

EDITORIAL

PERINATAL MORTALITY IN KENYA: TIME FOR ACTION

Globally perinatal mortality is the leading cause of death among children under five years of age. World Health Organization estimates that it accounts for 22% of deaths within this age bracket. The underlying cause in most of these cases is malnutrition.

The true perinatal mortality for Kenya is unknown. Most published data is health facility based; analysis is done from specialised units; the reporters are either purely obstetricians or pediatricians; the entire perinatal period has never been studied(1-12). The only study that comes closer to a population coverage is the Nairobi birth survey of 1981(4-7). This survey included nearly all health facilities in Nairobi and it was assumed to cover about 80% of all deliveries in the city. A recent survey of Kenya's referral hospitals reveal that in majority of them records concerning neonates were missing(14).

Why is this period so neglected? A number of reasons have been put forward: i). Events happen so fast no one notices except the parents of course. Most deaths occur during delivery or in the first 24 hours. ii). Incomplete reporting as mentioned above, iii). People think of extremely expensive technology and highly trained staff forgetting that there are many simple measures that can be utilised(1-15).

From the available reports most deaths are avoidable/preventable. The common causes of death are perinatal asphyxia with or without birth trauma, and problems related to prematurity and low birth weight (LBW). Neonatal infections are also very common(1-15).

The reported underlying problems include: poor attendance and quality antenatal care(2,5,13); poor conduct of labour and delivery(6); less than ideal neonatal resuscitation(15); poor neonatal services especially facilities for care of the LBW infants. Lack of trained personnel, inadequate staffing, lack of resource allocation and maintenance of equipment contribute to the poor care(11,14). It is also possible that those of us in the field have not acted when the need arose.

So what can we do to reduce this carnage? Probably first and foremost we need to stop mourning and start acting. We have said that most of the problems are avoidable/preventable. When we say this we often divide them into what can be done at patient/community level and at health facility level.

The failures at patient/community level are also health workers' failure. Communication between us and our clients is almost zero(14). Patient education is our responsibility. Knowledge kept to ourselves is useless knowledge. It is uncommon for patients to come back with similar problems because the mother was never told what went wrong the previous time. It takes longer and wastes more resources to have a repeat problem than educating that patient the first time the problem

occurs. We need to give information to the mothers on the value of antenatal care and reporting early when they notice a problem with their pregnancy. Many are scared to ask. If each one of us took a few minutes everyday to say something, certainly things can change for the better. We do not need resources to do this.

Simple changes within our areas of jurisdiction are many. Ayaya *et al*(15) in their current paper report that normal presumably term neonates are admitted into their neonatal unit simply because of Caesarean section; in their earlier paper they reported that these infants did not require admission(1). One wonders why they have not changed the practice. If the resources are limited and we misuse them then those who really require care get neglected ending up with poor outcome.

Health worker training: it will be a long time before we get enough obstetricians and paediatricians. So what can we do? We use what we have, namely nurses and midwives. Use of partogram in labour has been advocated in recognising problem in labour, have we trained our staff and re-emphasised its use by everybody conducting labour and delivery?

A well trained nurse can effectively resuscitate a baby. Judging from delivery room management at Moi Teaching and Referral Hospital(15) these nurses have not been adequately trained as one notices wrong procedures. We could do as some other developing countries are doing for example India, establish a training team that can go round the country and train everybody(16). Alternatively make it part of the training in integrated management of childhood illness (IMCI) this is already ongoing. But for us who are already in the care of the newborn, we can train locally without waiting for the national team.

Care of the LBW infant need not be expensive for the majority who could use the kangaroo mother care programme. In Kenya this has not been a well known or used as in other countries. It certainly reduces costs in many ways and survival is improved. There are hospitals in Kenya including Kenyatta National Hospital which are using this method of LBW baby care, but this could be expanded to more health facilities.

Development of clinical guidelines is also necessary. This has been done but we need to speed up the dissemination as well the training necessary to use them as indicated above(17).

Training goes hand in hand with availability of equipment and consumables(16). This will need commitment of the concerned people both at national level and the health management team in each area.

There is a proverb that comes to mind that fits the scenario at hand: 'you are continuing to sleep but the river is filling up' i.e. you will soon not be able

to cross'. We write, we recommend but do nothing about it. It is time we acted little by little; we shall get there.

R. N. Musoke, MBChB, MMed, Associate Professor, Department of Paediatrics and Child Health, College of Health Sciences, University of Nairobi, P.O. Box 19676-00200, Nairobi, Kenya

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