treatment.

'First I took time and came home to look for money, they told me that the deposit would be 20,000shs to remove my breast so I stayed about one month looking for that money and when I got it, I went back and booked and then they told me again to first come back to look for someone who can give a blood donation because they couldn't do an operation without that, in case I would be short of blood during the operation. So I had to look for someone who would first go and give blood so that I could get an operation.' [Breast cancer patient, urban area]

Many women felt that care for cancer patients was limited and that expensive treatments abroad were the best option.

'How do you feel about cancer care in Kenya?' *'It is of low quality because we have heard of Ministers, who have had cancer and we normally hear that they've been taken abroad for treatment rather than using our local facilities; but I can say that they are trying because they are bringing knowledge to the rural areas; but the facilities are not adequate.'* [Mother, semi-urban area]

VII.c – Cervical Cancer

As of 2008, GLOBOCAN figures show that Kenya's cervical cancer incidence rate is 23.9% (2,660 cases) while the mortality rate is 14.6% (1,491 deaths)[13]. A recent survey by Ipsos Synovate of 2,000 Kenyans found that 92% of Kenyan women have never been tested for cervical cancer. Findings also showed that

[13] International Agency for Research on Cancer. *GloboCan 2008 – Cancer Fact Sheet.* http://globocan.iarc.fr/factsheet.asp

the Northeastern, Western, Rift Valley and Eastern regions had the highest proportion of people who had never tested for cervical cancer while women in Central and Nairobi had the lowest proportion of those who have never been tested for breast and cervical cancer. In addition, the study found that women aged 25 to 44 years were the most likely to have been tested for these two cancers. Urban women were more likely to have been tested compared to their rural counterparts, which could be attributed to better access to health facilities in urban areas[14].

Although some projects in Kenya offer the HPV (Human Papilloma Virus) vaccine, Kenya's national reproductive health strategic plan has addressed cervical cancer largely through the roll-out of a low-cost screening tool - (visual inspection of the cervix using acetic acid). For the past two years, the government has aggressively trained healthcare workers to use this "see and treat model"[15].

Cervical cancer was known to the women who participated in the study but there is still a lot of misinformation.

'I think cervix cancer is not something as exposed as breast cancer; so that is why we are ignorant; but cancer is something more than this cervix cancer; I just feel I'm okay and it's not important for me to go; but for breast cancer I feel it.' [Older woman, urban area]

The idea of screening and its costs seem daunting, especially the idea of a man carrying out the test made the women uncomfortable.

'It's important to be done by a woman because it exposes you somehow.' [Older woman, urban area]

'*With that there was a time we went in a meeting in YWCA and women were asked why they don't go for cervical tests; some said they don't have money; in this private hospital you are asked for 350 for check-up; others said that if you go somewhere else you'll be told to pay 550; so that is why we don't go; A clinical officer of a public facility told us that the government offers free screenings; so we were told to go to room 11, the equipment is there and you'll be screened for free; I'm telling you it's only that women never knew; the place was full, the women flocked there to be tested; because each and every one wants to know if they are okay; and since you have seen somebody with the cancer and the suffering; you'd not want to suffer like your friend if there's a control or if you can be detected earlier; so everybody was there.'* [Older woman, urban area]

VII.d – Heart Disease

Age-standardized mortality rates in Kenya were on par with other African countries in 2008 (326.4 deaths per 100,000 women). While prevalence of daily tobacco smoking among women in the country was fairly low at 0.7%, 17% of women put themselves at risk for CVD and diabetes due to physical

[14] Ipsos Synovate survey, as reported in *90 Percent of Women Never Tested for Cancer,* All Africa. 2012.

[15] http://womennewsnetwork.net/2012/07/19/kenya-hpv-vaccine-roll-out/

inactivity. Twenty-four per cent were categorized as overweight, while 35.1% demonstrate a marked increase in blood pressure.[16]

The qualitative study showed a concern about lack of education and a fear of the disease as the heart is such an important organ. Generally the women spoke about stress and high blood pressure when asked about heart disease and didn't feel very well informed.

'The worry that I have is because I have never been educated on the diseases of the heart so I don't even know how it affects someone or what the symptoms are. It's not like cancer where we get taught that you can do this and know, for the heart I don't know and I can't even explain the symptoms so that's a very big worry.' [Mother, semi-rural]

[16] World Health Organization (WHO). *NCD Country Profiles-2011*. Geneva, World Health Organization, 2011. http://www.who.int/nmh/countries/en/index.html