



Failure to Deliver

Violations of Women's Human Rights
in Kenyan Health Facilities



CENTER
FOR
REPRODUCTIVE
RIGHTS

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in Kenyan Health Facilities

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Federation of Women Lawyers–Kenya

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EXECUTIVE SUMMARY

The Kenyan government has taken many positive steps to advance women’s reproductive health and rights. However, as this report from the Federation of Women Lawyers–Kenya (FIDA Kenya) and the Center for Reproductive Rights (CRR) demonstrates, much work remains to be done. For decades, women seeking reproductive health services in Kenya have been suffering serious human rights violations, including physical and verbal abuse and detention in health facilities for inability to pay. Shortages of funding, medical staff, and equipment plague the health care system, particularly the public sector, dramatically interfering with the ability of health care staff to provide adequate care. These systemic problems have persisted, in part, because of a dismal lack of accountability within the health care system, which in turn stems from a lack of basic awareness about patients’ rights and the absence of transparent and effective oversight mechanisms.

The situation at Pumwani Maternity Hospital (PMH), Kenya’s largest public maternity hospital, vividly illustrates the Kenyan government’s failure to take responsibility for severe human rights violations in health facilities. PMH’s patients are among the poorest and the youngest women in Kenya, making them particularly vulnerable to discrimination and abuse. Women who delivered at PMH described decades of egregious rights violations—including unsafe conditions for delivery and behaviour by medical staff that abused and humiliated women and endangered their lives and the lives of their infants. While the problems that plague PMH are not unique to the hospital, they have been exacerbated by the facility’s large number of patients and its struggles with mismanagement and corruption. Despite the fact that PMH’s shortcomings have been public knowledge for decades, only piecemeal and inadequate measures have been taken to address them.

The lack of funding for public health facilities contributes to the emergence of a two-tiered health care system in Kenya, which discriminates against poor women and prevents or delays access to much-needed care. The government of Kenya controls slightly over half of all health facilities in the country while the rest—including the majority of maternity homes—are controlled by non-governmental, private, and mission organizations. While government facilities cost less money, they tend to have long lines, suffer from congestion, lack supplies, and treat patients unequally. Women expressed a firm belief that money usually buys better treatment, and when they could afford it, they opted for private facilities. The difference between delivery in public and private facilities was often stark, with women contrasting the rude treatment from staff and dirty, overcrowded quarters at public facilities with the attentive care they received in a private facility.

However, the care at private facilities is not uniformly good. The private sector also suffers from lack of government regulation and private health facilities are not required to establish complaint processes for patients as a condition of registration. Nearly half of all women obtain their contraceptives from private facilities, a fact that has specific implications for women. Health facilities run by faith-based organizations often provide limited services and information depending on the facility’s religious affiliation. For instance, Catholic facilities offer counselling only on natural family planning and do not supply condoms. Although Catholic and non-Catholic Christian facilities treat survivors of gender-based violence, these facilities do not provide emergency contraception, as the method is considered too controversial.

At both public and private facilities, the imposition of user fees creates a significant barrier to obtaining quality care. Women reported not seeking certain kinds of services, such as reproductive health check-ups, because they could not afford to, which led to small problems becoming serious when left untreated. In other instances, women were denied services because they could not pay a deposit fee, resulting in unassisted deliveries and other serious consequences. Although the Kenyan government has implemented a fee exemption for certain services and a general waiver system in public facilities for those who cannot afford the user fees, these systems have failed to protect women needing reproductive health care services. The exemption system suffers from inconsistent and ineffective publicity and implementation, so that women and health care providers do not know about the exemption or a facility arbitrarily charges for a service that should be free. Although government policy provides that contraceptives at government facilities and government-supplied contraceptives at private facilities must be free-of-charge, women often still pay some kind of fee.

The process of determining who qualifies for a waiver based on financial need is a lengthy and degrading one that delays care and gives rise to serious human rights violations, largely in the form of detention. Detention of women who cannot pay their medical bills for maternity or other services occurs in both public and private facilities. Private facilities generally use detention to pressure the patient's relatives to pay the bill. Public facilities also use detention for this purpose and to determine whether or not a patient really is poor enough to qualify for a waiver. Thus, women who have only recently given birth are often forced to sleep on the floor or share a bed with others, are underfed, and suffer verbal abuse from staff over their failure to pay. For women whose babies have died, there is a particular psychological cruelty to being detained in a maternity ward, surrounded by other mothers and their infants.

In order for the safe motherhood initiatives being promoted in Kenya to succeed, women must receive quality care that respects their dignity when they seek maternity services at health care facilities. However, the reality of the delivery experiences reported to FIDA Kenya/CRR was starkly different. In some cases, women received little or no care during labour. Women described having to find the delivery ward on their own, and giving birth alone or with the assistance of another patient or an inexperienced trainee.

Assistance, when it did come, was sometimes accompanied by verbal and physical abuse. Women described being beaten and slapped during labour and being called "stupid" or "psycho" or told to "just die." Young mothers are particularly vulnerable to discrimination; one woman who delivered her first child as a teenager recalled nurses telling her, "You young girl, what were you looking for in a man? Now you can't even give birth." In a particularly egregious case of abuse, a woman described being sexually abused and subjected to genital mutilation when she gave birth at a private facility.

Women also reported that following delivery, they endured long, uncomfortable waits on a hard, wooden bench before being stitched; unreasonably painful and poorly performed stitching; refusal to provide sufficient anaesthesia—or any anaesthesia at all; and verbal abuse from medical providers during the process. One woman described being stitched by the medical staff as if "they were stitching a sack," and a doctor confirmed that the stitching process for women is often "like a conveyor belt—people just quickly stitching them."

Women and health care providers who spoke to FIDA Kenya/CRR described bleak conditions in health facilities, primarily public facilities. Health care providers in Kenya

encounter a number of serious challenges to providing quality care. These obstacles include understaffing, lack of institutional support, and inadequate supplies and equipment, which invariably lead to lower-quality services for women and their babies. Hospitals often lack the most basic supplies, such as anaesthesia, gloves, syringes, surgical blades, soap and disinfectant, speculums, and bed linens. Patients are often asked to bring their own supplies; when they have not done so, they must beg medical staff to buy the needed item for them or go without it. A woman who had not known to bring anaesthesia with her for her first delivery described pleading with the medical staff to locate the drug so that she would not have to be stitched without it. An insufficient number of beds and incubators is another recurring problem; PMH, which handles between 25,000 and 28,000 deliveries a year, had only two incubators for the entire facility in 2004 and ten in 2005. Shortages of contraceptives and the supplies necessary to insert certain methods also impede women's consistent access to their preferred method of contraception and expose them to the risks of unplanned pregnancy.

Moreover, staff shortages result in overworked and overstressed staff with low morale. Health care providers observed that poor work conditions demoralize staff and interfere with quality care: "Nurses want to give proper care but they can't." Understaffing can also lead to inexperienced medical students providing care, including performing surgeries, without adequate supervision. Similarly, non-medical staff sometimes performs the work of nurses, such as assisting with delivery or cutting women during labour. Without sufficient staff, patients do not receive the individual care they need. A former matron at PMH described the effects of understaffing: "Mothers go out and say they delivered alone because babies are just falling out by themselves."

Understaffing and lack of supplies and equipment contribute to unhygienic conditions, which can threaten the lives and health of women and their babies. Women described delivering on beds covered with the blood and bodily fluids of the women who had delivered before them and babies being wiped with soiled bed sheets after delivery. These conditions increase the risk of infection, including HIV, for both women and their babies. One woman attributes her contraction of HIV to the fact that she was cut during her first delivery by a pair of unsterilised scissors immediately after they were used to cut another patient.

These negative experiences have lasting psychological and physical repercussions on women and shape their subsequent decisions regarding health care use. Some women try to save enough money so that they need not return to the facility where they were mistreated, while others avoid health care facilities altogether by giving birth at home or no longer seeking contraceptive services. The negligence and abuse documented in this report have more than just public health implications; they also constitute serious violations of human rights that are protected under national, regional, and international law. Fundamental human rights that the government of Kenya is obligated to guarantee include the rights to life and health; the rights to equality and non-discrimination; the right to be free from torture and cruel, inhuman, or degrading treatment; the right to dignity; the right to information; the right to privacy and family; and the right to redress. The violations described in this report demonstrate that Kenya is not honouring its domestic and global commitments to respect, protect, and fulfil these rights.

FIDA Kenya/CRR urge the Kenyan government to back its stated commitment to women's reproductive health and health care reform with the necessary actions. Until the government corrects the problems outlined in this report and restores public confidence in

the health care system, the public's negative views of the system will be one more barrier to improving the care and overall health of the people of Kenya.

One key step is allocating the necessary funding to the health care sector in general, and to reproductive health care in particular, in order to improve conditions and remove maternity fees at public hospitals. The Minister of Health, Honourable Charity Ngilu, recently declared the Ministry's intention to remove maternity fees in public health facilities as of July 1, 2007. Should this plan be implemented, it would increase access to delivery services and eliminate the detention of women and their babies in public facilities for inability to pay delivery costs. However, the success of such a plan hinges on it being supported by necessary funding and the provision of enough health care professionals to provide sufficient care. Adequate funding would go a long way toward fixing the broken exemption and waiver system, and remove the incentive in public health facilities to detain patients in order to recoup costs. The government must also promote and implement laws and policies that protect the rights of health care users. This process should include establishing formalized internal complaint mechanisms in both public and private health facilities, as well as external mechanisms that enforce ethical and professional standards of care.

The report is based on research and interviews conducted by FIDA Kenya/CRR between November 2006 and May 2007. FIDA Kenya/CRR gathered the experiences of over 120 women through a combination of in-depth interviews, focus group discussions, and questionnaires. FIDA Kenya/CRR also interviewed health care providers and administrators, leaders of medical associations, and officials at licensing and regulatory bodies. Additionally, FIDA Kenya/CRR reviewed government guidelines, standards, and manuals on issues pertaining to reproductive health services and media coverage of reproductive health issues for the past ten years. Data from the 1998 and 2003 Kenya Demographic Health Survey and the 2004 Kenya Service Provision Assessment Survey has been used both to offer a national perspective on reproductive health and to corroborate specific rights violations. In order to protect their privacy, the names of the women who provided information for this report have been changed. For the same reason, certain identifying information has been withheld for other interviewees where necessary.

INTRODUCTION

Ensuring women affordable, accessible, and safe health services is a key obligation of the government of Kenya. However, as this report vividly illustrates, Kenya's health care sector suffers from longstanding systemic and widespread problems that impair the delivery of quality care. While this report focuses specifically on women's experiences with reproductive health services, it also provides a lens through which to look at the Kenyan health care system in general. In doing so, this report documents ongoing violations of a range of human rights and the difficulty seeking redress for these violations.

Objectives of this Report

The goal of this report is to highlight the existing flaws in reproductive health care in Kenya. It is not intended to be an indictment of health care providers. The providers with whom the Federation of Women Lawyers–Kenya (FIDA Kenya) and the Center for Reproductive Rights (CRR) spoke while conducting research were dedicated to providing quality care to their patients and deeply concerned about the state of health care and patients' rights in Kenya. It is also important to note that not all women reported negative experiences with health care providers, and no woman reported a negative experience with every health care provider she encountered. Women were quick to describe positive encounters and to express their deep appreciation of those moments when they were treated with care and compassion.

However, just as quality treatment makes a lasting impression, so do negligence and abuse. Memories of mistreatment and humiliation, particularly during delivery, remain fresh in women's minds years after they occurred. These negative experiences shape women's subsequent decisions regarding health care use; some women try to save enough money so that they need not return to the facility where they were mistreated, while others avoid health care facilities altogether by giving birth at home or no longer seeking contraceptive services. Abusive treatment during delivery also impacts women's decisions about future child-bearing. As one woman commented while discussing her traumatic experience at Pumwani Maternity Hospital, "People say that raising a child is hard; for me, giving birth was harder. I was young and unexposed and swore never to give birth again."¹

The lasting and destructive impact of negative health care experiences cuts to the heart of the need to remedy these abuses, which span decades. For the government's health care reform efforts to succeed, people must be able to trust the public health care system enough to use it, rather than forgoing care or seeking it from more informal sources. A program of reducing maternal mortality by encouraging women to seek skilled delivery assistance is undermined if women feel that they would be safer avoiding health care facilities and, as one woman described it, "giving birth on the roadside."² Another woman summarized the situation by saying: "We would want the government to know the nurses don't take care of the patients so we opt for TBAs [traditional birth attendants]."³ Furthermore, those who use private health facilities, either by choice or lack of other options, need to be assured that they will receive a high standard of care and the same range of services specified in government outlines. And, all health care users need to know that their rights will be respected and that there is a clear system by which they can seek redress for violations. Until the government corrects these problems and restores public confidence, the fear of going to health facilities will be one more barrier to health care.

Scope and Methodology

The information in this report is based on research and interviews conducted by FIDA Kenya/CRR between November 2006 and May 2007.

Sources of information

FIDA Kenya/CRR gathered the experiences of over 120 women through a combination of in-depth interviews, focus group discussions, and questionnaires. To protect their confidentiality, women's real names are not used in this report. The women whose voices are reflected in the report range in age from 17 to 50. They are single, separated, married, divorced, and widowed, and come from a variety of ethnic groups. They include very poor women living in informal settlements to middle-class women, as well as women who have moved through various income brackets during their lives. The educational levels of the women range from primary school to advanced degrees. Women living with HIV participated in both the in-depth interviews and the focus group discussions.

Information was gathered from women currently living in and around Nairobi and Nyanza provinces, but participants recounted experiences in the majority of provinces and in a range of facilities, from private clinics to district, provincial, and national public hospitals. Interviewees and focus group participants were identified through health care providers and community-based organizations, and by other participants. Some were FIDA Kenya clients or women seeking legal advice from FIDA Kenya. Questionnaires were distributed to women who came to the FIDA Kenya offices in Kisumu and Nairobi in search of legal advice.

By focusing on locations where health care facilities exist but are often unaffordable or provide an unacceptable quality of care, this report counters the frequent assertion that the barriers to access and problems with quality care are limited to rural areas, where facilities are few and far between. It is not enough for the Kenyan government to point to the existence of facilities in urban or more populous areas and declare that it has met its obligations to provide quality care to residents of those areas.

FIDA Kenya/CRR also conducted site visits to private and public facilities and spoke to health care providers and administrators, as well as leaders of medical associations. In addition, FIDA Kenya/CRR spoke with officials at licensing and regulatory bodies, including the Medical Practitioners and Dentists' Board, the Nursing Council of Kenya, the Clinical Officers Council, the Nairobi City Council Medical Officer of Health, and the Maternal Health Program Manager at the Ministry of Health's Division of Reproductive Health.

Additionally, FIDA Kenya/CRR reviewed government guidelines, standards, and manuals on issues pertaining to reproductive health services and media coverage of reproductive health issues for the past ten years. Data from the 1998 and 2003 Kenya Demographic Health Survey and the 2004 Kenya Service Provision Assessment Survey has been used both to provide a national perspective on reproductive health and to corroborate specific rights violations.

Time frame and subject matter

This report covers two decades of women’s experiences, with the most recent delivery experiences occurring in the past six months. Women were asked about their experiences with contraception, pregnancy, and delivery throughout their lives in order to understand the long-term repercussions of mistreatment in the health care context. In this manner, it was also possible to show how individual women’s health care experiences change depending on their age, income, and marital status.

Above all, the documentation of decades of ongoing, systemic violations throws into sharp relief the need for comprehensive measures to understand the dimensions and extent of the problem, remedy the rights violations that women have endured, and implement systematic changes to ensure that women’s rights are protected when they seek reproductive health care. As noted above, the legacy of ongoing, systemic rights violations in the health care context is widespread distrust of health care facilities—a distrust that governments have a duty to address in order to ensure genuine access to services.

A note on Pumwani Maternity Hospital (PMH)

Pumwani Maternity Hospital (PMH), one of East Africa’s largest public maternity hospitals, handles between 25,000 and 28,000 deliveries a year—the highest number of assisted deliveries in Kenya.⁴ PMH’s patients are also among the poorest and the youngest women in Kenya,⁵ making them particularly vulnerable to discrimination and abuse. PMH’s central role in providing maternity services, coupled with the repeated references in interviews and the media to abuses occurring at this facility, accounts for its prominence in this report. Women who delivered at PMH described decades of egregious rights violations—including unsafe conditions for delivery and behaviour by medical staff that humiliated women and endangered their lives and the lives of their infants. “For some time, going to Pumwani has been like a death sentence,” commented a *Nation* journalist who has investigated and reported on the hospital; women “[e]ither lost their lives or lost their babies.”⁶

The problems that plague PMH are not unique to the hospital, although they are exacerbated by the facility’s large number of patients and its problems with Local Government mismanagement. Understaffing, lack of supplies and equipment, mismanagement and corruption, and lack of record-keeping and transparency are widespread barriers to quality health care. Similarly, the types of abuses identified at PMH are also perpetrated at other facilities, both public and private, as this report indicates. But what PMH does vividly illustrate is the Kenyan government’s failure to take responsibility for severe human rights violations in health facilities.

Despite repeated efforts and meetings with the Medical Superintendent of PMH, FIDA Kenya/CRR were unable to obtain information on PMH’s existing procedures and standards. However, we were able to speak with a number of people who have worked at PMH in various capacities in the past two decades, as well as journalists who have covered the PMH story. We also interviewed the head of the government-appointed 2004 Pumwani Task Force, which investigated reports of abuse and mismanagement at PMH, although we were unable to acquire a copy of the task force’s report.

Structure of the Report

This report does not encompass all reproductive health services, but focuses primarily on women's experiences with family planning, pregnancy, and childbirth. Section One discusses barriers to contraception, followed by Section Two, a brief inset on the harmful effects of Kenya's restrictive abortion law. While this report does not focus specifically on abortion, it was important to include a discussion of the law's significant impact on women's reproductive health and on the health care sector. Section Three is an in-depth account of abuse and neglect associated with delivery, along with an overview of Pumwani Maternity Hospital. Section Four examines the structural barriers to providing quality care. Section Five discusses the discriminatory effects of user fees and the differences between public and private facilities. This is followed by Section Six, which reviews the complaint mechanisms and quality-assurance structures that exist when patients want to complain about the medical care they received. Section Seven provides an overview of the legal implications of the rights violations identified in the report. Recommendations to key stakeholders, based on input from the women, medical providers, and officials with whom FIDA Kenya/CRR spoke, are included at the end of the report.

Women's Reproductive Health in Kenya

Reproductive health statistics serve as indicators of women's health status and can highlight violations of women's human rights.

- Women in Kenya have a 1-in-25 lifetime risk of dying from a pregnancy-related cause. The maternal mortality rate is estimated to be between 414 and 590 deaths per 100,000 live births in Kenya per year.⁷
- The 2003 Kenya Demographic Health Survey (2003 KDHS) revealed that among all women, nearly 20% of births are unwanted and another 25% are mistimed.⁸ The contraceptive prevalence rate among currently married women is 39%.⁹
- When women terminate unwanted or mistimed pregnancies, they face the risk of unsafe abortion due to Kenya's restrictive abortion law, which permits the procedure only to save the life of the pregnant woman. Unsafe abortion causes 30 to 40% of maternal deaths in Kenya.¹⁰ Kenyan public hospitals treat an estimated 20,000 women each year for abortion-related complications.¹¹
- HIV/AIDS is a significant threat to women's lives and health and affects more women than men; HIV prevalence in Kenya among women aged 20-24 is over three times that of men in the same age group (9% and 2%, respectively).¹²

LACK OF ACCESS TO FAMILY PLANNING SERVICES AND INFORMATION

State of Contraceptive Access and Family Planning Services in Kenya

The 2003 Kenya Demographic and Health Survey (2003 KDHS) reveals that the nation's contraceptive prevalence rate is 39% among women who are currently married.¹³ According to the survey, a steady increase in contraceptive use among married women that took place during the 1980s has slowed considerably since 1998.¹⁴ In addition, the survey states that nearly 20% of births in Kenya are unwanted and another 25% are mistimed.¹⁵ Clearly, the family planning needs of Kenyan women are not being fulfilled.

The harmful consequences of an unwanted pregnancy are myriad. When a woman decides to end an unwanted pregnancy, she is exposed to the risks of unsafe, illegal abortion, because abortion is only legal in Kenya to save the life of the pregnant woman—and even that exception can be difficult to realize due to cost and health care providers' reluctance to perform the procedure. [For more on Kenya's restrictive abortion law, see the Abortion inset.] In the alternative, when a woman carries an unwanted pregnancy to term, there can be physical and mental health consequences as well as potential economic and social ramifications.

Barriers to Comprehensive Family Planning Services and Information

This section examines several barriers to family planning—informal and formal user fees, stockouts, lack of infrastructure and supplies, and incorrect or insufficient information about family planning services—and their effects on women's lives.

The costs associated with obtaining family planning services, such as transportation expenses or service fees, can pose significant obstacles. When a woman does not have the money to cover those charges herself, she often must ask her partner for assistance; if her partner opposes her decision to use family planning, his denial of funds can prevent her from doing so. Even when a woman has access to adequate funds, stockouts and the lack of equipment that is necessary to provide comprehensive services can have dramatic results. When a woman is told to return to a health facility at a later date due to these problems, she may not have the time or resources for a second visit. Even if she does plan to return or to find a different facility that can provide her contraceptive method of choice, she risks becoming pregnant while waiting to access family planning services.

The following account demonstrates how inadequate and inaccurate information coupled with stockouts, supply shortages, and unaffordable user fees can combine to result in an unplanned pregnancy. Alice, a woman in her mid-thirties with an advanced degree, described her efforts to get her preferred family planning method, an intra-uterine device (IUD), after the birth of her third child in late 2004:

I went to the [Fatima Catholic] Mission hospital for [family planning services]. They are anti-condoms even though they have VCT [voluntary counselling and

testing for HIV]. They didn't suggest different kinds of contraception there. The nurse said a person with a coil [IUD] would conceive every month and every month would be aborting. They talked about safe days . . . but natural family planning didn't work for me. I realized later there was so much to know about with natural family planning.¹⁶

Alice decided to get an IUD because she had difficulties with hormonal methods. Not having much money at the time, she chose a government hospital, where an IUD would have cost Kshs. 200 (\$3 US)—far less than the Kshs. 2500 (\$36 US) or Kshs. 800 (\$11 US) that local private doctors or private hospitals would charge, respectively. The first two times that she went to the public hospital, IUDs were out of stock and she was told to try again at a later date. On her third visit, the hospital had the IUD but no gloves, so the health care provider could not insert it. During the two-month period when she was using natural family planning while trying to obtain an IUD, Alice became pregnant again and miscarried.

Finally, Alice turned to Sinai, a local private hospital, for the coil. After the procedure, she received no information about follow-up care: “They just inserted the coil. No follow-up visit was scheduled. I missed out on information and it was information that I needed. Information is expensive.” Today, Alice has health insurance through her employer, and has finally started getting more information on family planning. “Information and family planning have to go together. At the private hospital I could get the coil but not the information. If I had gone to [the] government hospital, maybe I could have gotten both. I could have gotten both at the private doctor who charged Kshs. 2500.” For Alice, her ability to obtain an IUD hinged upon financial resources: “I think about money—if I hadn't been able to get Kshs. 800, I would still be in the queue at the city council hospital.”

User fees in public and private facilities

[The] government will say family planning methods are free but how many people actually know what's available? Or do they say it's free but only one kind of family planning method might be free and another method isn't . . . ? Most services have some cost. . . . The drugs are free [only] when politicians visit.¹⁷

—Administrator of private clinic that serves as point-of-service for government-supplied contraceptives

Women encounter formal and informal user fees at both public and private facilities.

According to the Family Planning Key Findings (Family Planning Findings) of the 2004 Kenya Service Provision Assessment Survey (2004 KSPAS), 53% of all women obtain their contraceptives from government facilities—a decline of 15% from 1993.¹⁸ Private facilities, including those run by non-governmental organizations (NGOs), faith-based organizations, and for-profit groups, were providing contraceptives to 45% of women at the time of the survey, compared to 25% in 1993.¹⁹

Women encounter formal and informal user fees at both public and private facilities. Although government policy provides that contraceptives at government facilities and government-supplied contraceptives at private facilities must be free-of-charge, women often still pay some kind of fee. This charge can be for maintaining the client record, family-planning-related laboratory tests, the consultation, and/or the family planning method itself.²⁰

According to the Family Planning Findings, “government facilities can and do charge a registration fee for the client card, while private facilities usually charge a consultation fee.”²¹



The 2004 KSPAS found that some type of user fee for family planning services was charged in 51% of the surveyed family planning facilities.²² Forty-two percent of government facilities charged such fees, along with 62% of faith-based organizations and 95% of private-for-profit facilities.²³ Eight percent of government facilities charged for the contraceptive method itself, even though the method should have been free.²⁴ Of the 344 exit interviews conducted with clients for the 2004 KSPAS, almost two-thirds of the women paid some type of user fee during their visit, and half of the clients paid Kshs. 25 (\$0.35 US) or more. Although these fees may seem relatively small in some

instances, they can prove to be insurmountable barriers when almost 60% of the Kenyan population lives on less than Kshs. 140—\$2 US—a day.²⁵ Costs were significantly higher at private facilities.²⁶

In addition to encountering formal user fees, women sometimes also had to pay informal fees that were being levied by medical staff for their own financial benefit. Prudence, who worked as a non-medical member of the staff at the Maternal and Child Health unit at the Kisumu District Hospital, described how women seeking family planning services encountered inappropriately levied costs and were denied services:

First I worked at the MCH [Maternal and Child Health Unit] and . . . I would see how they treat women. For example family planning should be free because we would get [the contraceptives] freely from where they are taken from. But if a mother came for family planning, she would be told to buy a [registration] card. Yet the card should have been free. Now the nurse would tell them to produce twenty shillings before they get the card and might be the mama didn't have or only had ten shillings. She would be told to wait outside simply because she lacked the twenty shillings. The woman would wait until she sees she is not being attended to and she would go. . . . She would come back at lunch time . . . and she would be told to go and come back in the afternoon. In the afternoon she would be told that family planning is done in the morning and asked why she didn't come in the morning. We would sympathize but there was nothing we could do.

Sometimes you would pay the twenty shillings for the card, but [then] they would ask you if you have a syringe and a needle. This they sell for ten shillings—if you don't have, they would tell you to go and buy while those things are there [in the facility]. But if you gave them the ten shillings they would automatically . . . give you the injection. And if you complain or talk badly you are told 'Mama there is no medicine. Go and buy the medicine. You bring, we inject you.' I was seeing . . . they were unkind to these mamas or they were not giving these services the way they should be. Because if the [supervising nurse] was there, then things would be normal. They would be given the services and they would not pay and they would leave without any argument.²⁷

Stockouts

When [certain contraceptives] are not available, we have to convince clients to use another method . . . there's a high chance of pregnancy when changing contraception or lacking contraception.²⁸

—Cyprian Awiti, Marie Stopes Kenya

Both health care providers and clients noted that stockouts, especially of particular contraceptive methods, are not uncommon. The Family Planning Findings confirm this. Nearly one-fifth of facilities providing combined oral contraceptives or progestin-only injectables reported experiencing a stockout in the six months preceding the survey.²⁹ Stockouts of implants (75%), IUDs (37%), and emergency contraceptives (69%) were even more common.³⁰

One woman who visits a community health centre for her family planning needs commented that she was able to get the services she required on certain days, but that “other times you are told that there are no drugs and sometimes you are asked to come another day.”³¹ Because it is a community health centre, she noted, “There are many people seeking treatment and I am forced to wait.” At times, when the health centre has run out of medicines, she is instructed to buy them from a chemist.

SERVICE	FEE
CONSULTATION	400/-
PILLS (PER 3 CYCLES)	150/-
INJ. DEPO	220/-
NORPLANT INSERTION	1650/-
NORPLANT REMOVAL	220/-
CHILD WELFARE	2750/-
TUBAL LIGATION	2750/-
VASECTOMY	750/-
PAP SMEAR	2200/-
ANTE NATAL FOLLOW UP	220/-
PDT (PREGNANCY TEST)	3300/-
CIRCUMCISION	VARY
DRUGS & TREATMENT	VARY
LABORATORY	VARY
PROCEDURE	VARY
CONDOMY FORMING TABLETS	VARY
IUCD INSERTION/REMOVAL	750/-
PLIZ: ENQUIRE FOR OTHER SERVICES	
NB: REVISIT CHARGED AFTER 2 WEEKS	

According to the 2004 KSPAS, NGO and faith-based facilities were more likely than for-profit and government facilities to have stockouts of the most popular methods, such as oral contraceptives and progestin-only injectables.³² This trend was confirmed in FIDA Kenya/CRR interviews: private facilities that receive government supplies reported that they encountered supply shortages more often than government facilities. One doctor who is supposed to receive contraceptives from the Ministry of Health commented, “Frequently, the government doesn’t have. They are often out of implants and injectables and only have one kind of pill.”³³ A nurse-administrator of a private clinic that receives government-supplied contraceptives commented that stockouts happened “often, many times a year. It becomes very bad for the patients.”³⁴ Moreover, an official at the Christian Health Association of Kenya (CHAK), the umbrella organization for non-Catholic, Christian faith-based health facilities, noted that even when the government’s budget includes adequate contraceptive funding, they can still experience problems with the supply chain: “We find that the mission does not receive some medication that is meant to be free.”³⁵

An administrator of a private clinic that receives government contraceptives commented:

We get contraceptives from the government. . . . Sometimes you go and they don't have but in 2006 the situation was much better. What's missing now is Norplant and Jadel [contraceptive implants]. In private sector you have to be prepared to buy [what government cannot supply] or you'll lose the client. . . . When private sector goes for contraceptives, they are second or last. Priority is given to government facilities. If not enough, then you miss out. If there's surplus, then they'll consider you. Some misunderstand the concept of private practice—in some cases, you're dealing with even needier women.³⁶

She emphasized that the government should focus on the fact that a facility is providing contraceptives to women rather than on the nature of the facility itself. This assertion that some private facilities serve a needier population than public facilities was echoed by other providers who spoke with FIDA Kenya/CRR.³⁷

When the government is experiencing a stockout and private facilities must buy drugs on the open market, contraceptive methods can quickly become too expensive for clients. According to a CHAK official, the organization relies on the government to provide family planning devices but encounters supply problems with implants and injectables. When they are unable to acquire them from the government without charge, they must purchase them on the open market—at approximately Kshs. 350 (\$5 US) per item. They are then forced to pass these costs on to the client. Family Health Options Kenya (FHOK), a major non-governmental family planning organization, reported similar supply problems; a two-month injectable can cost as much as Kshs. 500 (approximately \$7 US) per vial on the market, which is unaffordable for many clients.³⁸

Forty-eight percent of the facilities lacked disinfecting solution, while 28% had no soap.

Lack of access to a preferred method can be particularly problematic when women’s partners or relatives oppose their use of contraceptives. In these instances, women often choose a more discreet method, such as injectables or Norplant, or they hide the fact that they are taking pills. Martha Waratho, the Human Resources/National Clinical Services Manager at Marie Stopes Kenya, explained that women tend to prefer injectables over oral contraceptives, particularly in rural areas. Women often want their contraception to be private, she noted. “They don’t want their husbands to see them swallowing pills.”³⁹

The difficulties of concealing oral contraceptive use are apparent in the following account of a woman who had returned to university and was trying to avoid another pregnancy by taking contraceptive pills:

*There was a lot of pressure from my husband’s relatives [to have another child] so I went to Mombasa and got pills without his [my husband’s] knowledge. I had to keep my [registration] card with a friend; she would bring for me the pills, then go back with the card. I used to swallow the pills in the toilet. I would put them in my bra. The pills would not stay in my house. My friend would carry one each day for me.*⁴⁰

The fact that facilities often do not maintain clients’ cards on file, requiring instead that the clients keep the cards, can pose significant problems for women who do not want their husbands or families to know they are using contraceptives.

Lack of infrastructure and supplies

In order to provide quality family planning services, facilities must have the necessary infrastructure and resources, which includes the ability to control infection and provide pelvic examinations. However, the basic necessities for conducting these functions were missing from the majority of the family planning facilities surveyed in the 2004 KSPAS. Only 41% of the facilities had all necessary items for infection control, such as soap, water, latex gloves, disinfecting solution, and a sharps box.⁴¹ Forty-eight percent of the facilities lacked disinfecting solution, while 28% had no soap.⁴² The equipment to conduct pelvic examinations, which are an important component of quality family planning

services and can be necessary to determine method suitability, to insert a method, or to evaluate problems with a method, was even harder to find.⁴³ To conduct a quality pelvic exam, a facility must have a private room, an examination bed and light, and a vaginal speculum.⁴⁴ Only 27% of the surveyed facilities had a vaginal speculum and only 22% had a spotlight.⁴⁵ Moreover, only 8% of surveyed facilities met all of the conditions for proper pelvic examination, while a mere 3% of the facilities possessed all items necessary for both infection control and pelvic examinations.⁴⁶

Lack of Comprehensive Family Planning Information

Stockouts and lack of other supplies are not the only barriers that women encounter when seeking family planning. Accurate, comprehensive, and understandable information, which is a key component of effective, quality family planning services, can also be hard to find.

“There won’t be a time when we will promote contraception. Fidelity will always be the gold standard for us.”

Health facilities run by faith-based organizations often provide limited services and information depending on the facility’s religious affiliation. Even though both CHAK and Catholic facilities treat survivors of gender-based violence, none of these facilities provide emergency contraception, as the method is considered too controversial.⁴⁷ According to a CHAK official, Methodist mission hospitals do not provide IUDs.⁴⁸ Catholic facilities offer counselling only on natural family planning and do not supply condoms, even though some Catholic facilities provide voluntary counselling and testing on HIV and services

to prevent mother-to-child transmission of HIV.⁴⁹ According to CHAK and the Catholic Secretariat, facilities that do not offer certain reproductive health services refer patients elsewhere, although neither group has a written policy on this issue.⁵⁰

Most Catholic facilities provide information only on “natural family planning.” “There won’t be a time when we will promote contraception. . . . Fidelity will always be the gold standard for us,” stated Dr. Margaret Ogola of the Catholic Secretariat.⁵¹ One focus group participant explained that after her second delivery at a Catholic hospital in 2006, the staff advised her only on natural family planning and did not discuss any other methods. She currently uses no family planning method.⁵² Periodic abstinence, as natural family planning is referred to in the 2003 KDHS, showed the highest rate of method failure at 44% of users.⁵³

One woman described her experiences with what she called “Catholic family planning”:

*You have to take your temperature always. You have to know yourself. It works for a person with regular menses. I chose this because I don’t like pills—I get dizzy. Some women introduced me to this method. The women teach the youth. They tell us that the method may fail to work but you just try. . . . After giving birth you count days but it depends on your husband. You wait for your periods before you start the method. It’s risky. It’s something you have to be educated on.*⁵⁴

Alice recounted both the misinformation she received and how hard it was to express her difficulties with using natural family planning to the staff at the Catholic mission hospital where she delivered her third child.⁵⁵ The hospital counselled clients only on natural family planning and told her that a person using a coil [IUD] would be conceiving and aborting every month.

They made you feel like using [‘artificial contraception’] was a sin. They told me that you need to know your own body to use natural family planning. If you can’t, then there’s something wrong with you and your husband. They emphasized the need to agree with your husband and the counsellor said—‘don’t you talk to your husband?’

“I felt if I had more information that I wouldn’t have had the third baby.”

The need for partner cooperation in natural family planning also raises serious concerns in cases of domestic violence or other situations where a woman is unable to negotiate when and how she will have sex with her partner. The 2003 KDHS reports that 47% of married or once-married women reported experiencing sexual, emotional, or physical violence at the hands of their partners.⁵⁶

In other instances, facilities simply do not provide comprehensive information about contraception to their clients. Alice, in the narrative above, expressed her frustration with not being able to obtain both the information and the contraceptive method she wanted hand-in-hand.⁵⁷ Many women also reported being surprised by, or not fully understanding, the side effects of a method, which can contribute to method discontinuation. According to the 2003 KDHS, side effects accounted for 25% of discontinuations.⁵⁸

The effects of lack of information and unwanted pregnancy are long-lasting. Tina, a university-educated woman in her late thirties, described the distress caused by her third pregnancy, which was unplanned.⁵⁹ After being traumatized by a close friend’s death from pregnancy-related causes, she had not wanted to have another child:

I didn’t expect the pregnancy. I had stopped breastfeeding [and became pregnant]. I had to be coaxed into accepting [the pregnancy]. I had to see a psychiatrist. The doctor recommended it. My husband was very supportive of the pregnancy. I was the only one really against it. Everyone else was happy about it. . . . I felt if I had more information that I wouldn’t have had the third baby. I was shy on talking about these things. In my mind, I knew I wanted two children. [I] didn’t receive any family planning counselling after [my] first two pregnancies—just delivery. If someone had told me . . . [but I received] no family planning counselling, no alternatives. Now I am aware of choices—I have gotten information from friends.

Violations of Informed Decision Making About Surgical Contraception (Female Sterilization)

Violations of informed consent around surgical contraception appear to be a longstanding problem. As far back as 1985, a *Sunday Nation* article describes a Pumwani Maternity Hospital (PMH) doctor stating that some of the women who had been sterilized after delivering at PMH had returned to the hospital inquiring when they could expect their next child.⁶⁰ According to the doctor, the women had never been informed that the procedure was irreversible.⁶¹

The 2003 KDHS found that among women who had been sterilized, only 18.8% had been told about side effects or potential problems with sterilization, and only 21.3% had been informed of other contraceptive methods that could be used.⁶² Most troubling of all, almost 10% had *not* been informed that sterilization was permanent.⁶³ Women who received

the service from a public source were slightly less likely to learn about its permanence (88.5%) than women who were sterilized at a private medical facility (91.1%).⁶⁴

The 1997 Reproductive Health/Family Planning Policy Guidelines and Standards, which would have been in effect at the time the 2003 KDHS was conducted, contained an “Informed and Voluntary Consent Form” that explained that there are other methods of family planning and that sterilization is permanent. However, the 2004 KSPAS found that family planning guidelines were available in only 31% of surveyed health care facilities throughout the nation.⁶⁵ The 2003 KDHS figures suggest that appropriate voluntary consent was not being consistently sought.⁶⁶ The current Family Planning Guidelines for Service Providers, which were revised in 2005, emphasise the importance of voluntary informed consent⁶⁷ and include the same voluntary consent form.⁶⁸ Given the centrality of informed decision-making and consent to protecting women’s rights and providing quality medical services, more must be done to ensure that all health care providers understand and observe these principles.

Informed decision-making and consent are particularly vital when permanent procedures are being performed. The International Federation of Gynaecologists and Obstetricians (FIGO) has issued informed consent guidelines that emphasise:

*The process of informed choice must precede informed consent to surgical sterilization. Recognised available alternatives, especially reversible forms of family planning which may be equally effective, must be given due consideration. The physician performing sterilization has the responsibility of ensuring that the person has been properly counselled concerning the risks and benefits of the procedure and its alternatives.*⁶⁹

The FIGO guidelines also specifically note that the difficulty or time-consuming nature of providing the necessary information for a woman’s informed consent—for example, to patients who have “little education”—does not absolve medical providers from striving to fulfil these criteria for informed consent.⁷⁰ They also emphasise that “informed consent is not a signature but a process of communication and interaction.”⁷¹

At the same time, women need to receive balanced and accurate information that will allow them to make an informed choice. Biased or inaccurate counselling can occur in other contexts, as well. In some instances, doctors seem to set their own prerequisites before they will provide surgical contraception to women requesting the procedure, or will provide biased counselling to clients. A professor described her recent attempt to have a tubal ligation after developing high blood pressure while taking oral contraceptives:

*In July [2006] I went to see [a private doctor] for the TL [tubal ligation]. He said it was not advisable for women my age [mid-thirties] and it was advisable for women over 40. He said it was a big decision and he referred me for counselling. I saw [a matron] who told me about the side effects of TL. She said it was serious and irreversible and she gave me an example of a lady who lost her children and husband in a car accident and couldn’t have more [children]. Another lady had TL after two children and later the hubby wanted kids and they broke up. [She told me] that TL affects sex life and I would have problems with lubrication and I would have effects of not having children. I then left it at that and resumed the pill.*⁷²

After again suffering side effects from the oral contraceptive, she went to see another doctor, who did not discourage her from pursuing tubal ligation. However, she was told that the cost of the procedure would be a prohibitive Kshs. 120,000 (approximately \$1700 US).

A key element of informed consent is respecting the patient's decision and allowing her to make that decision as an individual. The World Health Organization's handbook for its clinic staff declares that "the decision about female sterilization belongs to the woman herself."⁷³ It goes on to stress that this choice is not one that can be made for her by her husband, a health care provider, a family member, or anyone else.⁷⁴ However, the current Kenyan Ministry of Health family planning guidelines state that, in cases of surgical contraception, the "partner's consent is not mandatory but counselling should be provided and consent obtained from both partners if possible."⁷⁵ One woman described how her husband wanted her to be sterilized and was actually taking her to a clinic for the procedure when her mother intervened, thereby preventing the sterilization.⁷⁶ Her experience illustrates the difficulties that Kenyan women encounter in making independent decisions about surgical contraception.

Victims of sexual violence need access to emergency contraception no matter where they go for treatment

While sexual violence is widely under-reported, making it difficult to gather comprehensive statistics on its prevalence, figures indicate that it is a serious blight on women's lives in Kenya. According to police sources, 2,908 cases of rape were reported for 2004⁷⁷ and 2,867 for 2005, but hospital statistics indicate that approximately 16,000 cases of rape occur each year.⁷⁸

Emergency contraception (EC), which can be used up to 120 hours after unprotected intercourse, is an important tool in preventing unwanted pregnancies, including those resulting from sexual violence. However, according to the Family Planning Findings only 11% of the surveyed facilities offer EC and the progestin-only pill, which also can be used as EC, is available in less than half of facilities.⁷⁹ Neither Catholic facilities nor those under CHAK provide EC, although some of these facilities treat victims of sexual violence.⁸⁰

The lack of EC in these facilities is directly contrary to the National Guidelines for the Medical Management of Rape and Sexual Violence issued by the Division of Reproductive Health.⁸¹ These guidelines state: "In view of the psychological consequences of conceiving after being raped, *every non-pregnant woman/girl* of childbearing age... should be offered emergency contraception (EC)."⁸² The foreword from the Director of Medical Services affirms that "*these guidelines should be available in all health facilities and should be used consistently for management of survivors of violence.*"⁸³

Since EC is only effective for a limited amount of time, it is vital that sexual violence survivors be able to use EC as quickly as possible. This is especially crucial given that Kenya's abortion law does not explicitly provide for abortion in cases of rape, and unsafe clandestine abortion is a serious threat to the lives and health of women. The high rates of unwanted and mistimed pregnancies and problems with contraceptive supply make access to EC all the more important.

THE DEVASTATING EFFECTS OF KENYA'S RESTRICTIVE ABORTION LAW

Three out of four PAC [post-abortion care] patients arrive in critical condition—gasping. . . . We try our best to save their lives if they reach here in time. One woman's infection was so bad that we could smell her while she was outside approaching the building, and flies were following her. She had had an abortion about a week ago, and everything was toxic. In most cases, it's not easy to keep fertility. . . . [Another] woman had a biro pen that perforated her uterus and went into her intestine. She had it in there for one month, and was bent over in pain by the time she came in for help.

—A nurse administrator describing women seeking care after botched unsafe, clandestine abortions⁸⁴

Unsafe abortion causes 30 to 40% of maternal deaths in Kenya, according to the Kenya Medical Association and Kenya Obstetrical and Gynaecological Society.⁸⁵ An estimated 20,000 women in Kenya are treated for abortion-related complications in public hospitals each year.⁸⁶ This number does not capture the additional women who seek post-abortion care in private facilities. Although unsafe abortion is one of the most easily preventable causes of maternal mortality and morbidity, and despite Kenya's stated commitment to reducing maternal mortality, the nation's abortion law is among the most restrictive in the world. It permits abortion only when there is a threat to the life of the pregnant woman; there are no exceptions for issues regarding women's health or age, or for cases of rape and incest.⁸⁷ In a context of widespread sexual violence and limited, inconsistent availability of contraceptives, Kenya's highly restrictive law poses a significant threat to the lives of Kenyan women and exposes survivors of sexual violence to the risk of being further victimized by the lack of access to safe and legal abortion.

This omission of a rape or incest exception in Kenya's abortion law directly contradicts the United Nations Human Rights Committee's General Comment 28, which emphasises the need for access to safe abortion for women who have become pregnant as a result

of rape—as well as the provision for access to safe abortion in the Protocol to the African Charter on Women's Rights.⁸⁸ The Human Rights Committee recently recommended that Kenya “review its abortion laws, with a view to bringing them into conformity with the [International Covenant on Civil and Political Rights].”⁸⁹

The Restrictive Abortion Law Discriminates against Adolescents

- Unsafe abortions among adolescents are on the rise in Kenya; according to Kenya's Director of Medical Services, this can be attributed to “limited availability of youth-friendly reproductive health services.”⁹⁰
- In January 2005, a young orphaned girl bled to death while undergoing a backstreet abortion.⁹¹ When she realized that being pregnant and having a child would not allow her to continue on her very promising educational path, she sought an illegal, unsafe abortion.⁹² The United Nations Special Rapporteur on the Right to Education recently noted this lack of options when he wrote that “when poverty combines with marriage and early motherhood, formal education becomes even more distant for teenage girls, who have virtually no choices other than domestic work and raising their children.”⁹³

- In a recent study of the Provincial General Hospital in Kakamega, slightly more than half of the patients being treated for abortion complications were under 20 years of age.⁹⁴

The Restrictive Law Stigmatizes Abortion Services and Creates Opportunities for Abuse

- Women who can afford private hospitals and the necessary doctors' signoff can usually acquire legal abortions.⁹⁵ However, even in cases where an abortion is permissible under the law, doctors in public hospitals can be reluctant to perform the procedure. An experienced doctor who practices in a public facility noted that even when a hospital says it will provide abortions, medical staff will sometimes introduce a series of delays: "They will say something is not available and delay until the patient will decide to go elsewhere. The health care providers don't want to be associated with the stigma. They aim to make patients frustrated and give up."⁹⁶ In some cases, he added, medical staff "will call in nuns and counsellors to talk to women to discourage [them] from seeking abortion."
- Women delay receiving post-abortion care when something goes wrong, due to what one provider described as "a combination of legal and social fears."⁹⁷ Women fear being reported to the authorities and having people know that they had an abortion.
- Health care workers are sometimes judgmental and delay the care of women seeking treatment for complications after actual or suspected induced abortions. One woman described the experience of her sister, Rosemary, at a large referral hospital in early 2000, when she went in to be treated for a miscarriage.⁹⁸ The hospital staff was convinced that Rosemary had undergone an abortion and refused to treat her until she would "admit" that she had tried to terminate the pregnancy. The staff wrote in Rosemary's medical chart that she had received an abortion, which caused serious problems with her husband. She later died of related complications.
- One provider of post-abortion care observed that women's fear of being arrested for procuring an abortion makes them vulnerable to persecution by the police. She described instances of police harassing women who had sought or received abortions, and threatening to report them unless the women gave them money.⁹⁹ Although providers reported that the stigma around PAC had lessened with government training, they observed that women were still fearful about seeking treatment and worried that their records would fall into the hands of the police.¹⁰⁰
- A disturbing tendency to use law enforcement and the legal system to harass reproductive health providers, such as through unsubstantiated prosecutions and clinic raids, could discourage medical professionals from providing abortions even when the law permits them to do so. In one case of such harassment, three reproductive health care workers were arrested and charged with the murder of two fetuses.¹⁰¹ Murder carries a death penalty sentence in Kenya, while performing an illegal abortion carries a jail sentence of 14 years. Although the health care providers were acquitted of murder,¹⁰² they had already spent more than a year in prison during the trial and still face public stigma for their association with the case. This case continues to have a chilling effect for reproductive health care providers.¹⁰³ In addition, such prosecutions and harassment could curtail the ongoing debate on reforming the abortion law.

ABUSE AND NEGLECT AROUND DELIVERY

I have seen . . . you are beaten and told, 'Mama you are splashing blood on me—did I tell you to give birth?' [The nurses] use abusive language, they beat you, even when stitching. . . . "Spread your legs the way you did when you got pregnant," they tell you. . . . The woman will scream until she is tired . . . now we are advised to tear. Even me [a non-medical member of the hospital staff], I have done so. And you don't use a knife, you use scissors. . . . I also witnessed [the nurse] would just cut patients just like that. . . . she would just cut and leave you. That happens . . . because they will make money from stitching you. . . . When you are being stitched, they put anaesthesia but they make sure it wears off, then they stitch you. . . . You see [women] being mistreated and not being given their rights and you sympathize, [but] there is nothing you can do.

—Prudence, describing her observations as a casual worker in a delivery ward of a district hospital in Kisumu, April 2007¹⁰⁴

The Kenyan government has acknowledged the need to improve the quality of the nation's maternal health care services. Two of the primary objectives of the 1997 National Reproductive Health Strategy are to reduce maternal mortality to 170 per 100,000 live births and to ensure the presence of skilled attendants during 90% of deliveries by 2010.¹⁰⁵ Moreover, in 2002, the Ministry of Health collaborated with various health-professional associations—including the National Nurses Association of Kenya, the Nursing Council of Kenya, the Kenya Obstetrical and Gynaecological Society, and the Kenya Clinical Officers Association—to issue Standards for Maternal Care in Kenya (Maternal Care Standards) that aim to “prevent the aspects of care that are disrespectful and unnecessary which will impact negatively on the confidence of women in using a specific facility.”¹⁰⁶

The Kenyan government has failed to implement its own maternal health care standards and is neglecting to protect women from gross rights violations.

The findings of this report reveal, however, that the Kenyan government has failed to implement its own maternal health care standards and is neglecting to protect women from the gross rights violations that occur before, during, and after delivery in the nation's health care facilities. Women described egregiously substandard medical services and structures, negligent and abusive treatment at the hands of health care providers, and serious human rights abuses, especially in public facilities. Health care providers and hospital staff members confirmed the occurrence of these practices; they also reported having to work in extremely difficult situations without adequate equipment, supplies, and staffing.

The interviews further indicate that the violations taking place when women deliver in health care facilities have been present for decades. This widespread and deep-rooted pattern of abuse cannot be addressed through short-lived, piecemeal efforts. Rather, the government must undertake comprehensive measures to understand the dimensions and extent of the problem, remedy the rights violations that women have endured, and implement systematic changes to ensure that women's rights are protected in health facilities during the vulnerable time surrounding childbirth.

Neglect and Mistreatment around Delivery

According to the 2003 Kenya Demographic and Health Survey (2003 KDHS), there are approximately 414 maternal deaths per 100,000 live births in Kenya each year—with women having a 1-in-25 lifetime risk of dying from a pregnancy-related cause.¹⁰⁷ When sampling errors are taken into account, this figure does not differ significantly from the 1998 KDHS finding of 590 maternal deaths per 100,000 live births. Thus, in the last five years, despite global advances in the field of medicine, the 2003 KDHS concluded that “it is impossible to say with confidence that maternal mortality has declined” in Kenya.¹⁰⁸

The majority of maternal deaths are due to obstetric complications that could have been prevented with adequate medical care.¹⁰⁹ As the 2003 KDHS noted, “Proper medical attention under hygienic conditions during delivery can reduce the risk of complications and infections that may cause death or serious illness either to the mother, baby, or both.”¹¹⁰ Furthermore, the government recognized in its Maternal Care Standards that “good quality care provides a woman with dignity during childbirth.”¹¹¹

Women reported decades of unhygienic conditions, humiliating treatment, and lack of medical attention in the health facilities where they delivered babies. The neglect and abuse begin when the women arrive at the facility and continue throughout their experience, even after they have given birth—with women and their infants being detained if they cannot pay their medical bills. [For more on detention, see Discrimination section.] A 2004 task force report on Pumwani Maternity Hospital (PMH), the largest maternity hospital in the country, confirmed, “There exists glaring professional negligence and laxity among doctors, nurses, security and administrative [staff] . . . in dealing with expectant mothers, babies and their relatives.”¹¹²

Obstacles upon arrival at facilities

In an effort to reduce long queues and delays at health facilities, the government’s Maternal Care Standards call for every pregnant woman seeking medical care to be attended to by a skilled health care provider within 30 minutes of arriving at a facility.¹¹³ The Standards specify the resources that every facility should have for achieving this goal, including a client flow plan that all staff members understand, clearly displayed directions and signs, an “informed and alert” receptionist, and a “fair and safe system of fee collection that does not prevent access to care.”¹¹⁴ The Standards also state that pregnant women should be directed to the appropriate unit and that fees should be collected only after the patient’s condition has stabilized.¹¹⁵ Furthermore, the Standards recommend that women be given the choice of having a companion with them during delivery, because clinical trials have demonstrated that “continuous empathetic and physical support during labour has a number of associate benefits.”¹¹⁶

In interviews and focus groups, however, women reported encountering a very different reality when they arrived at health care facilities for delivery. They described being harassed or forbidden from entering hospitals, including public facilities like PMH, if they did not have enough money to pay the deposit or fees. [For more on this issue, see Discrimination section.] Moreover, contrary to the Maternal Care Standards’ recognition of the benefits of having a companion present, women who delivered in both private and public facilities stated that their spouses and other family members were often not even allowed to accompany them inside the premises, let alone be present during delivery.



Many women also recalled being given no assistance in finding the labour ward.

Felicity, who delivered her first child at PMH in 1988, described her arrival at the hospital as follows:

My parents and siblings took me there. The place was not very good. My family was chased away at the gate of the hospital and therefore I took myself inside the hospital. . . . They do not show you where the ward is so you have to look for it yourself. . . . The woman who inspected me told to get down from the bed and to go to the delivery room alone. I was feeling scared and one nurse told me not to cry as she was not the one who made me pregnant. . . . God just knows you are in the hands of very uncaring people.¹¹⁷

Similarly, Grace—who delivered her baby at the same maternity hospital ten years later—recounted that upon arriving at PMH, her relatives were ordered to leave the hospital premises.¹¹⁸

Although Grace was in great pain, she was told to find her own way to the delivery ward and she had to lift herself onto the maternity bed without any assistance from the hospital staff. A nurse told Grace to “stop pretending to be in pain.”

Lack of medical attention

Once a woman has been admitted into a health care facility for delivery, recommended medical practice calls for medical providers to monitor foetal heart rate, maternal pulse rate, and uterine contractions every 30 minutes, and to check maternal blood pressure every four hours.¹¹⁹ The 2004 Kenya Service Provision Assessment Survey (2004 KSPAS) found, however, that these four critical practices were documented in only 5% of the normal delivery records that were reviewed.¹²⁰ Women’s accounts of their experiences further revealed that health care providers not only fail to regularly monitor their patients’ labour, but are also negligent and abusive toward women during this vulnerable pre-delivery period. Women described nurses as “reluctant” to provide them with any care.¹²¹

Grace, who had been told to find her own way to the maternity ward at PMH, said that when her pain got worse, she was told by a staff member to continue suffering because she was responsible for her pregnancy.¹²² During the night, Grace’s pain became so intense that she was forced to crawl to the nurses for assistance. The nurses mocked her, asking if she “was exercising.” Even when Grace’s water broke, no staff member came to help her, so she made her own way to the delivery ward. Another patient who had just delivered helped Grace to climb upon the delivery bed and called out to the nurses for help. Grace recalled that the nurses did not have the proper equipment ready and had to leave to find it.

Felicity, whose relatives were chased away at PMH, said, “You just go into labour and no one cares about you. The nurses are telling you not to cry out. [They] are not coming the way they are supposed to come.”¹²³ Hellen, who delivered at PMH in 1993, concurred that the hospital staff were reluctant to help her—“until I almost delivered on the waiting bench before even being booked in.”¹²⁴ Yet another woman who delivered at PMH in 1997 said, “They didn’t attend to me and I needed them because it was my first time.”¹²⁵ She added that the nurses were “very rude” and would ask patients, “Are you the first one to give birth?”

Carole, who also delivered her first child at PMH in 1988, confirmed the alarming lack of medical help given to labouring women.¹²⁶ “It was bad—I almost died,” she said. “The nurses were bad. They left me to give birth on my own. I waited from 1:00 at night till 6:00 in the morning to be attended to. The nurses were talking to each other, but not to me.” Carole added that when the nurses did talk to her, they were abusive and insulted her for getting pregnant at a young age. The nurses refused to attend to Carole until her baby’s head was crowning, even though she called out to them many times before that. A trainee eventually began helping her, and only then did the nurses come to assist. “They were abusing other women while attending to me—calling them ‘stupid’ and using other words like that,” Carole observed.

Carole returned to PMH in 1998 to deliver her fourth child and, although ten years had passed, her second experience at the hospital was similarly negative. This time, the hospital staff was so unresponsive that Carole had to seek assistance from another expectant woman:

I was taken to the labour ward and left alone on the bed. I stayed the whole day without eating. Water was coming out and they refused to change the bedding. I slept on wet bedding until the doctor came at night. I was then induced. The nurses refused to assist me with anything. They said there were no sheets. After the injection, I gave birth. The doctor had left by then and the nurse said she would not help me until the head of the baby came out. I was assisted by one of the patients who was waiting to give birth. [The nurse] later came and took the baby . . . [and] told me to get off the bed and wipe the bed.

Carole attributes the extreme vaginal tearing she suffered during her second delivery to the fact that she received no help from the medical staff. “The person who stitched me asked who had done this to me because she said it was bad,” Carole recalled.

Carole also noted that the nurses discriminated against younger mothers. “They were abusive and telling me I came to give birth while young so what was I looking for,” she recounted about her first delivery. “They said if I wanted to die, I should just die. . . . I was not even checked. They were choosing who to attend to and I think they were not attending to younger women.” Other women have made similar observations. Regina, who delivered as a teenager at Siaya District Hospital in 1992 said, “The nurses came and started abusing me, saying, ‘You young girl, what were you looking for in a man? Now you can’t even give birth.’”¹²⁷ Florence described the treatment of young mothers at New Nyanza Provincial Hospital, saying: “There are young girls who are giving birth early, even at nine years. They labour and [the doctors and nurses] don’t care. They abuse them and the child gets confused.”¹²⁸

“They were abusive and telling me I came to give birth while young so what was I looking for.”

Negligent behaviour by medical providers is not found only in public hospitals. One woman who delivered at a city council hospital in Kakamega and at St. Catherine’s Hospital, a private hospital, said the nurses at both facilities made it clear that they did not want to be called by the patients. “I called the sisters and they abused me, saying I was disturbing them,” she recalled.¹²⁹ The woman added that a nurse at St. Catherine’s Hospital cut her badly during labour but did not apologize, because the nurse was annoyed with her for having asked for assistance. She was never seen by a doctor during her labour.

Less than 10% of medical facilities in the country are able to offer basic emergency obstetric care, and less than 6% provide comprehensive emergency obstetric treatment.

Many women also expressed terror at the prospect of undergoing caesarean sections at the hands of uncaring, inept doctors. “I remember I was the only one who came from the theatre alive,” said Regina. “The rest died in Siaya Medical [District Hospital] the same day. . . . In fact, you would come from the theatre and hear nurses say, ‘We know no patient of [the doctor] survives.’”¹³⁰ Regina herself endured devastating consequences after her surgery because the doctor left a rusty blade in her uterus. In addition, women reported feeling coerced into having caesarean sections, as discussed in greater detail below.

The 2004 KSPAS highlighted yet another critical problem that pregnant women in Kenya face: “Capacity to manage common or serious complications of labour and delivery is weak in all facilities, including hospitals.”¹³¹ Less than 10% of medical facilities in the country are able to offer basic emergency obstetric care, and less than 6% can provide comprehensive emergency obstetric treatment.¹³² Only 7% of Kenya’s facilities offer caesarean services.¹³³ Furthermore, only 27% of all facilities—and barely half of facilities specifically offering delivery services—have the ability to provide emergency transportation to another facility for obstetric emergencies.¹³⁴ The 2004 KSPAS stressed that “[t]hese results demonstrate the urgent need to upgrade the nation’s facilities to offer these critical services to women.”¹³⁵

Violations of dignity

The Maternal Care Standards emphasize the importance of respecting women’s rights to dignity, privacy, and confidentiality.¹³⁶ To protect these rights, the Standards call upon staff in medical facilities to be polite and respectful, wear uniforms and name badges, use appropriate language, exhibit positive attitudes toward patients and their escorts, seek patients’ opinions about their medical conditions, and allow patients to ask questions.¹³⁷ In addition, the Standards specify that facilities should provide curtains, screens, and clean linen coverings in order to protect the patients’ privacy during examinations and labour, and that staff should “actively protect” women’s confidentiality.¹³⁸ The Standards specifically note that women should not be rudely addressed or unnecessarily exposed, and that both medical providers and support staff must take the clients’ right to dignity into account.¹³⁹ Furthermore, every patient should know “who has attended to her and in what capacity.”¹⁴⁰ The goal of these Standards is for every woman who receives services in a Kenyan health facility to feel “listened to” and “treated with dignity,” and to know “that her privacy and confidentiality [have] been respected.”¹⁴¹

The reality of the delivery experiences recounted by the majority of the women interviewed fell far short of these criteria. Women reported that medical providers do not wear name badges and do not introduce themselves, thereby forcing expectant mothers to navigate the health care system without adequate guidance. “When my water broke I had to go looking for a doctor; I couldn’t tell who the doctor was,” recalled a woman who delivered at St. Mary’s Hospital in Langata.¹⁴² Josephine, who suffered a traumatic delivery experience at the same hospital in 2005, stated that she was physically and verbally abused during and after labour by several male staff members who never identified themselves, which prevented her from understanding their roles at the hospital.¹⁴³

Women also described rough, painful, and degrading treatment during physical examinations and delivery, as well as verbal abuse from medical staff if they expressed pain or fear. Prudence, who is currently a casual worker in a maternity ward at a district

hospital in Kisumu, said that she consistently observes nurses being abusive towards women during delivery. “When you go to give birth, they always shout, ‘Did I send you here? Spread your legs the way you did when you got pregnant. That day you did not scream, but today you are screaming at us.’”¹⁴⁴ Patients also reported a wide array of verbal abuse from the hospital staff; they were told to stop pretending to be in pain, to continue suffering because they were responsible for their pregnancy, to go ahead and die if they wanted to die, and not to complain because the nurses were not the ones who impregnated them.¹⁴⁵ One woman who delivered at PMH recalled how hurt she was by the way the nurses referred to her. “Something disturbed me for a long time: the nurse commented, ‘The loudest one has given birth—the psycho.’”¹⁴⁶

Jane, who gave birth to her first child while still in secondary school, recalled the neglect she experienced during that delivery: “I remember I was a kid and when I was asked to push I didn’t know what to push. I pushed till I went for a long call [had a bowel movement]. The nurses left me and told me it’s my problem.”¹⁴⁷ Jane was also greatly disturbed by a recent incident she witnessed in a Kisumu district hospital:

I saw something that didn’t make me happy. There was a woman who was pregnant and wanted to use the toilet. She went to the toilet [but you have to pay to use it] and she didn’t have money. She tried talking to the person [in charge], who refused, and the woman just urinated on herself. To me the toilets in government hospital should be free.

A woman who delivered at PMH recounted a similar humiliation: “When I told [the nurse] I wanted to go to the toilet, she told me to do it right there. I felt bad. I took a newspaper and did it there.”¹⁴⁸

A businessman who helped a woman deliver on the side of a road in April 2006 told the *Nation* that observing the abuse that expectant women endure in Kenyan health facilities had a lasting impact on him. “I once took a friend of mine to Pumwani Maternity Hospital and while there, I saw women on the verge of delivering screaming their heads off while nurses insulted them. I felt something move inside me and gained new respect for mothers. I think that’s why I jumped in to help.”¹⁴⁹

“A key problem is unfriendly services,” acknowledged an experienced midwife who trains other midwives to provide more compassionate care. “Women want someone to reassure them during labour, [but] midwives don’t understand women and women don’t understand midwives.”¹⁵⁰

Physical abuse

Physical abuse during delivery is also common in Kenyan medical facilities. Women reported being pinched on the thighs, slapped, or beaten into compliance during labour. “When a woman goes into the second stage of delivery, you don’t want her to close her legs, so you’re beating her,” admitted one experienced midwife.¹⁵¹ Susan recalled a traumatic delivery experience at PMH in 1997. The nurses were verbally and physically abusive while she was labouring.¹⁵² Even when the doctor decided that she would need a caesarean section because her baby was too large to deliver vaginally, the nurses continued to insult and beat her while preparing her for the operation. However, Susan managed to have a vaginal delivery before the caesarean section was performed. During her time at PMH, Susan saw a nurse beating another patient who was struggling to deliver. She later

saw a medical student operating on that same patient, who ultimately bled to death. “I felt that the hospital did not treat me and the other patients fairly, and I could not recommend the hospital to anyone,” Susan said. Another patient who delivered at PMH in the 1990s reported seeing a nurse slap a woman for looking at the newborn children.¹⁵³ More recently, a woman who delivered at PMH in 2003 confirmed that the nurses were very harsh and were still slapping their patients.¹⁵⁴

Abusive behaviour by health care providers is not limited to public facilities. Josephine described her 2005 delivery at St. Mary’s Hospital in Langata as “the most traumatizing experience” she has ever faced, and stated that it still “haunts” her to this day.¹⁵⁵ When she arrived at the hospital for delivery, a man at the reception area rudely ordered her husband to leave immediately. The same man then gave Josephine a very rough physical examination, while touching himself in a sexual manner.

He just made sure I get a lot of pain. . . . I don’t know what he had in his hands. I screamed. I even had to go to the toilet to see if there was blood. My mind was asking: that man has really hated me. . . ? What I noticed was when I laid down and he was checking: I saw him touching his private part as if he felt erect. I tell you when he entered his hands there [into my vagina], he scratched there. I felt a lot of pain.

When Josephine went into labour, she made her own way to the delivery room and climbed onto the bed without any assistance. The same man who had examined her then came into the delivery room and harassed her by laughing at her, insulting her, telling her that she was not pushing correctly, and roughly pulling her legs apart. He continued forcefully and repeatedly shoving his fingers into her vagina, causing her enormous pain. “I felt violated and kept asking myself what I had done to deserve this treatment,” Josephine recalled.

After the birth, the man held up Josephine’s infant daughter—hiding her head and spreading her legs with spite, so that Josephine could see that it was a girl—saying, “You see what you have given birth to?” Josephine began to fear for her daughter and herself: “Imagine, I thanked him because I could see now my life is in danger, my child’s life is in danger, so I just thanked him.”

Neglect following delivery

“They refused to give me any painkillers. I was naked and had covered myself with a bed sheet. After birth, they do not attend to you.”

Many women reported receiving no assistance from medical staff, even after the painful and exhausting experience of giving birth. Carole, who stayed at the hospital for two days following her delivery, was never given a post-delivery medical check-up.¹⁵⁶ The nurses continued to be abusive toward her, and would react with anger if she asked for anything, including water. Another woman who delivered at PMH in 1998 explained that she was completely neglected after she had given birth: “They refused to give me any painkillers. I was naked and had covered myself with a bed sheet. I waited for my relatives to bring clothing. After birth, they do not attend to you. They are still abusive.”¹⁵⁷

One woman who delivered her first child at PMH in 1991 said she was told to carry the baby herself from the delivery room to the general ward. Exhausted from the exertion of labour, she fainted on the way and fell with her baby. A security guard then came forward



and assisted her to the ward; no nurse bothered to help.¹⁵⁸ In 2004, the *Nation* highlighted the story of another PMH patient, Anastasia Wairimu, who fell in the corridors of the hospital after undergoing a caesarean section.¹⁵⁹ “One of the nurses pushed me hard and I fell down, and they kept threatening and shouting at me for what they termed causing trouble on the hospital corridor,” she states in the article.¹⁶⁰ As a result of the fall, Anastasia is currently paralyzed in her left leg and bedridden.¹⁶¹

Violations Involving Post-Delivery Stitching

It is common for women to experience rips and cuts during vaginal delivery,¹⁶² particularly when they lack adequate medical assistance while in labour. Such injuries, if left unattended, can lead to chronic pain, abnormal swelling, painful intercourse, and incontinence (the inability to control the excretion of urine or faeces).¹⁶³ Standard medical practice dictates that after vaginal delivery, women should be carefully and thoroughly examined under adequate light and anaesthesia.¹⁶⁴ Wounds

should be repaired using proper surgical equipment, including sterile gloves, irrigation solution, scissors, forceps, clamps, syringes, and suture material.¹⁶⁵ Medical experts stress the importance of administering anaesthesia prior to stitching.¹⁶⁶ In addition, a “careful emphasis” on hygiene is critical during this time,¹⁶⁷ and stitching of severe lacerations should occur in sterile conditions.¹⁶⁸ Refraining from cutting women during delivery decreases the chances of serious wounds and infection.¹⁶⁹

Women reported experiencing some of the most flagrant rights abuses during this crucial aspect of post-delivery care. They described enduring long, uncomfortable waits on a hard, wooden bench before being stitched; unreasonably painful and poorly performed stitching; refusal to provide sufficient anaesthesia—or any anaesthesia at all; and verbal abuse from medical providers during the process.

Unreasonable delays

Waiting for extended periods of time for post-delivery stitching is a longstanding problem. Experienced obstetrician-gynaecologist Dr. Shadrack Ojwang affirmed this, saying, “Sometimes they have to wait because there is a lot of work—there are 10-20 patients delivering at the same time.”¹⁷⁰ Prudence, the district hospital casual worker, added that “the nurses are never attentive to the women who are to be stitched because they are always attentive to the new admissions, to see new patients who they can make money from.”¹⁷¹

Susan, who delivered her first child at PMH, remembered that she sat on the bench with her newborn baby from 4 a.m. to 8 a.m., waiting to be stitched.¹⁷² Another woman, who gave birth at PMH, reported waiting from 1 a.m. until 5 a.m. for the stitching. “I was asked to wait for others to give birth so that they could stitch us all at the same time,” she said. “It was very painful.”¹⁷³ Describing a similar ordeal at PMH, Carole—who waited all night after her delivery to be stitched—said, “I couldn’t sit properly because the bench was wooden. There were many women on the bench. It was very painful.”¹⁷⁴ A woman who delivered at a district hospital reported waiting seven hours—from 4 p.m. to 11 p.m.—to receive post-delivery stitching.¹⁷⁵

Felicity, who gave birth twice at PMH, described her post-delivery stitching experiences as follows:

*After delivery one is handed the baby, who is naked, and told to wait on a bench for stitching. It took 30 minutes before I was stitched as there is only one person doing the work. . . . [The next day,] I had to line-up for further stitches and luckily in the evening I was discharged.*¹⁷⁶

After her second delivery at PMH a decade later, Felicity waited 45 minutes to be stitched. Another patient waiting on the bench beside her said, “It’s like they want to torture you for some time and make you stay there.” Former PMH matron, Evelyn Mutio, confirmed that delays were a problem: “The women would wait for a long time to be sutured.”¹⁷⁷

In the case of Grace, who also delivered at PMH, the hospital’s neglect and bureaucracy made her ordeal especially long.¹⁷⁸ After giving birth, Grace sat on a wooden bench with her naked newborn all night—from 2 a.m. until 8 a.m.—waiting to be stitched. When she inquired why she was waiting so long, the nurses on night duty informed her that her file had been misplaced and that she could not be stitched until it was found. Finally, in the morning, a nurse reporting for day duty assisted Grace by searching for and finding the file, which permitted her to be stitched. The same nurse also provided Grace with clothing for her baby and water to bathe—neither of which had been offered to her before then. Another woman who gave birth at PMH in 1997 reported a similar experience: “They threw my form away so I couldn’t go for stitching till the form was found.”¹⁷⁹

Abuse and negligence during stitching

Women expressed enduring an unreasonable amount of pain and discomfort during the stitching process, which was often poorly performed. “When stitching was done it was like they were stitching a sack,” said a woman who delivered at the Kitale District Hospital in 1997. “I complained but they said they were organizing me. They stitched me badly till my backside. I couldn’t go for a long call properly for two years.”¹⁸⁰ As a result of this ordeal, she refused to be stitched after her second delivery. Felicity, who delivered twice at PMH, said: “The stitching is a very bad experience as the person who does it shouts at you and pulls your legs apart. They keep on shouting at you as if you should know what you are supposed to do.”¹⁸¹ Dr. Ojwang concurred that women are not treated with dignity during the stitching process. “It’s like a conveyor belt—people just quickly stitching them,” he said. “The personal touch is not there.”¹⁸²

Dr. Ojwang also noted that some facilities do not provide patients with anaesthesia during the very painful stitching process.¹⁸³ Betty, who delivered her first child at a provincial hospital in Kisumu in 1991, recalled having to fight for painkillers:

*They asked if I had anaesthesia with me. They told me I should have known to bring anaesthesia. I pleaded with them for it. One of them decided to borrow it from the ward and then I had to reimburse them. The hospital should have had anaesthesia. I felt angry and desperate. I really had to beg them to get it.*¹⁸⁴

Similarly, Carole, who required many stitches after a fellow patient helped her deliver at PMH, said, “I then went and sat on a bench for an hour. . . . I became very sick and asked for a painkiller. They refused and I had to send a cleaner to buy it for me from outside.”¹⁸⁵

“It’s like a conveyor belt—people just quickly stitching them. The personal touch is not there.”

Prudence, the casual worker in a Kisumu district hospital, explained that nurses purposely cut women with scissors during labour in order to make money from stitching them, even if the cut will not facilitate the delivery.¹⁸⁶ “Stitching is charged at Kshs. 250 (\$3.50 US)—Kshs. 150 (\$2 US) goes to the government and [the nurses] take Kshs. 100 (\$1.50 US),” she said. “They cut even if it is your tenth birth. . . . [They] will cut you and you will give birth on your own.” Prudence also noted that nurses are verbally and physically abusive towards women while stitching them, and that they apply anaesthesia but then wait until it wears off before beginning the stitching. “That is why women say they were not given anaesthesia,” she explained.

A woman who delivered at PMH observed that patients who refused to be stitched were told, “That’s your problem with your husband.”¹⁸⁷ Furthermore, women reported receiving no help from hospital staff, even after undergoing the painful process of stitching. “The cleaner told me to go to the labour ward after I had just been stitched,” said one woman who delivered at Kikuyu Hospital. “I asked for his assistance and he refused. In the ward, there was no bed so I sat down to wait. . . . It was not nice. There was no proper care.”¹⁸⁸

Mutilation

Josephine, who gave birth at St. Mary’s in 2005, suffered a gross violation under the guise of stitching. The medical provider who had verbally and physically abused her during her delivery took her child away from her, and then mutilated Josephine’s clitoris and part of her labia with an object that Josephine could not see, although she later saw scissors on the side table.¹⁸⁹

There were scissors on the side but he did that very fast. There were two types of scissors. Even when I was [getting] up to go they were still there full of blood, they were not removed. . . . That place was numb. I can’t explain how it felt. . . . Now I was there helpless. Imagine somebody doing like this to you—laughing, mocking.

The medical provider who had mutilated Josephine then called over another man, who pretended to stitch her vaginal tears from delivery—only to continue to torment her.

He had a needle, which he used only to pretend to stitch—just poking me with the needle. The place he was doing that to—you can identify the place—he persisted in that same place. . . . I screamed, I cried—I said just leave me alone. The man was saying, ‘We are not going to leave you.’ . . . There were no stitches. Even the doctor at [a later] clinic said there was no sign of stitches.

Josephine bled excessively afterwards, but was not provided with absorbent pads. “When I stepped down from bed, he [the medical provider who had mutilated her] came screaming at me, ‘Just go!’” she recalled. “I didn’t know what to do, I was bleeding a lot.”

A doctor who came by to examine Josephine later was taken aback by her mutilated state. “He came by and checked. Do you know, he was shocked. When he saw I was looking at him, he just pretended he’s not shocked. He just told me congratulations [on the baby].” Similarly, another doctor who examined Josephine in the morning had a strong reaction to what he saw. “We had to line up to be checked,” she recounted. “When my time came, he

checked and he said, ‘Oh my, put on your panty quickly!’—because my private part was swollen. You can imagine that stab, that cut, that pretence of stitching, that pain”

“You can imagine what I underwent at the hands of people who are supposed to take care of me. They got pleasure torturing me so if this can come to an end, at least they are answerable.”

Josephine did not have access to a mirror at the hospital, so she was only able to look at her genital area after she returned home: “I was able to see what had happened. I cried. From then on, until now, I have been a crying woman.” A month later, when Josephine returned to the hospital for a follow-up visit, the doctor who examined her was again shocked. “What shocked him most was where [I had been] stabbed,” she said. “Blood was still coming, you can imagine the pain.”

A year after the incident, when Josephine finally confronted the man at the hospital who had mutilated her, he claimed that he did not even remember her. “I said that shows me you do such to many women, so you don’t remember whom you have tortured,” Josephine recounted. She also stated that a doctor at another medical facility told her that he had seen “many” other cases of mutilation like hers. “‘I’ve been in delivery room for over 35 years and I’ve seen women are cut like that,’ he told me,” Josephine recalled. “He said he was worried about my stab but it would heal. ‘After all, it’s to please men,’ he said. I left that place crying also.”

Josephine has faced overwhelming obstacles in her struggle to obtain redress. [See Complaints section.] “You can imagine what I underwent at the hands of people who are supposed to take care of me,” she said. “They got pleasure torturing me so if this can come to an end, at least they are answerable.”

Violations of Rights to Consent and Information

The government’s 2002 Maternal Care Standards require health facilities to respect women’s right to information.¹⁹⁰ According to the Standards, this means ensuring that personnel are informed; counselling and support services are available; staff members take the time to explain procedures, diagnoses, progress, results, and options; patients are encouraged to ask questions; the staff provides appropriate responses; and “information is given in an open and friendly manner.”¹⁹¹ The goal of these requirements is to ensure that “[w]omen are able to make informed choices.”¹⁹²

However, the right of women to receive full information about their pregnancies is not being respected in practice. One woman who gave birth to her first child at a private Catholic hospital in Thika in 1994 said she was “really scared,” did not know what to expect or what the doctor was supposed to do, and nobody was telling her what was happening during the process of delivery.¹⁹³ During her second delivery at Nairobi Hospital in 1998, she again wanted more information from the medical staff. She said the doctor ignored her request for a caesarean section and did not understand when she tried to express her frustration to him. The woman said that although she did not feel she was getting the best care, she “did not have the energy to argue.” A woman who delivered at Kikuyu Hospital similarly said, “I didn’t get information when I went to the labour ward.”¹⁹⁴ Another woman who delivered at PMH said, “They injected me without explaining.”¹⁹⁵ Patients also complained about being unable to access their medical files. A woman who had delivered six times at the district hospital in Kisumu said, “They do not allow any patient to read them and know the actual illness she has.”¹⁹⁶

Other women reported having procedures performed upon them against their wishes. A woman who delivered her child at Victoria Hospital in Kisumu in 1994, for instance, felt coerced into undergoing a caesarean section. “The doctor looked like he wanted money,” she said. “I didn’t want the operation. I wanted to try the natural way, but I wasn’t given time. I tried talking to the doctor and he said I wasn’t supposed to go through the pain. I was taken for the operation before nine months were over . . . I was not satisfied with the decision to do the operation. I was forced by the doctor and my husband.”¹⁹⁷

Josephine, who suffered mutilation after giving birth at St. Mary’s Mission Hospital in Langata, stated that she was induced into labour against her wishes.¹⁹⁸ Although she told the health care worker that she felt ready to push and was certain that the baby was ready to be born, he ignored her. “He said, ‘I’m putting for you this drip so that you can deliver quickly.’ I said, ‘You’re the doctor, I don’t know—but I’m feeling like [pushing already].’” In addition, the doctor broke Josephine’s water, yet refused to assist her into the labour ward. “After my water had broken, he made me run to labour ward. He did not help me climb the bed. He just stood there. I did it on my own.” Following delivery, another medical provider immediately took Josephine’s baby away without giving her any information about the infant.

A hospital’s refusal to provide adequate information can place women at great risk. Rose, who gave birth in St. Mulumba hospital in late 2005, was initially carrying twins.¹⁹⁹ Although the medical staff had discovered during a routine check-up that one foetus had died in the womb, they did not tell Rose; upon entering the hospital for delivery, she still believed that she carried two foetuses. When Rose went into premature labour, she explained that she was expecting twins, and the St. Mulumba staff informed her that the hospital’s incubator could only accommodate one baby. Rose was therefore taken to St. Mary’s Mission Hospital in Langata, instead. The guards at St. Mary’s denied Rose entry, despite the fact that she was nearing birth, because she could not provide the required deposit. Rose was then taken back to St. Mulumba Hospital, where she delivered through caesarean section. The child that was born alive was placed in the incubator. Rose only learned of the dead foetus after the delivery. Had she been given this information at the time it was discovered, she would have avoided the ordeal of travelling repeatedly between hospitals at the brink of labour.

Why the Right to Information is Central to Protecting the Right to Health

Unfortunately, [in Kenya,] even simple policies on health and education are not easily accessible to the public, even though such information is crucial and can have such a major positive effect on people’s lives. . . . Right to information laws open up government records to public scrutiny, thereby arming citizens with a vital tool to inform themselves about what the government has done, at what cost and how effectively.²⁰⁰

The right to information is a fundamental human right; its realization is also central to fulfilling other fundamental human rights. Access to information is necessary to ensure good governance through transparency and accountability. However, the right to information in Kenya is actively impaired by the existence of the Official Secrets Act, which has been described as “a colonial relic that criminalizes disclosure of information by public officials.”²⁰¹

Article 19 of the International Covenant on Civil and Political Rights²⁰² and Article 9 of the African Charter—both of which Kenya has ratified—recognize the right to information,²⁰³ and this right is

reaffirmed in the Declaration of Principles on Freedom of Expression in Africa, which was adopted by the African Commission on Human and Peoples' Rights. The declaration states that "everyone has the right to access information held by public bodies" and "the right to access information held by private bodies which is necessary for the exercise or protection of any right."²⁰⁴ Refusals to disclose information "shall be subject to appeal to an independent body and/or the courts," and public bodies are required to publish "important information of significant public interest," even in the absence of a request to do so.²⁰⁵ Furthermore, the declaration provides that those who release in good faith "information on wrongdoing, or that which would disclose a serious threat to health, safety or the environment" shall not be subject to sanctions.²⁰⁶

However, the research for this report identified several ways in which these principles are violated in the context of the Kenyan health care system:

- **Lack of access to information by public bodies or private bodies where the information is necessary to protect a right:** Patients (or their relatives, in instances where the patient had died) who felt that they had been subject to mistreatment, abuse, or neglect reported experiencing difficulties getting the comprehensive medical records they needed to seek redress.²⁰⁷ This difficulty in obtaining records was present in both private and public facilities.
- **Failure to make key information available:** Despite repeated efforts, FIDA Kenya/CRR were unable to obtain basic information about standards and procedures at Pumwani Maternity Hospital (PMH). The Chief Medical Superintendent at PMH told FIDA Kenya/CRR, "I can't even tell you how many doctors work here. What happens if it ends up in the press?"²⁰⁸ He noted that three years ago, when PMH was the subject of frequent negative media coverage, the hospital was a "fertile place for information," but now the PMH board must approve requests for information.²⁰⁹
- **Failure to release results of investigations into wrongdoing:** Despite the Pumwani Task Force's wide mandate and intensive investigation into problems at PMH, its report was never disseminated to more than a handful of people.²¹⁰ Neither its findings nor its recommendations were released to the public, making it almost impossible to follow up on any implementation of the recommendations or to seek redress for those whose rights were violated at the hospital.
- **Lack of protections for individuals who release information on wrongdoing or a serious threat to health and safety:** The fear of losing one's job or suffering retaliation for speaking about conditions in one's workplace was evident among some of the health care staff and public officials whom FIDA Kenya/CRR approached for information. Some health care providers were reluctant to speak in their professional capacity as an employee of a public health institution, and would only speak to us in their capacity as a member of a professional association—or more generally, without referring specifically to practices and conditions at the facilities where they worked. Their fears were not unfounded. Health care staff and government officials who shared information about the state of PMH with the media and the public have been threatened with losing their jobs.²¹¹ According to a *Nation* reporter who covered the PMH story closely, those who released a copy of the PMH Task Force report in 2004 were fired for doing so.²¹²

Negative Effects and Consequences

The fact that many of the violations reported at hospitals like PMH occurred decades apart indicates systemic and entrenched patterns of abuse. Such experiences have long-lasting and harmful repercussions and shape women's attitudes about childbearing and seeking reproductive health care for years to come. It is not then surprising that the 2003 KDHS found that women are shifting away from seeking the services of doctors during delivery.²¹³ Only 42% of deliveries in Kenya are supervised by a health professional, usually a nurse or midwife.²¹⁴ Traditional birth attendants (TBAs) deliver 28% of babies, and relatives and friends assist in 22% of births.²¹⁵ Moreover, women in Kenya are seeking

medical attention later in their pregnancies than they once did, which also results in fewer women having four or more ante-natal visits during the course of their pregnancies.²¹⁶

Betty, who disliked the way the male medical staff treated her during her first delivery and who had to plead for anaesthesia during post-delivery stitching, expressed a longstanding fear of male doctors.²¹⁷ She explained that she chose her family planning clinic based on the fact that she could be treated by women there. Another woman, who had her first child when she was 18, was so terrified of delivering in a hospital that she decided to run away: “I was to be taken to the theatre but I was scared because the person who went in before me died. So I hid and escaped from the hospital and went to my sister. I was very tired so they took me back to the hospital.”²¹⁸

“We would want the government to know the nurses don’t take care of the patients so we opt for traditional birth attendants. I fear going to the hospital.”

A woman who delivered her first child at PMH in 1991 recalled, “We were many and people were screaming. I assumed that people don’t get attention. I was abused and beaten. They would say, ‘Let her scream.’”²¹⁹ The negative experience coloured her feelings about having more children:

I stayed for five years without conceiving because of that experience. People say that raising a child is hard—for me, giving birth was harder. . . I was young and unexposed. I swore never to give birth again. Initially, I used to say I would outnumber my mother who had 10 children. I wanted to have 14 children.

Although she did get pregnant again, she chose to deliver her second child at home and was happier with that experience. “I even decided that should I have a third child, I would have it at home,” she said.

The harms of substandard care are multifold. Jackline suspects that she contracted HIV during her 2002 delivery at Madiany Hospital, as a result of being cut with the same unsterilised scissors that were used earlier to cut another patient. After finding that she had tested positive for HIV while her husband’s results were negative, she came to a startling conclusion: “I started thinking about where I could have gotten the virus and I flashed back to the time I gave birth. . . . I said I do not want to have another child if a baby can mess up your life.”²²⁰ Florence summed up the situation by saying: “We would want the government to know the nurses don’t take care of the patients so we opt for TBAs [traditional birth attendants] . . . I fear going to the hospital.”²²¹

Josephine, who was assaulted and mutilated during her delivery at a private hospital, repeatedly expressed her horror at being violated at a place where she thought she would be safe and receive care:

You wonder did they ever go to school for that? They choose to torture me, I have no doubt. . . . I could never imagine myself in such a place. Maybe this has happened to women and they just keep quiet. It was a bad experience [in the] hospital where you’re supposed to get help—that’s why you go.”²²²

Regarding the devastating consequences of her experience, she said: “I’m coping. Even if I feel pain, I try to cope because there’s nothing I can do. I wish I gave birth on the roadside so I could’ve been helped by well-wishers who were just passing. Or at home. Instead of being tortured like that.”

PUMWANI MATERNITY HOSPITAL

Pumwani Maternity Hospital (PMH), which was founded in 1926 as Lady Griggs Welfare Hospital,²²³ is the largest and busiest maternity hospital in East and Central Africa.²²⁴ The hospital oversaw 24,000 deliveries in 2002, and the annual number of deliveries rose to 27,000 in 2005.²²⁵ A journalist who recently investigated the hospital reported that it now handles an average of 80–100 deliveries per day.²²⁶ According to the doctor in charge of PMH's clinical services, as of 2005, 80% of the deliveries that occur in Kenyan health facilities take place at PMH.²²⁷ Yet PMH had only 150 nurses, 28 doctors, and two incubators in 2004.²²⁸

The patients at PMH tend to be the poorest and the youngest women in Kenya; the majority are between 14 and 18 years of age.²²⁹ The hospital's frequent refrain for trying to justify its high levels of maternal and infant mortality is the overall vulnerability of its patient base and the large number of deliveries it handles. Dr Daniel Nguku, Medical Officer at the Nairobi City Council, which is responsible for PMH, offered the following explanation: "They deliver 20–24,000 babies a year at Pumwani. You can't compare the mortality rates with other places. They're already sick people. You're treating the sickest people at Pumwani."²³⁰ Similarly, current Local Government Minister, Honourable Musikari Kombo, told

the press in December 2004, "I believe that one death is one too many and the hospital management needs to find strategies to reduce this. . . . However, I'm informed that a majority of these deaths occur among mothers who are referred to this institution late and with complications."²³¹

PMH's high maternal mortality rate may, in part, stem from its particular client base. However, since the facility does serve a large number of young women who are more likely to suffer complications during delivery, along with women who are at a higher risk of ill health and are less able to afford regular health care, the government response should be to strengthen staffing and resources at PMH in order to better meet the needs of this population.

This report did not set out to focus on PMH. However, the repeated references in interviews and in media coverage to abuses occurring at this facility have made it impossible to avoid highlighting it. Women who delivered at PMH described decades of egregious rights violations—including unsafe conditions for delivery and behaviour by medical staff that humiliated women and endangered their lives and the lives of their infants. "For some time, going to Pumwani has been like a death sentence," stated a *Nation* journalist who has investigated and reported on the

hospital. Women "[e]ither lost their lives or lost their babies."²³² "That Nairobi's Pumwani Maternity Hospital is a disgrace was documented a long time ago and that the institution is understaffed has never been in doubt," declares a December 2004 editorial in *The Standard*.²³³

The horrors of PMH highlight the Kenyan government's systemic failure to protect women's health, despite its stated commitment to doing so. The treatment that women have received at this hospital negates the government's claim to have ensured quality health care services for people living in urban areas.

Mismanagement and Corruption

Evelyn Mutio, who served as matron of PMH in the early 1990s, said the hospital has been plagued with a host of problems, including too many patients, shortages of staff and beds, long delays for services, lack of critical equipment and supplies, and widespread corruption.²³⁴ "You may not understand Pumwani if you have not worked there—there is no individual care," she said. According to Mutio, in the 1960s and 70s PMH was a good hospital with enough doctors and supplies. However, the 1980s brought unfortunate changes: "Corruption set into every corner. Supplies decreased. . . . One day they put up new curtains for the ward and

it looked good. [After the weekend], all the curtains were gone.” Mutio, who was called upon by PMH “to fix things,” closed all the exits to the hospital except one and started monitoring what was being taken out. They found that people were smuggling out brand new sheets, milk, sugar, even drugs—by covering them with discarded placentas. “The corruption was so deep-rooted,” remarked Mutio, adding that anyone it did not touch was considered “the odd man out.” The media reported that City Hall even gave away PMH’s only working ambulance to a defunct fire brigade.²³⁵ “When [Nairobi] City Council was cash-strapped, it was not a priority for them to equip the hospital,” said one journalist. “To them, giving birth is a natural phenomenon that should just happen.”²³⁶

Indeed, many of PMH’s problems stem from the inefficiency and corruption of the Nairobi City Council, which assumed management of the facility in 1944.²³⁷ Unlike other large referral hospitals, such as Kenyatta National Hospital (KNH), which are supervised by the Ministry of Health, PMH is under the control of the Nairobi City Council, which falls under the Ministry of Local Government. For an extended period of time, the money collected through user fees at the hospital went straight to the Council, and

never returned to the facility. “The money would go to City Hall and get diverted to other activities,” noted a *Nation* journalist. “City Council would not pay salaries, so midwives would go three months without money.”²³⁸ Moreover, although the local government had allocated an additional Kshs. 3 million (\$42,857 US) per month for PMH, City Hall never sent those funds to the hospital.²³⁹ “There was a lot of financial mismanagement,” said Dr. Shadrack Ojwang, who headed the PMH task force described below.²⁴⁰ Only recently did the hospital begin controlling the money it collects.²⁴¹ “The infrastructure is dilapidated,” declared a journalist who reported on the hospital.²⁴²

A series of national media articles published in 2004 revealed that conditions at PMH seemed only to have worsened in the last few decades, with growing accounts of death, neglect, swapped babies, and missing bodies.²⁴³ The hospital’s refusal to acknowledge the problems

in a forthright manner became clear when Karisa Maitha, the Local Government Minister at the time, threatened to fire PMH staff for talking to the media when the *Nation* stories broke.²⁴⁴

The 2004 PMH Task Force

In response to the negative media attention, the local government constituted a PMH task force in 2004.²⁴⁵ The task force was led by Dr. Shadrack Ojwang, an obstetrician-gynaecologist at Kenyatta National Hospital and professor at the University of Nairobi. According to Dr. Ojwang, the task force was formed “because the hospital was not running properly—it was going down [and] there were a lot of complaints in the media.”²⁴⁶ The members of the task force, who were selected through ministerial appointment, included Dr. James Nyikal, the Director of Medical



Services in the Ministry of Health, and Dr. Josephine Kibaru, head of the Ministry of Health's Division of Reproductive Health. Dr. Ojwang noted that the task force had "a very wide mandate . . . to make sure that the hospital worked—we were to go in and do our own investigation and suggest how to solve the problems."²⁴⁷ To accomplish this goal, Dr. Ojwang explained, the task force made visits to PMH, questioned people at the facility, conducted a survey, visited other public health institutions in Nairobi, and obtained views from a broad range of people, including ministers and members of the public. "People were invited through radio and newspaper advertisements to give their views," Dr. Ojwang said. "Hundreds were coming to tell us of their experiences or their relatives' experiences."

Task Force Findings

"There were many problems—the report was 400 pages," said Dr. Ojwang, discussing the task force's findings. "Generally, administration was poor, especially from City Council . . . City Council was not looking after Pumwani."²⁴⁸ Dr. Ojwang explained that tender was over-inflated—so much so that the Council would charge the hospital Kshs. 10 for an envelope costing Kshs. 2. Corruption was

rampant throughout the facility's administration:

Supplies were disappearing. Money was disappearing in the treasury side of City Council. The way money was handled was not transparent. Even employment was haywire—they would get anyone and just employ them. Distribution of housing was also corrupt. Houses meant for doctors and nurses had people who were not supposed to be there. Nurses and doctors were thrown out and had to live far away from where they worked.

Dr. Ojwang further noted that there were widespread complaints of mismanagement and verbal abuse of patients by the hospital staff.

The usefulness of the task force's findings, however, has been seriously undermined by the fact that the final report is not a public document. According to Dr. Ojwang, the report was distributed only to the Ministry of Health, the Director of Medical Services, the Superintendent of PMH, and City Council.²⁴⁹ Moreover, the extent to which those who received the report have actually engaged with it remains unclear. The Superintendent of PMH, for example, said that he did not have the report when asked for a copy in May 2007.²⁵⁰ Although

"To them, giving birth is a natural phenomenon that should just happen."

he claimed that the hospital had given the report to the press,²⁵¹ a reporter who had covered the story for the *Nation* said that the paper had received the report through a leak, and that those responsible for the leak had been fired.²⁵² "Normally in Kenya, when these things are done, they [government officials] do not want to make it public," he remarked. "Once a document comes out, it is put on the shelf to gather dust."

The efforts of FIDA Kenya/CRR to obtain copies of the report were unsuccessful. However, the *Nation* has printed the following excerpts from the report:

- *"Staff shortages and financial problems, compounded with poor administration, led to unnecessary sickness and deaths of mothers and babies."*²⁵³
- *"There exists glaring professional negligence and laxity among doctors, nurses, security and administrative (staff) . . . in dealing with expectant mothers, babies and their relatives."*²⁵⁴

Despite these alarming findings of negligence, the task force failed to bring legal charges against anyone. “It was very difficult to pinpoint any one person,” alleged Dr. Ojwang. “There were no legal charges brought because we didn’t find any serious breach that would require it.”²⁵⁵

Current Status

Dr. Ojwang said he believes the task force helped improve conditions and services at PMH. “The labour ward is okay; the theatre and kitchen are refurbished; collection and distribution [of funds] are streamlined,” he said. A December 2005 *Nation* article notes that the hospital has increased its number of incubators from two to ten (although the task force recommended 100 incubators), has repaired its ambulance and bought an additional one, and has begun the construction of an amenities ward.²⁵⁶ A key change is that PMH is now run by an independent board.²⁵⁷

Many of the task force’s recommendations have not, however, been implemented.²⁵⁸ “We achieved what we wanted to achieve to some extent—until it comes down again,” said Dr. Ojwang. He also noted that the hospital “could be significantly better” if it employed more nurses and doctors.²⁵⁹ PMH’s Medical Superintendent, Dr. Charles Wanyonyi, commented that the task

force recommended several things, some of which were achievable, while others were not.²⁶⁰

Moreover, PMH has raised user fees in order to pay for some of the changes—thereby placing the financial burden upon the women who deliver there.²⁶¹ Dr. Wanyonyi noted that in 2004, City Hall owed the hospital Kshs. 88 million (\$1,257,143 US), which they never gave him: “I told them ‘you either raise the money or I’ll raise charges.’”²⁶² The charges for both normal and complicated deliveries increased shortly thereafter.²⁶³ As Dr. Wanyonyi himself put it, “The money I pick from poor women here is improving our own hospital.”²⁶⁴

Given the longstanding, systemic rights violations that women who give birth at PMH have been suffering, piecemeal gestures toward addressing the facility’s shortcomings simply will not suffice. The Kenyan government has made no attempts to ensure transparency in its attempts to reform PMH. FIDA Kenya/CRR’s repeated efforts to obtain information from PMH about its operating procedures and guidelines were unsuccessful. Nor has the government provided any public hearings or redress for those who have been killed, maimed, or emotionally scarred by their experiences at PMH. A June 2004 *Nation* article observes: “There is a sense in which politicians

use task-forces to buy time in the hope that Kenyans will have calmed down by the time a report is released, if ever. It shouldn’t happen to the good women of Kenya. Safe motherhood will remain a dream until the ministries of health and local government play a meaningful oversight role.”²⁶⁵ PMH must also do significant work in order to rehabilitate its reputation among the Kenyan people. As one woman who delivered there in the mid-90s commented, “I wouldn’t recommend anybody to go there. Get help elsewhere.”²⁶⁶

STRUCTURAL BARRIERS TO QUALITY MATERNAL HEALTH CARE

[I]n the labour ward we were three women and there was only one nurse who was attending to us. She was not nice. She treated us badly. It was my firstborn. She came and abused me and slapped me as I was screaming. The other women were also being abused. . . . The first woman gave birth—she was helped—and within three minutes my baby came and the nurse used the same scissors she had used on the other woman. I can't forget. . . . There was no water there. There is always a complaint about water. She took my baby and wrapped my baby in my lessso. She asked me if I had cotton [and told me where to put it]. . . . I was just alone from 3:00 when I gave birth, to 7:00, [when] the woman next to me noticed I was bleeding. I couldn't sit. I was squatting on the bed. There was blood all over. . . . I was not checked. The woman got water for me and I bathed. I didn't have anything to wear or sleep on. Another woman gave me her lessso to sleep.

—Jackline, who suspects that she contracted HIV as a result of the conditions of her 2002 delivery at Madiany Hospital in Bondo District²⁶⁷

“Nurses want to give proper care but they can't.”

Health care providers in Kenya encounter a number of serious challenges to providing quality care. These obstacles include understaffing, lack of institutional support, and inadequate supplies and equipment. In a May 2007 *Standard* article, health care workers attribute high rates of infant mortality at Coast General Hospital to shortages of medical staff and equipment, along with low morale and negligence.²⁶⁸

Health care providers observed that poor work conditions demoralize staff and interfere with quality care. A clinic administrator commented that in those conditions, “Nurses want to give proper care but they can't.”²⁶⁹

Understaffing/Lack of Institutional Support

Offering women access to a skilled medical provider during delivery is a key element of the National Reproductive Health Strategy. However, according to the 2004 Kenya Service Provision Assessment Survey (2004 KSPAS), there is a skewed distribution of doctors, clinical officers, and nurses in urban areas, as well as a severe overall shortage of providers across the country.²⁷⁰ Understaffing is a persistent problem throughout Kenya—a problem that invariably leads to lower-quality services for women and their babies.

Evelyn Mutio, a former matron at Pumwani Maternity Hospital (PMH), recalled working at PMH in the early 1990s, when there were only 10 staff doctors although there should have been 30, and the hospital was handling between 80 and 100 deliveries per day, including about 10 caesarean sections.²⁷¹ On some days, only three nurses would be on duty at a time.²⁷² “Pumwani is not made for the number of patients that are seen there,” Mutio noted, adding that the staff was overworked and tired, leading to a lack of individual attention. “Mothers go out and say they delivered alone because babies are just falling out by themselves.”

The problem is not limited to urban hospitals. Mutio recalled visiting a smaller health centre at which she encountered a woman who had been on duty, alone, for three days in a row. Three women had just given birth at the facility, and some were on drips. Apparently, all the medical staff with experience had “left for greener pastures.”²⁷³ Elizabeth Oywer,

“The trainees just want to study our private parts yet you want to give birth. If they want to train, the doctors should come with the trainees.”

Registrar of the Nursing Council of Kenya, described a recent visit to a district hospital where the sole nurse on duty had to attend to a woman in labour, another who had just delivered, and two women in the operating theater.²⁷⁴ The nurse was supposed to wheel all four of the women because there was no lift. Oywer said she was concerned about one of the newborns being left unattended because people steal babies, so she had to ask a patient to watch the baby while she helped the nurse move another patient.

An experienced midwife recalled that on one night, she delivered 11 babies in 12 hours.²⁷⁵ “I was sleepy and tired,” she said. “By the ninth, tenth, eleventh delivery, I would have been rated minus zero.” She noted that midwifery is a particularly stressful job, which is compounded by the fact that midwives and nurses do not receive adequate support and are often treated poorly. The conditions are particularly rough for night nurses, whose “shifts are cruel.” She further observed that many nurses have difficult personal situations: they are underpaid, commute long distances to work, and often receive no food or tea during their shifts. “If you care for them, they will care for the patients,” she remarked.

Staff shortages affect all levels of care providers, and often result in medical students treating women—and even performing surgeries—without adequate supervision.²⁷⁶ Florence discovered this while delivering her child at Kisumu District Hospital. “The doctors don’t assist in giving birth,” she stated. “It is only the trainees who help. The trainees just want to study our private parts yet you want to give birth. If they want to train, the doctors should come with the trainees.”²⁷⁷ A woman who delivered at PMH in 1997 experienced the risks of such practices: “A trainee attended to me. The trainee didn’t know what to do and there was no doctor. . . . [S]o I pushed on my own. I got cut badly. I bled a lot, and that’s when [the nurses] came. I was alone for an hour [and] was feeling dizzy.”²⁷⁸ A 2004 *Nation* article on PMH states, “Most of the services to the newborns and their mothers are provided by the 215 trainees.”²⁷⁹ Another article detailing the 2004 task force report on PMH, discussed in the PMH section above, published an alarming fact revealed by the report: “the maternity was most of the time manned by a single doctor as other doctors worked elsewhere.”²⁸⁰

Prudence, the casual worker in a Kisumu district hospital, said she and other non-medical staff members are often instructed to perform the work of nurses and that people call her ‘sister’—a term used for nurses—even though she has no medical training.²⁸¹ She explained that she has assisted women giving birth and has been asked to cut them with scissors during labour. Prudence added that sometimes there are emergency cases at night and the doctors say they are too far away to come to the district hospital, so she must accompany patients to the nearby New Nyanza Provincial Hospital (informally referred to as Russia):

[Some women] give birth on the way, others when we reach Russia. The nurses there abuse us, asking why we don’t have a doctor. We wait and sometimes the patient bleeds . . . and all this time the patient is in pain. And you just wait and there is nothing you can do. Once they clear you and admit the patient you leave, but you will not know the fate of the patient.

Kenyatta National Hospital’s Dr. Ojwang stressed the importance of addressing staffing shortages, stating “The only thing one can do is hire more doctors and nurses and empower them to do these procedures. They need training and empowerment.”²⁸²

Lack of Supplies

Understaffing is compounded by the dearth of supplies in Kenya's health care system. According to the 2004 KSPAS, only 29% of medical facilities have all of the basic delivery-room infrastructure and equipment, such as a bed, an examination light, and both visual and auditory privacy.²⁸³ The basic supplies required for a normal delivery—a scissor or blade, umbilical cord clamps or ties, a suction apparatus, antibiotic eye ointment for the infant, and a disinfectant for cleaning the perineum—were available in the delivery areas of only 36% of facilities.²⁸⁴ In fact, the availability of cord ties/clamps decreased from 72% in 1999 to 64% in 2004.²⁸⁵ Partographs for monitoring labour were available in only 39% of facilities.²⁸⁶ A mere quarter of facilities that offer delivery services had the medicines and supplies necessary for managing common delivery complications, and the additional items required for serious complications were available in only 13% of facilities.²⁸⁷

“If you have five babies coming, how do you sterilize the forceps?”

Women reported that the hospitals in which they delivered lacked even more basic supplies, such as cotton wool, pads, gloves, syringes, surgical blades, material to wrap babies, anaesthesia, disinfectant, medicines, bed sheets, and blankets.²⁸⁸ Women were expected to buy such items on their own, or to undergo childbirth without them. Prudence, the casual worker at a district hospital in Kisumu, described a typical patient admission: “So when a woman comes to give birth and before they take any action and before palpitation is done . . . and you can see this woman is in pain, she will be asked, ‘Mama did you carry Jik [disinfectant], gloves, cord clamp, and such things?’ And if she didn’t, they ask her, ‘You want me take my hand and insert it inside you? Tell your man to go buy gloves.’”²⁸⁹

Susan, who delivered her first child at PMH in 1997, recalled that a staff member asked her whether she had brought cotton wool with her, which she had not. “Fortunately a fellow patient assisted me by sharing her cotton wool,” Susan recalled. Betty, who delivered her first child at a provincial hospital in Kisumu in 1991, confirmed that patients were expected to buy the gloves, cotton wool, and other such supplies required for delivery. “Tools of work should be there,” said Nursing Council Registrar Oywer. “Where there are no tools it is very depressing. . . . [Nurses] can’t get job satisfaction.”²⁹⁰

Former PMH matron Mutio confirmed that the lack of medical supplies was a constant challenge for the facility:

*We would tell patients to buy their own things because of the shortage of supplies. We told patients to come with gloves, to buy their own syringes and needles and cotton wool [and] maternity pads. [The hospital] did not have enough for the number of patients We also asked women to bring a kanga to wrap the baby in. Whatever you wrap babies in, women go home with it.*²⁹¹

According to Mutio, the shortage of supplies, coupled with the large number of patients, prevents medical staff from providing adequate care. “The hospitals need supplies, equipment, and tools,” she said. “If you have five babies coming, how do you sterilize the forceps?” Mutio suggested that the government devote funding to improving facilities and access to supplies for medical providers, because “salary is not as motivating as if you make everything smoother . . . salary is secondary to [working] environment.” Dr. Ojwang, who recently headed the task force that investigated PMH in 2004, noted that lack of supplies is still one of the biggest problems at the hospital.²⁹²

Unhygienic Conditions

Understaffing and lack of supplies create unhygienic conditions that pose dramatic threats to the lives and health of mothers and their babies. The 2004 KSPAS found that only four out of ten facilities offering delivery services had all of the items recognized as necessary for infection control during delivery—hand-washing supplies, clean or sterile latex gloves, disinfecting solution, and a sharps box—available in the delivery area.²⁹³ In particular, disinfecting solution was missing in 33% of facilities and hand-washing soap was unavailable in 41% of facilities.²⁹⁴ Moreover, only one-third of the facilities had the capacity to sterilize delivery equipment; “the remainder either lack equipment or knowledge” necessary for adequate disinfection.²⁹⁵ Only a quarter of the facilities had written guidelines for sterilization available in the relevant area.²⁹⁶

Women reported encountering appalling conditions that placed them and their newborn infants at grave risks of infection. In many accounts, the hospital lacked bed linens, the beds were not cleaned between deliveries, and patients were made to wipe down the beds and wrap their newborn babies with their own clothes or soiled linens. One woman who delivered at PMH in 2004 remembered being placed on a soiled delivery table upon which another woman had just given birth.²⁹⁷ Several other women who gave birth at PMH also noted that the delivery beds lacked sheets,²⁹⁸ which was confirmed by a visit to the facility in April 2007.

Carole described the conditions of her delivery at PMH as follows:

A wooden bench is used to wait for others to give birth before you can climb up on the bed. We sit in a line on the bench. Once you give birth you wipe the bed and then another woman climbs onto the bed. If you are unable to climb, then the next person just climbs [and you lose your turn]. There are no bed sheets, just the plastic cover.²⁹⁹

Carole noted that when it was her turn on the bed, it had not been cleaned since the last woman gave birth on it. “I asked [the staff] to clean the bed but they refused and told me to use my clothes [to clean it myself]. I just used the dirty bed because I didn’t have a choice. I asked for beddings and they refused.”

Carole also noted that she was given no assistance in protecting herself or her child from infection following the birth:

[The nurses] told me to get off the bed. . . . I wiped the bed. . . . I covered the baby with a sweater, and put the baby on the bench. I was in pain but I couldn’t do anything. Blood poured onto the floor and they made me use some used linen to clean all the blood. . . . I was hurt and discouraged. I was not happy with the way I was treated because I could have died and the baby could have died.

When Carole returned to PMH to deliver another baby a decade later, she found that that the conditions were just as unhygienic. “It was very bad,” she said. “I suspected that my baby got an infection at PMH because they wiped the baby with soiled bed sheets that had been used by other patients.” Carole’s baby became ill and died a year later. Another woman, who delivered twice at PMH in the 1990s, noted that the facility was “very dirty” and that the delivery area was bloody.³⁰⁰

After giving birth, women reported being forced to share beds or even to sleep on the floor. They said that no food was provided, or that they received no meals if they did not bring their own utensils. Patients were also made to fetch their own water for bathing—and often, no hot water was available.

Carole described the post-delivery conditions at PMH as follows:

“The biggest problems are supplies, cleanliness of the hospital, and adequacy of equipment.”

There was no water to bathe. The doctor saw me when I had not bathed. I was then taken to a bed in which I was alone at first, but later there were two of us [sharing it]. I only bathed when my relatives came to bring water. There was no further attendance from the staff. I was waiting to be released. They never checked me the two days I was there. They were still very abusive and if you asked for anything, including water, you would be abused.³⁰¹

After the delivery of her first baby at PMH, Felicity recounted:

I was taken to the ward by a security officer, where I luckily got a bed but slept hungry until the next morning . . . The beds are so full that sometimes you have to sleep on floor. . . . There are no mosquito nets and one is bitten by mosquitoes the whole night. If you do not have utensils, you will not have breakfast and at lunchtime it is the same case. You also have to fetch water for bathing yourself and the bathing water is always cold The experience at the hospital is not pleasant at all.³⁰²

Felicity returned to PMH in 1996 for her third delivery because she lacked the money to attend a private hospital. “It was not as bad as my first experience there,” she said. “At least this time I was provided with a blanket. However, we still had to carry our utensils from home. Overall the services at the hospital had not changed much from my first experience there.”

Dr. Ojwang, who headed the task force that investigated PMH in 2004, found:

The biggest problems are supplies, cleanliness of the hospital, and adequacy of equipment. It was a dirty hospital; you couldn't believe it was a hospital When you are given a task to look into it, it opens up and you see new things. Where you've been working is very dirty and you just didn't know about it.³⁰³

A visit to PMH in April 2007 revealed that the women are still sharing beds in the pre-delivery wards, although those in the post-delivery wards appeared to have their own beds. The hospital has started providing patients with sheets, blankets, and mosquito nets in the post-delivery wards, but the beds in the labour ward still contain only plastic mattresses with no bed linens.

Prudence, the casual worker at a Kisumu district hospital, stated that her facility puts three women and their babies in one bed.³⁰⁴ A woman who delivered at KNH in 2005 recounted that she had to sleep on the floor with her baby.³⁰⁵ Another woman, whose own delivery experience at KNH was adequate, noted that she knew of many patients at the facility who were forced to sleep on the floor.³⁰⁶ “But at least [they] were provided with a mattress and a blanket,” she commented, indicating that many have to tolerate even worse conditions.

Former PMH matron Mutio described the dangers of these conditions: “There’s doubling of patients in one bed because facilities are few. . . . With delivery and the blood, with HIV, you can’t have people sharing a bed. Women would rather deliver and just sit on the bench, waiting to be sutured by the doctor.”³⁰⁷

Lack of Record-keeping and Transparency

Good record-keeping practices can play a critical role in fulfilling patients’ rights to health and information. The Maternal Care Standards state that each woman receiving maternity care should have a “clear and comprehensive” obstetric medical record.³⁰⁸ The Standards suggest that health facilities immediately and accurately document patient information, and implement an effective storage and retrieval system for records.³⁰⁹ The goals of such practices are to reduce client waiting time and to obtain clear data on patterns of maternal morbidity and mortality.³¹⁰

The 2004 KSPAS found that 76% of facilities offering delivery services have an updated delivery registry.³¹¹ However, only 23% of facilities conduct reviews of maternal or newborn deaths or near misses—a critical source of information for identifying contributing factors to and avoiding future occurrences of such instances.³¹² “Data collection tools and reporting are not up to date,” confirmed Dr. Helton Jilo, Director of Maternal Health in the Ministry of Health’s Division of Reproductive Health.³¹³

Only 23% of facilities conduct reviews of maternal or newborn deaths or near misses.

Some facilities, like PMH, go out of their way to conceal deaths or near misses, thereby adding to the violations and suffering of women and their family members. Several cases of concealment at PMH broke in the national press in 2004. In May 2004, Margaret Waithera was admitted to PMH.³¹⁴ On the following day, her husband, Erastus Onyango, visited her and found her in good health. Upon returning on the third day, however, Onyango found that his wife was missing and her name was not on the delivery list. The hospital staff initially told him to look for his wife in all of the wards, which he did to no avail. When he demanded information from various staff members, Onyango was finally taken to the matron’s office. After a hushed consultation with two other people, the matron told Onyango that his wife had been transferred to KNH due to delivery complications. According to a *Nation* article, Onyango spent “an agonizing six days shunting between PMH and Kenyatta National Hospital,” looking for his wife.³¹⁵ Finally, the PMH staff informed him that his wife had died and that her body had been transferred to the City Mortuary. Onyango never found the baby that she had delivered.

Gilbert Odira had a similar experience at PMH in June 2000.³¹⁶ His wife died while giving birth at the hospital, and Odira spent the next four years trying to discover what had happened. “The agony I underwent in trying to get information and dealing with rude and contemptuous nurses and their matrons is without equal,” he writes in a 2004 article for the *Nation*.³¹⁷ At first, Odira was simply told that his wife’s name was not on the patient register. When a matron finally broke the news of her death to him, the reason she gave was different than the reason noted on the death certificate signed by the hospital—which he obtained “one year later after a lot of struggle.” Odira notes that his wife’s file was also difficult to trace, and that the pathologist listed was not the one that PMH claimed had examined the body. Furthermore, PMH never informed Odira before transferring his wife’s body to the City Mortuary, so he spent several days trying to find and identify it.

Odira eventually went to the police, who accompanied him to the hospital. The staff feigned ignorance about the incident, until Odira and the police refused to leave without accurate information. Finally, one nurse admitted that Odira's wife had died, but would not offer any details; she told them to speak to the Ministry of Health or the matron who had been on duty at the time to obtain more information. "Four years after [his] wife's death and numerous calls and visits later," Odira has not yet been able to talk to these two sources or to the doctor who operated on his wife. "Nobody wanted to talk about this issue and everyone was keen to pass the buck," he declares in the *Nation* article, expressing frustration over the utter lack of information available from "indifferent, uncaring and inhuman" medical providers. He demands, "[D]o we still believe in the adage that for an expectant woman, it is a grave that is opening until delivery when the same grave closes?"

This pervasive lack of transparency extends not only to maternal deaths, but also to infant mortalities. In 2003, a baby born at PMH was given a blood transfusion and subsequently tested positive for HIV, even though both parents were HIV-negative.³¹⁸ The baby disappeared from the hospital five months later, and the parents traced her body to the City Mortuary after a frantic four-day search.³¹⁹ The parents are now suing the hospital, alleging that the baby they were given either was not theirs or had been transfused with infected blood.³²⁰ Such tragedies are not uncommon. In January 2004, a woman who gave birth at PMH was told that her baby had died of "unexplained causes," although she later learned that the infant has suffered burns caused by the hospital incubator.³²¹

Women who were told by PMH that their babies died during or shortly after delivery also report never being given the bodies of their infants to identify and bury.³²² "Mothers who have been discharged without being given either a baby or a body claim to feel a sense of powerlessness," writes a *Nation* journalist in a 2004 article on PMH. "They don't want to be seen as troublemakers in a political culture that has conditioned the people to fear authority. And why not? They have seen people who ask hard questions end up being branded as the problem!"³²³

DISCRIMINATION IN THE HEALTH CARE SYSTEM

At times you go to the hospital you are being told [you will] not get in and somebody else comes, and she just entered, while you, you are just [seated] not even knowing what to do. They are discriminating [against] people, mostly in public hospitals. At times you are being told the drug you wanted is not there and yet you see another person is being given [the same drug].

—Woman describing her experience seeking reproductive health care services³²⁴

Health care costs—which can include the cost of the health good or service itself; fees for transportation; food, supplies or drugs that must be purchased and brought to the facility, and informal board charges³²⁵—affect women’s experiences with reproductive health services in a variety of ways. Informal and formal user fees can prevent or delay women from accessing services, and can impose additional hardship. Women who cannot pay for health care themselves must ask their partner or family for financial assistance; when partners and relatives lack the necessary funds or choose not to provide them, women may be forced to forgo care or be abused or detained within the facility for their inability to pay.

“They want you to pay first and then go in. If you don’t, you’ll stay waiting for a long time.”

Similarly, asking women and their families to provide their own supplies can delay care or expose women to the risks and pain of treatment without key supplies, such as anaesthesia and antibiotics.

Affordability of services also determines what type of facility a woman will go to. Women spoke frequently of trying to find the funds to obtain care in private facilities after they or their family members experienced abusive or sub-standard treatment in public facilities.

The Impact of User Fees

The Kenyan government introduced user fees at public health facilities in 1989 as part of a World Bank push for cost-sharing in public services.³²⁶ User fees tend to hit women harder than men. As with most countries, poverty in Kenya has a higher impact on women, and female-headed households fare worse than other households.³²⁷ Yet, women must frequently finance their own reproductive health care—a cost that men do not incur.

User fees in Africa have had a profoundly negative effect on women’s access to maternal health services.³²⁸ A study in Nigeria revealed that the number of deliveries at a main regional hospital plummeted by 46% following the introduction of user fees.³²⁹ Dr. Shadrack Ojwang, an obstetrician-gynaecologist at Kenyatta National Hospital (KNH) noted:

[There are] worse things happening to health services in Kenya to make poor people pay. [There was a] move by World Bank/IMF [International Monetary Fund] to force governments to do cost-sharing. We are asking people to die because they can’t be treated. They want you to pay first and then go in. If you don’t, you’ll stay waiting for a long time—maybe half a day—while they decide what to do with you. We can’t do anything about this until parliament repeals cost sharing. We went into this blindly. Nobody thought of it properly.³³⁰

Cost-sharing has also been criticized by Honourable Charity Ngilu, the Minister of Health, who has commented: “Thousands of Kenyans do not dare to seek treatment in clinics, health centres and hospitals as they are well aware that they cannot raise the monies for meeting the costs of treatment. How do the poor share the costs of treatment when they cannot even afford food?”³³¹ In the face of the negative results of user fees on health care systems, the World Bank has now backed away from its aggressive promotion of user fees and supports the provision of free basic health care, including maternal health services.³³²

In Kenya, where there is currently a charge for delivery services,³³³ low-income, rural, and less-educated women are the least likely segments of the population to receive delivery assistance from medical professionals.³³⁴ One group interview participant who lives in Mathare, a poor area of informal settlements, explained that she delivered her three children at home, assisted only by her mother and grandmother, because she did not have the money to pay hospital bills.³³⁵ However, she recommended hospital delivery if one could afford it.

User fees can also serve as a barrier to services in faith-based and non-profit facilities. The Quality Assurance Officer at the Christian Health Association of Kenya (CHAK) noted that financing is a significant challenge; CHAK facilities must charge for services in order to be sustainable, yet those charges can hinder access for the women they serve.³³⁶ He commented, “We need grants. Part of the money given to the Ministry of Health should be used to sustain mission hospitals. It’s a public service. . . . If mission hospitals had more government funding, we could reduce fees for services and improve health care access for women.”³³⁷

Not seeking certain kinds of services

Many of the women who provided information for this report said that they simply did not obtain certain services, such as women’s health exams or other kinds of gynaecological services, because they could not afford them. The staff at Family Health Options Kenya and other facilities confirmed that the lack of medical checkups is a common problem: “They only come when things are bad. They don’t know they’re sick. They only come when the symptoms are there. . . . Going for a checkup is not a priority for women.”³³⁸ Based on her own experiences, one woman commented: “The women of Kenya are begging for affordable gynaecological services. Women have problems but cannot access [these] services due to financial incapability. This leads to a big percentage growing infertile—because of small problems that would be rectified growing very big because of poverty.”³³⁹

“There were women who couldn’t go to the labour ward because they had not paid. They were giving birth outside.”

Denial of services

At private facilities, which do not offer waiver systems, or at public facilities that require deposits or refuse to implement the waiver system, women can find that they are simply denied services or told to return when they are able to gather a sufficient deposit.

Refusal of services to women who cannot afford the fee has been an ongoing problem at Pumwani Maternity Hospital (PMH), with accounts of women dying “on the waiting bench because they could not raise a modest admission fee.”³⁴⁰ Susan, who delivered her first child at PMH, witnessed an expectant woman being harassed by a staff member at the hospital gate because she lacked sufficient funds.³⁴¹ The woman was refused entry



into the hospital. Another woman who gave birth at PMH recalled, “There were women who couldn’t go to the labour ward because they had not paid. They were giving birth outside. The ones who had not paid were being given work to do.”³⁴² A 2000 *Nation* article recounts the story of a woman who died in the operating theatre after being denied delivery services at PMH because her husband could not raise the Kshs. 1200 (\$17 US), which was the admission fee at the time. “She writhed in pain as other patients pleaded for her in vain. The nurse in charge refused to admit or refer her to doctors.”³⁴³ Rose’s experience, described above in the Delivery section, of being turned away from a mission

hospital on the verge of delivering twins is another vivid illustration of denial of assistance at a critical moment due to the inability to raise the necessary deposit.³⁴⁴

The practice of requiring a deposit at PMH continues to this day, as a sign at the gate indicates. A 2005 *Nation* article describes Dr. Charles Wanyonyi, the Chief Medical Superintendent at PMH, as saying, “All mothers who deserve attention get it, so long as they can raise a small deposit.”³⁴⁵ As of May 2007, the amount of the “deposit” is the cost of the delivery service: Kshs. 3,000 (\$43 US) for a normal delivery and Kshs. 6,000 (\$86 US) for a Caesarean, along with Kshs. 400 (\$6 US) to cover the bed charge for the first day. Daily bed charges of Kshs. 400 accrue throughout the woman’s stay at the hospital.³⁴⁶ Although PMH’s delivery fees are comparatively low, the fees are still substantial when close to 60% of Kenyans live on less than Kshs. 140 (\$2 US) a day. However, Dr. Wanyonyi does not believe that the fee is a barrier for most women.³⁴⁷ He commented that “as much as we think people don’t have money,” they actually do—they are simply “giving it in the wrong direction” such as spending it on alternative cures.³⁴⁸

“You feel they are being denied their rights because delivery should be free, those things should be free.”

Not all facilities turn away women in need who lack funds. Some of the private facilities with which FIDA Kenya/CRR spoke—both NGO and for-profit—commented that they had existing debts on their books from patients who could not pay for their services. One nurse administrator of a private clinic noted that they usually charge between Kshs. 4000 and 5000 (between approximately \$55 and \$70 US) for a delivery, but that some of her patients can pay nothing and she even buys baby diapers for them.³⁴⁹ Another doctor with a private clinic noted that he would negotiate fees for reproductive health services with patients who had no money. He explained, “Sometimes we get ladies from the street who have no work.”³⁵⁰ According to Dr. Margaret Ogola, National Executive Secretary of the Catholic Secretariat, the Catholic Secretariat’s facilities do not turn away patients who cannot pay; as a result, the organization is carrying a large debt for drugs alone.³⁵¹

Patients who cannot pay the entire cost upfront may also find that they are denied full services even if they are admitted to a facility. Prudence, the casual worker in a district hospital, further noted that medical providers sometimes withhold necessary supplies and equipment when a patient has not paid the full fee.

You will see that the woman is being mishandled because of lack of money. She will be told that she only paid Kshs. 400 [approximately \$6 US] and asked what

will be used to tie the baby's umbilical cord? She is told to tell her husband to look for the balance. The cord clamp is just there [but] they will not use it until you bring the cash.³⁵²

Expressing her frustrations with the system, Prudence said, “If you see how they treat the other women you really sympathize. You feel they are being denied their rights because delivery should be free, those things should be free.”

Exemptions

Along with user fees, Kenya introduced a cost exemption for certain services for those who cannot afford the fees, in an attempt to safeguard poor people's access to health care. Reproductive health services that should be free—in other words, fully exempt from cost—in government facilities include ante-natal care (with the exception of the first visit), post-natal care, and family planning.³⁵³ Treatment for HIV/AIDS is supposed to be free as well.³⁵⁴ In addition, partial or full waivers should be available for non-exempt services when clients cannot pay.

However, both of these systems have failed to protect low-income clients from the harmful effects of user fees.³⁵⁵ As the Contraception section of this report demonstrates, even services such as family planning, which are required by law to be free, often involve some kind of cost. In a 2005 study surveying health care providers in Kenya, only 43% knew that ante-natal care qualified as a free service.³⁵⁶ In reality, the survey providers reported, clients pay additional fees for ante-natal care ranging from \$0.13 to \$4.57 US.³⁵⁷

Waivers

Although Kenya has implemented a general waiver in public hospitals for those who cannot meet their medical costs,³⁵⁸ the process of obtaining this waiver can be burdensome, demeaning, and dangerous for the health of the client. Health care facilities must absorb the costs of both administering the waiver system and providing the services they have waived, which discourages staff from publicizing or granting waivers.³⁵⁹ Health care users themselves tend to have little knowledge about the existence or implementation of the waiver system; even those aware of waivers do not necessarily understand the eligibility criteria or tend to view the waiver package as a favour from hospital staff.³⁶⁰ A 2005 study showed that of the 203 Kenyan mothers surveyed, 50.7% reported having difficulty locating the funds for delivery services but only 3.4% actually received a waiver for these services.³⁶¹

Hellen described her May 2006 experience of trying to obtain gynaecological services at KNH when she could not pay the entire fee as follows: “I cannot accept to be admitted in Kenyatta because before you get that good treatment, they [have] you undergo a lot of frustrations and if you happen not to have money you can die on the way following their waiver system.”³⁶²

“There are ten steps to the process and it's very tedious. It can take a week or more,” said Dr. Joseph Karanja, the former chairperson of the Kenyan Obstetrical and Gynaecological Society.³⁶³ A public-hospital social worker responsible for administering the waiver system was quoted in a June 2007 *Standard* article as saying, “We have to verify inability to pay. That means visiting homes and conducting investigation[s]. It takes time and

“If you happen not to have money you can die on the way following their waiver system.”

sometimes transport is not provided, after all the hospital is not a charity.”³⁶⁴ In some cases, patients might be discouraged from using the waiver system altogether and be told that they should simply gather the necessary money since it is, according to the hospital, a small amount.³⁶⁵ Dr. Stephen Ochiel, the current chairperson of the Kenyan Medical Association, has also critiqued the system for permitting individual institutions and their staff too much discretion in determining who gets a waiver.³⁶⁶ This view is echoed in a June 2007 *Standard* article describing the social workers who administer the waiver system in public hospitals:

“For their work, the social workers are emerging as very influential figures wielding power as they reserve the right to recommend who to release [based on receipt of a waiver]. It is a common sight to find relatives and patients chasing them for favours.”³⁶⁷

Challenges to Abolishing Maternity Fees

On May 5, 2007, Honourable Minister Charity Ngilu announced that there would no longer be maternity fees in public hospitals from July 1, 2007 onward.³⁶⁸ This is a positive move that could significantly improve maternal health in Kenya. However, it remains to be seen how the maternity fee exemption will actually function, given the flaws in the existing exemption system and the manner in which each public health facility tends to tailor waivers and exemptions to suit itself.

Implementing the introduction of free maternal health care could be a particular challenge at PMH, which has continually struggled with Nairobi City Council on funding issues and relies heavily on user fees. When asked about this possible move, Dr. Wanyonyi, PMH’s Medical Superintendent, and Dr. Frida Govedi, the doctor in charge of clinical services at PMH, expressed scepticism. Dr. Wanyonyi commented that the government often gives all kinds of waivers that just are not feasible: “You need proper consultation with the right stakeholders.”³⁶⁹ Dr. Govedi observed that “politicians talk a lot of things” and noted that City Council still owed PMH money.³⁷⁰ “They owe him [Dr. Wanyonyi] over 100 million shillings (\$1,423,000 US). How can he run this institution? It can’t run.”³⁷¹

DETENTION IN HEALTH FACILITIES FOR INABILITY TO PAY: A CASE STUDY IN THE IMPACT OF USER FEES

My baby died. I don't know what killed her but I've got to pay the bill first. I don't know what I'm going to tell my family. . . . At night I stay awake [and] hear babies suckling or crying. The milk then flows from my breasts. . . . I wish mine was alive.

—Woman detained at PMH for failure to pay hospital fee³⁷²

The introduction of user fees in public health facilities was accompanied by measures aimed at offsetting their potential harm. However, the cost exemption for certain services and the general waiver system for those who cannot afford the fees have brought about their own set of problems. When exemption and waiver systems are not properly implemented, people seeking health care are often denied services or told to return when they have found enough money for a deposit.

In many other cases, concerns about making the waiver process too “easy” for patients has resulted in situations where patients are sometimes kept in the health facility longer than necessary, or detained against their will until they pay the fees or the facility has determined to its satisfaction that they cannot pay. Private facilities also detain patients in order to put pressure on their relatives to pay the bills.

“[Detention] is there—even if you go to the wards today, we are detaining patients,” commented Dr. Shadrack Ojwang, an obstetrician-gynaecologist at Kenyatta National Hospital (KNH) and former head of a 2004 task force that was commissioned to investigate reports of abuse and mismanagement at Pumwani Maternity Hospital (PMH). “All institutions—not only Pumwani—are doing it. Even Nairobi Hospital detains people who haven’t paid them. And Pumwani of course detains.”³⁷³ Another high-ranking doctor who works at a large public hospital noted that the practice of detaining patients until they pay their bills is “widespread” and that every facility, including his own and KNH, engages in this practice—even though the Ministry of Health denies it.³⁷⁴ When asked about policies regarding the detention of patients for inability to pay, Karugu Ngatia at the National Coordinating Agency for Population and Development, a semi-autonomous government body responsible for developing and implementing the government’s population policies and strategies commented: “The policy is that you should be able to pay your bills. [Patients are] not detained—just given time to tell relatives to organize themselves.”³⁷⁵

Prudence, a casual worker in a district hospital in Kisumu,

described the way women who had given birth recently and could not pay their bills were treated:

*Generally, in the ward there are some people who have delivered but there is no cash for discharge. Now the beds will be full as most district hospitals [are] and three women [share] one bed. Now, if you have not paid, you will be told to sleep on the floor. You will be told, ‘You are wasting food for nothing. You came here for free services, free food. Beds are full. Tell your husband to bring the money.’ She is then removed and told to sleep on the floor. . . . The ones who stay for a long time are the ones who hide their problems and they don’t want to say [the difficulties they are having paying their bills]. In fact, you only notice [them] during meal times—they are the ones who struggle to get the food first because they know automatically they will be denied. . . .*³⁷⁶

Describing one particularly severe case at New Nyanza Provincial Hospital (informally referred to as Russia), Prudence said:

I have seen [a] woman who gave birth a long time ago, and the baby is now very big, and she tells you that she has no money and has been there for years but she can’t leave. In Russia there are restrictions

“There are restrictions and the women can’t run away, because they are very strict and have watchmen everywhere.”

*and the women can’t run away, because they are very strict and have watchmen everywhere.*³⁷⁷

A woman who gave birth at KNH in 1999 recalled that she and her baby were treated well because she was able to pay her bills, which totalled Kshs. 8000 (approximately \$120 US).³⁷⁸ However, she observed that women who were unable to clear their hospital bills were detained forcibly in the general wards and afterwards taken to the nurses’ hostel and detained there until they settled their debt. An experienced obstetrician-gynaecologist at KNH confirmed, “There may be a corner in a ward where people are there who can’t pay . . . Last week during a ward round at KNH’s maternity ward, there was a woman on the floor in the corner.”³⁷⁹ A woman who delivered at St. Mary’s Langata in 2003 and another who delivered

at a private hospital also reported encountering fellow patients who were being detained for failure to pay medical bills.³⁸⁰

A recent *Standard* article confirmed the widespread prevalence of detention in medical facilities. Discussing the practice at PMH, the article noted:

*At any one time, about 50 women and their babies are detained for failing to settle medical bills. They are pushed to the far ends of the wards, next to the toilets, where they are under the watch of hawk-eyed nurses and guards. Their diet is austere and often baby and mother yawn in hunger.*³⁸¹

One woman who was detained at PMH said, “I’m poor but this is not the way to raise a child. Not on a diet of black tea.”³⁸²

The *Standard* article also reports on detention at KNH, where the hospital is regarded by detainees as a prison. One woman who was held at KNH for three weeks was quoted as saying, “Prisons are better. You work and forget your misery. Here you’re idle, depressed and constantly reminded of your crime—poverty. You see patients suffer in their beds and you watch others die. You speak

in hushed tones, yet in prisons you can even scream.”³⁸³

Hellen, who was detained at KNH for a week after not being able to pay for gynaecological services, described being subjected to “abusive and frustrating statements,” and not being given a bed. She commented that the hospital “should consider the operated patients [and] not pile three or four in one bed since they cannot afford to leave the hospital.”³⁸⁴ While she was there, some of the patients who could not pay their bills decided to “abscond” without paying, because if “you wait to get the money, you’ll be more frustrated.” According to a recent *Standard* article, however, women who manage to escape detention leave behind critical prescription drugs and medical notes, which could lead to life threatening medical complications.³⁸⁵ New mothers at PMH and KNH have even abandoned their infants in order to escape from the hospital facilities.³⁸⁶

The trauma of detention in maternity wards impacts certain women more acutely. Detaining women who have lost their babies can inflict a particular kind of emotional cruelty, as the account in the opening quote

to this section illustrates. One woman described it as “double punishment” to be “holding someone who should be grieving.”³⁸⁷ Furthermore, women who have other children at home worry about them throughout their detention.³⁸⁸

Family members are often used as a criterion for judging whether or not a patient can pay her medical bills. Knowing that they will be harassed for payment often discourages family members from visiting women in health care facilities, both before and after they give birth, leaving women isolated during a vulnerable period. Furthermore, women reported being at the mercy of their relatives for their release.³⁸⁹ The detention system thereby provides abusive spouses with an added weapon against their wives. Esther, who delivered at KNH in 2004, recounted her struggles:

I had a lot of problems. I never used to eat well and for that my pregnancy was problematic. . . . I lost the baby immediately. My husband treated me badly and refused to remove me from hospital. . . . Since he had refused to pay the hospital bill, I was detained for some time and later he was forced to pay by my relatives.³⁹⁰

Although the goal of detaining patients is to ensure payment, the method can actually be counter-productive and cost the facility money. One long-practicing

obstetrician-gynaecologist explained that patients who cannot pay their bills are made to sleep on the floor in order to provide beds for new, paying patients. “This [system of detaining] is not economical,” he asserted. “There needs to be a national policy for financing poor people’s health care. Hospitals are expected to absorb certain costs. Sometimes, it’s a matter of getting paid or closing.”³⁹¹

Discussing the tension between the possible misuse of the waiver system and the inefficiency and problems of detaining patients, KNH’s Dr. Ojwang said:

People misuse it and say ‘I’m poor and can’t pay,’ but they can. Some want to stay because they like hospital food and having three meals a day. Who wouldn’t like that? . . . If someone has a small baby and lives in a ramshackle place, she wants to stay in the hospital as long as possible. But one day, the patients [who have been detained] are released without paying. . . . This defeats the system.

Patients are misusing the system. It’s wrong. But it’s also wrong to detain patients. But hospitals will lose a lot if patients don’t pay. Many women keep the money for themselves, but when she realizes she’s going to be detained, she quickly pays it. It’s like a person who tries to make a lawyer pay his bail but when he’s threatened with

going down to the cells, he quickly pays or makes relatives pay. I as a person would not like them to pay anything, but since the system is there I have to work with it. I can’t be interfering. I can’t go to the ward and say, ‘let all patients go.’³⁹²

Detention Rights Violations

The practice of detaining patients who are unable to pay their medical bills, particularly women who have recently given birth, violates a series of human rights protected by domestic, regional, and international law, including:

- **The right not to be subjected to cruel, inhuman, or degrading treatment:**
Cruel, inhuman, and degrading treatment is not restricted to acts that cause physical pain; it also encompasses acts that cause mental suffering.³⁹³
- **The right to liberty and security of person:**
As a consequence of the deprivation of liberty, the practice of detaining patients violates a number of related human rights, such as the right to work,³⁹⁴ the right to freely participate in the cultural life of the community,³⁹⁵ and the right to move freely within state borders.³⁹⁶
- **The right not to be detained for non-payment of debt:**
States have an affirmative obligation to enact laws and other measures to prevent governmental and private creditors from limiting the personal liberty of debtors who are unable to pay.³⁹⁷
- **The right to dignity:**
The special status of pregnant women and new mothers has been recognized by the United Nations Human Rights Committee, which has noted that women should “receive humane treatment and respect for their inherent dignity at all times, and in particular during the birth and while caring for their newborn children.”³⁹⁸
- **The right to health:**
The obligation to ensure reproductive, maternal (ante-natal as well as post-natal), and child health care falls within the minimum core obligations of states.³⁹⁹
- **The right to be free from discrimination:**
The Human Rights Committee states: “Payment for health care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups.”⁴⁰⁰
- **The right to privacy and family:**
The Kenyan government is required “to ensure the unity or reunification of families, particularly when their members are separated for political, economic or similar reasons.”⁴⁰¹
- **The rights of children:**
Detaining new mothers and their infants denies children the right to protection and the care necessary for their well-being,⁴⁰² and violates their right to an adequate standard of living.⁴⁰³

The Human Rights Committee has emphasized the duty of the state to protect against people acting in a private capacity, as in the case of staff at a private hospital detaining patients, stating: “It is the duty of the State party to afford everyone protection through legislative and other measures as may be necessary against the acts prohibited . . . whether inflicted by people acting in their official capacity, outside their official capacity or in a private capacity.”⁴⁰⁴

The Difference between Public and Private

The general consensus among the women with whom FIDA Kenya/CRR spoke was that although government facilities cost less money, they tended to have long lines, lack supplies, suffer from congestion, and treat patients unequally. When women could afford to, they frequently tried to bypass public facilities in favour of private ones. A civil servant living in Luanda observed:

The most rampant violations normally take place in public facilities—i.e. you may be denied drugs and be told to buy from the medical crew . . . in charge that particular day. Sometimes you stay on the queue while they are doing nothing, yet you're sick and in pain. Most of these workers use dirty language towards patients. The services offered may not be up to date. In the health centres, they begin work as late as 10:30 [a.m.] while patients begin to arrive as early as 7:00 in the morning. This makes most people who are able to . . . go to private facilities.⁴⁰⁵

Congestion/long waits

Government facilities are plagued with congestion and long queues. One woman summarized the reproductive health care field as follows: “The kind of service I need depends on the hospital I will visit. If it is private and it is expensive, the quicker the service. If it is public, I may have to wait for long.”⁴⁰⁶ An administrator of a private facility explained that time constraints are a significant factor in why women prefer her clinic over a public facility. “Women prefer here because they get referrals here [from their friends]. Patients also don’t like KNH because of the congestion or sometimes labs aren’t working and they don’t want to waste their time . . . and they also have money. They fear the line.”⁴⁰⁷ A 36-year-old woman with her own business commented that she gets her family planning services from a private clinic and does not use government services because “I want to save time and go for my business.”⁴⁰⁸

Poor quality treatment

The women that FIDA Kenya/CRR interviewed were acutely aware of the fact that money usually buys better treatment and that poor people seeking services were discriminated against. Hellen, who was detained at KNH for a week in 2006, declared that “KNH should treat the poor patients the same way they treat the rich” and that it should be made a “pocket-friendly” hospital.⁴⁰⁹ Many of the women described dramatic differences between their delivery experiences at a public facility versus those at a private facility.

“One is treated like a human being; they even rub your back. Maybe it is because one pays a lot of money there.”

Felicity, whose traumatic first delivery at PMH is described in the Delivery section above, explained that her parents took her there because she was young and unmarried, with no money.⁴¹⁰ She commented that her experience at PMH was “not pleasant at all” and that such treatment was wrong “because it’s not people’s wish to go to such a place. At a government hospital, you expect them to give you these services because you are citizens. You wonder about training nurses get. If we had a choice, we’d go to better places.” Her second delivery in 1994 at Mater Hospital, a private facility, was very different. The baby’s father chose the hospital

and she attended the ante-natal clinic there. “This was a very good hospital . . . One is treated like a human being; they even rub your back. Maybe it is because one pays a lot of money there.”

Mary described the dramatic difference between her four deliveries at New Nyanza General Hospital (informally known as Russia) and her two deliveries at Aga Khan, a private hospital:

I got the [last] baby from Russia. You know mainly they let trainees do the work. I got a male trainee but he didn't know anything and I did things for myself. The matrons are there but they don't come near you. They leave [you] for the trainees who only came to cut the cord. This was my sixth baby and I got all my kids from the same hospital and others at Aga Khan before my husband died. At Aga Khan the services were different . . . the doctors were there and the nurses take care of you. They even wash you. The doctor removes the baby. They let you get enough rest and you have eaten before they bring the baby for you to breastfeed. When I gave birth in Russia, my lessa [wrapper] was wet and I only had one which was again used to cover the baby. I went to Russia because this time my husband was ailing and we couldn't pay. For me it was the money. We decided to go to Russia but if I had money, I would have gone to Aga Khan.⁴¹¹

Carole, whose first delivery at PMH is recounted in the Delivery section, described a similar contrast between that and her second delivery at a private facility:

I went to Alice nursing home [a private facility]. I decided never to go back to Pumwani as I could die. . . . I was attended to immediately [at Alice] and even gave birth immediately. It was natural. I was alone on the bed and it was clean. They were not abusive. They pampered me. I stayed for two days. They checked me after giving birth. I was checked immediately. This place was better. I paid Kshs. 5000 (\$70 US). I was able to pay . . . I don't know what will happen to patients who go to Pumwani. . . . Not everyone has money to go to a private hospital and to go there means you can die.⁴¹²

Generally, the worst experiences were at PMH, but women who had delivered at a number of different district hospitals or provincial hospitals described these facilities as dirty places with rude and abusive nurses.⁴¹³ Public facilities are more likely to be overcrowded—Esther, who gave birth to her third child at KNH in late 2005, described sleeping on the floor with her baby.⁴¹⁴ Although women often spoke highly of the expertise and equipment available at KNH and other referral facilities, they did not necessarily feel that they were benefiting from those public goods.⁴¹⁵

Even in cases of positive personal experiences with public health facilities, women sometimes still had a negative view of public health services. One woman who delivered her five children at a public hospital described the experiences as “good,” yet commented that she had seen many people suffer because they did not have money.⁴¹⁶ She saw poor women with their babies, who were ready to be discharged but could not pay their bills, being kicked out of their beds and forced to sleep on the floor so that the beds could be given to “people with money.” She also noted that poor people “come to the hospitals for help but . . . will leave without medication because [they do not] have money. Unfortunately [they are] going to die because of that. Too bad.”

Women's description of their experiences with public services echo the types of complaints that Dr. Daniel Nguku, the Medical Officer of Health for Nairobi City Council, described receiving: waiting too long, encountering rude health care workers and dirty buildings, being manhandled, not receiving timely referrals, and having to compete for attention from medical staff.⁴¹⁷

Some women did describe receiving quality care in public facilities, and accounts of experiences in private facilities were not uniformly positive. In general, however, women said that they went to a particular public facility, despite thinking poorly of it, only because they or their families could not afford a private or better public facility.

THE CHALLENGES OF SEEKING REDRESS

The government of Kenya controls approximately 53% of all health facilities in the country.⁴¹⁸ The remaining 47% of health facilities—including over 90% of maternity homes—are controlled by non-governmental, private, and mission organizations.⁴¹⁹ It is critical for the government to regulate the quality of services offered by both public and private health care providers, and to establish complaint and redress mechanisms for situations in which patients' rights are violated.

Legal Protections

Kenya has no comprehensive health care law that ensures the right to health by providing clear guidelines to health care providers.⁴²⁰ However, Kenyan law requires medical practitioners to render treatment with reasonable care and skill, and with the informed consent of the person undergoing the services.

The Penal Code provides that any person who renders medical or surgical treatment “in a manner so rash or negligent as to endanger human life or to be likely to cause harm to any other person” is guilty of an offence.⁴²¹ In the event that a medical practitioner performing a medical or surgical procedure does not use reasonable care and skill, that practitioner “shall be deemed to have caused any consequences which adversely affect the life or health of any person by reason of any omission to observe or perform that duty.”⁴²² A patient who suffers injury due to the negligence of a medical practitioner may be able to bring a legal claim against the practitioner under tort principles of common law.⁴²³

The requirement of informed consent is also an established principle of the English common law, which is applicable in Kenyan courts. To constitute valid consent, the person undergoing medical treatment must know the risks involved and willingly consent to undertake those risks.⁴²⁴ By consenting to the procedure, the patient consents to the risks inherent in the procedure, but does not consent to negligence on the part of the surgeon.⁴²⁵ Medical procedures that are performed without a client's consent may constitute an actionable tort of “trespass” to the patient's body.⁴²⁶

Poor regulation of health care in Kenya is enabling rights violations in public and private health care facilities to continue.

However, as a 2004 study by the Kenya Institute for Public Policy Research and Analysis (KIPPRA) explains, “Tort law is not well developed for medical cases. Given that tort law is created through judges (common law), there are very few precedents in Kenya for medical malpractice and negligence to strengthen our tort laws.”⁴²⁷ The study further notes that “[a]lthough medical ethics are supposed to play a very big role in promoting quality health care, lack of appropriate malpractice laws may compromise health care services.”⁴²⁸ Moreover, the existing laws are poorly enforced, leading to a void in effective channels for legal redress of rights violations in health care facilities.⁴²⁹

Regulatory Framework

Poor regulation of the health care industry in Kenya is enabling the rights violations in public and private health care facilities to continue without accountability or redress. The 2004 KIPPRA analysis notes:

*The laws governing medical councils and boards show that these bodies have failed to use the laws to establish their monopoly for regulation of medical care. This has left the consumers of health services unprotected. According to [a 1998 Institute of Economic Affairs study on Kenya], the prevailing legal regime on health care is largely inadequate and inefficient. On provision of services, there are no laws to protect patients against negligent health care staff, including doctors. The physicians are not legally required to update their skills with a view to providing quality services. Weak enforcement and monitoring in the health system is evident.*⁴³⁰

It is imperative that the government strengthen the regulatory framework of the health care system to address these weaknesses.

Governmental bodies

The Ministry of Health is the main public provider of health services in Kenya. Its functions include formulating and implementing national health policy, organizing and administering central health services, training health personnel, maintaining medical and health standards, and ensuring internal health regulations.⁴³¹ Meanwhile, Kenya's Ministry of Local Government is charged with overseeing local authorities, such as city and municipal councils, that provide health services.⁴³² Pumwani Maternity Hospital (PMH) falls under the authority of Nairobi City Council, which is supervised by the Ministry of Local Government.

The Ministry of Health has established several statutory bodies to assist with the regulation of the medical profession, including the Medical Practitioners and Dentists' Board (Medical Board), the Nursing Council of Kenya (Nursing Council), and the Clinical Officers Council (Clinical Council). These are the only regulatory bodies in the Kenyan health sector,⁴³³ and they have strong governmental representation.⁴³⁴ Although the Public Health Act provides for the establishment of a Central Board of Public Health to advise the Ministry of Health on all matters affecting public health,⁴³⁵ this Board has never been constituted.⁴³⁶

The Medical Board, which was established under the Medical Practitioners and Dentists Act, registers and licenses public and private medical practitioners who are “fit and proper” and “of good moral character.”⁴³⁷ The Board is also empowered to conduct disciplinary proceedings against and to cancel the registration or license of a practitioner who engages in “infamous or disgraceful conduct in a professional respect.”⁴³⁸

The functions of the Nursing Council, established under the Nurses Act, include regulating the training and standard of conduct of nurses and “tak[ing] such disciplinary or appropriate measures as may be necessary to maintain proper standard[s] of nursing care in health institutions.”⁴³⁹ The council also handles the registration and licensing of nurses, midwives, community health nurses, psychiatric nurses, and paediatric nurses—all of whom must meet certain requirements of “good character” and training.⁴⁴⁰

Similarly, the Clinical Council, which was established under the Clinical Officers (Training, Registration and Licensing) Act, is responsible for registering, licensing, disciplining, and improving standards for clinical officers in both the public and private sectors.⁴⁴¹ All clinical officers going into private practice have to be licensed; those working in public practice need only register with the council.

Non-governmental bodies

Kenya Medical Association

The Kenya Medical Association (KMA), a voluntary membership organization open to all medical and dental practitioners registered in Kenya, also plays a role in regulating the medical profession. The KMA currently has over 1200 members.⁴⁴² Its main objectives include “promoting the practice of medicine in Kenya; upholding high standards of medical ethics and conduct; advis[ing] the Government and the general public on matters related to health; fighting for the welfare of doctors; and support[ing] continuing medical education through its periodic publications, seminars and scientific conferences.”⁴⁴³

Religious Associations

Faith-based organizations, such as the Catholic Secretariat and the Christian Health Association of Kenya (CHAK), own more than two-thirds of private hospitals, 86.6% of private health centres, and 42% of other private facilities—making the mission sector the largest non-government provider of curative health care.⁴⁴⁴ These associations can therefore play an important role in regulating health services. However, they operate as independent entities. The government has not provided financial support to the Catholic Secretariat or CHAK for over a decade.⁴⁴⁵

The Catholic Secretariat oversees 45 hospitals, 94 health centres, 281 dispensaries, and 46 community-based programs in Kenya.⁴⁴⁶ These facilities provide services for over four million outpatients, 200,000 inpatients, and 43,000 deliveries every year.⁴⁴⁷ “We assure standards set by the Ministry of Health are kept,” said Dr. Margaret Ogola, National Executive Secretary of the Catholic Secretariat, explaining that the Secretariat conducts quality-control visits to its facilities and assists them in accessing government guidelines. “Our facilities are scattered so we are their voice and we are also the voice of the government or others who want to approach them with projects.”⁴⁴⁸ Dr. Ogola complained, however, that the government continuously “grabs” health workers that the Catholic Secretariat has trained, because it can afford to pay them more. She also noted that most of the patient complaints they receive concern user fees, which many people cannot afford.

CHAK’s membership consists of 24 hospitals, 45 health centres, 311 dispensaries, and 55 community-based health programs.⁴⁴⁹ Joseph Oyongo, the association’s Quality Assurance Officer, also complained of a lack of funding and problems with the government poaching experienced medical staff from CHAK facilities by offering better pay.⁴⁵⁰

The Expansion of Private Facilities in the Health Care Sector

The tremendous growth in private facilities over the past two decades has been attributed largely to the lack of adequate public health care services.⁴⁵¹ The government's introduction of user fees was accompanied by a move "to create a conducive environment for greater private sector involvement in health care," which has led to "a two-tier health system in which some people are served by government facilities and others by the private sector."⁴⁵² While, as described above, private facilities are generally viewed as providing more efficient and higher quality service,⁴⁵³ the dramatic growth of the private health sector in Kenya is not without problems.

One key concern is the government turning over a large part of the provision of a "public good"—health—to the private sector. In doing so, it abdicates to some degree its responsibility to improve a deeply troubled public sector. Those who would have the political clout to complain about and remedy the state of the public health sector can now bypass the problem by accessing higher-quality private services by paying higher fees. Furthermore, a 2004 analysis by KIPPRA observes, "The level and quality of services obtainable from these providers are as varied as the providers themselves," because "these private facilities thrive in an unregulated environment."⁴⁵⁴

Policy analysts have noted that "when a government allows the private sector to provide goods and services, it may also want to influence private sector behaviour."⁴⁵⁵ This is particularly important in a realm like health care, where controls of standards and quality are critical to ensuring the safety and wellbeing of the Kenyan people. As the 2004 KIPRA analysis states, "Regulations are required to ensure that quality standards are met, that financial fraud and other abuses do not take place, and that those entitled to health care are not denied the services."⁴⁵⁶

In its National Development Plan (2002-2008), the Kenyan government recognized the need to regulate the activities of private health care providers.⁴⁵⁷ Unfortunately, development and enforcement of regulations have been weak, leaving consumers of health services largely unprotected.⁴⁵⁸ Moreover, the lack of governmental oversight in private facilities makes it difficult to seek remedies when violations occur in the process of using what is ultimately a "public good".

Government policies that allow consultant physicians to work in private practice alongside their government duties are also a cause for concern: "[I]t is likely that the public sector does not get the full output of these consultants. Other consultants admit their private patients to government facilities and never pay the facilities for the services rendered."⁴⁵⁹ FIDA Kenya/CRR witnessed some of these issues in the course of conducting research. For example, top medical officials at a government facility gave us their private practice cards when we met with them, although it was clear that the visit related to their official public function. One doctor carefully explained where his private practice was located even though we were not there to seek his medical services.

Complaint Mechanisms

Women who suffer rights violations in health care facilities in Kenya have very limited avenues of recourse.

The Kenyan government has an obligation to provide accessible, affordable, and quality health services, and to ensure that patients can seek redress when their rights are violated in this context. Thus, it is essential to establish formalized internal complaint mechanisms in both public and private health facilities, as well as external mechanisms that enforce ethical and professional standards of care. FIDA Kenya/CRR interviews with providers, patients, and regulatory bodies revealed that women who suffer rights violations in health care facilities in Kenya have very limited avenues of recourse.

Shortcomings in external complaint mechanisms

Kenya Medical Association

The KMA receives complaints about medical providers. “The most frequent kinds of complaints are about delayed treatment and inappropriate attention,” said the current chairperson of the KMA, Dr. Stephen Ochiel, adding that other patient grievances commonly relate to payment issues, misrepresentation of facts, cheating, lying, and sexual offences (e.g., “if a doctor mishandles a female patient”).⁴⁶⁰

The KMA refers such complaints to the Medical Board. “We make sure they are channelled to the right people,” explained Dr. Ochiel, noting however that the KMA aims to protect not only the public good, but also its own membership. “If there’s a complaint about a member, we make sure they get a fair hearing.” KMA Program Officer Rose Kioko further pointed out that “KMA officials are part of the Board so it’s a complementary role. Complaints referred [by the KMA] to the Board may still be handled by a KMA member.”⁴⁶¹ However, the KMA’s regulatory role is a limited one, because it can only enforce its rules among its members—and registration with the KMA is not mandatory for medical practitioners in Kenya.⁴⁶²

The Medical Practitioners and Dentists’ Board

Despite the low number of cases that appear before the tribunal, the Medical Board takes an average of one year to resolve a case.

The Medical Board oversees complaints against medical providers in both private and public facilities.⁴⁶³ The Medical Board’s Code of Professional Conduct and Discipline states that “the Board shall always act in such a manner as to protect the public by ensuring that medical practitioners and dentists are properly qualified, that they perform their services to patients with skill and diligence and that they observe at all times high moral and ethical standards.”⁴⁶⁴ However, Medical Board officials stated in an interview that their primary aim is to prevent unregistered and unqualified individuals from providing health services.⁴⁶⁵

The Medical Board may receive patient complaints through medical facilities, through the KMA, or directly from aggrieved individuals.⁴⁶⁶ A Preliminary Inquiry Committee, which consists of seven members, is responsible for receiving and reviewing complaints to determine whether the Medical Board should hold a disciplinary inquiry.⁴⁶⁷ On average, this process takes approximately six months.⁴⁶⁸ If a complaint is deemed meritorious, it is referred to the Medical Board’s tribunal and the matter proceeds to a hearing.⁴⁶⁹ Each party is given an opportunity to present its case, with or without legal representation, and the tribunal may administer oaths, call witnesses, or require the production of books and documents.⁴⁷⁰ The cost of filing a complaint is Kshs. 1000 (approximately \$14 US), with possible additional costs for legal representation at the tribunal stage.⁴⁷¹

The Preliminary Inquiry Committee is currently assessing about 300 complaints, although the extent to which they are being seriously considered is questionable.⁴⁷² Stella Mwihaki, the Legal Adviser to the Medical Board, stated, “Only about 10% of the cases are legitimate, the rest are mostly misunderstandings.”⁴⁷³ Mwihaki further noted that only 4% of complaints pass the initial screening stage, and there are currently only 10 cases being heard by the tribunal.⁴⁷⁴

Despite the low number of cases that appear before the tribunal, the Medical Board takes an average of one year to resolve a case.⁴⁷⁵ The KMA's Dr. Ochiel described this as a "very lengthy" process that "tests patience and tolerance."⁴⁷⁶ The delays stem in part from the fact that the Medical Board members are not full-time employees, but rather, medical and legal service providers who fulfil their Board obligations on a part-time basis.⁴⁷⁷ So, for example, there were only three hearings scheduled to be held before the tribunal in the month of June.

The Medical Board's decisions are final and there is no internal appeals process. A party "aggrieved" by a decision has 30 days to file an appeal to the Kenyan High Court, which may "annul or vary the decision as it thinks fit."⁴⁷⁸ This short time frame makes it difficult for many complainants to secure the financial resources and legal representation necessary to further pursue their case. The high legal costs and additional delays of judicial adjudication are also substantial deterrents. On appeal, the decision of the Medical Board is subject to judicial review—the Court does not determine whether the tribunal's decision is right or wrong, but rather, whether the process used in reaching the decision was just and in accordance with the law.⁴⁷⁹ In the last two years, only one appeal has been filed, and the Court found in favour of the Board.⁴⁸⁰

The small number of complaints that the Medical Board accepts for hearing suggests that its complaints procedure acts as a filter to protect medical providers, rather than an open forum through which to promote accountability, transparency, and the right to health. A 2004 KIPPRAs analysis notes:

*Health laws do not seem to be designed to protect the patient from negligent doctors or those whose skills have atrophied. Although malpractices such as caesarean births designed to charge a patient more money, poor surgical operations resulting in complications or death, wrong prescriptions, etc. are regularly reported, the Medical Practitioners and Dentists Board has not taken necessary disciplinary measures in most cases.*⁴⁸¹

In fact, the Medical Board recently decided that Josephine, the woman who was abused during delivery and subjected to forcible genital mutilation at a private facility in 2005, did not have sufficient grounds for a hearing before the Board—even though a Nairobi Women's Hospital report and the police's P-3 form confirmed that she had been mutilated.⁴⁸²

The Medical Board's apparent reluctance to discipline practitioners was reinforced by the legal adviser's comment that they are attempting to "curb complaints" by introducing a consent form for patients to sign before undergoing any medical procedure.⁴⁸³ "This deters complaints because once you sign then you can't say you didn't know what was happening," she stated.⁴⁸⁴ The legal adviser added that the Medical Board employs a "public relations person" whose task is to educate people about their rights, although she did not indicate whether this individual is taking measures to ensure that medical practitioners provide patients with complete information before asking them to sign the consent forms.⁴⁸⁵

The Medical Practitioners and Dentists Act requires all members of the Medical Board to be medical and dental practitioners, thereby enabling the profession to be largely self-regulated.⁴⁸⁶ This leads to the danger of regulatory capture, which the 2004 KIPPRAs paper explains as follows:

[T]here are very real issues of effectiveness and transparency in self-regulation because a close relationship between the regulatory body and the regulatee

*may jeopardize the implementation of regulations, as the regulator may be sympathetic towards or easily manipulated by the regulators. . . . Being peers, medical practitioners may not be ready to take action, in order to protect the reputation of the profession. This may encourage malpractice and negligence in the medical profession.*⁴⁸⁷

The paper notes that “the Board has not publicized any cases of malpractice for fear of damaging the reputation of the profession.”⁴⁸⁸

Nursing Council of Kenya

The disciplinary board of the Nursing Council accepts complaints about the conduct of nurses from members of the public, nurses’ supervisors, or even press reports.⁴⁸⁹ According to the Nursing Council’s Code of Ethics and Professional Conduct, nurses must “respect and promote the autonomy of clients,” “value and advocate for the dignity” of patients, and “apply and promote principles of equity and fairness to assist clients.”⁴⁹⁰ In its list of offences, the code specifically prohibits “failure to observe patients as required” and “[a] ssault, abuse etc. of patients. . . . or threat thereof.”⁴⁹¹ According to the Registrar of the Nursing Council, Elizabeth Oywer, “A common charge is professional negligence. People feel if they go to the hospital, it must go well.”⁴⁹²

Elaborating on the Nursing Council’s disciplinary process, Oywer said:

*We act on press releases. We computerize our data and we are able to detect anomalies. We investigate, we employ services of other departments. We convene a disciplinary committee. We draw a charge sheet. The AG [attorney general] gives a legal adviser to advise. . . . We use the health authorities in the area to help out.*⁴⁹³

The disciplinary committee of the Nursing Council generally requests the medical provisional officer or local authority, depending on where the alleged violation occurred, to conduct an investigation.⁴⁹⁴ Oywer added that the Nursing Council also arranges visits to health care institutions to ensure that it “approves the right places,” that established standards are being maintained in those approved facilities, and that policies are “changing with the times.”⁴⁹⁵

The Nursing Council takes between three months and two years to resolve cases.⁴⁹⁶ According to Oywer, the process tends to be on the longer side because the disciplinary committee meets only quarterly, and it must then forward its report for approval to the council, which also meets only quarterly.⁴⁹⁷ The Nursing Council is empowered to take disciplinary action against nurses, which may include a warning, suspension, or cancellation of a nurse’s license and registration.⁴⁹⁸ In addition, the Nursing Council may impose penalties, such as retraining or additional training, supervision, or performance assessment and appraisal.⁴⁹⁹ Aggrieved parties have the right to appeal the Nursing Council’s decision to the High Court within 28 days—“and in any such appeal the High Court may annul or vary the decision as it thinks fit.”⁵⁰⁰ However, according to Oywer, no decision of the Nursing Council has ever been appealed.⁵⁰¹

All members of the Nursing Council are nurses⁵⁰² and the disciplinary process is purely internal; there is no role for outside actors, including the complainant and the accused nurse.⁵⁰³ The latter is required to submit a written statement and may attend the hearing

“Patients’ rights are not a well-developed issue. There is no component of patients’ rights in medical training.”

with a legal representative, but will not be called as a witness.⁵⁰⁴ Complainants incur no filing costs (other than the personal costs associated with submitting the complaint), and they are allowed, but not required, to attend the hearing with a legal representative.⁵⁰⁵

Clinical Officers Council

Clinical officers train in medicine for three years, usually in a teaching hospital, and then do a one year internship before they qualify for registration.⁵⁰⁶ Unlike doctors, the training for clinical officers is conducted at the diploma level and lasts for four years, as opposed to six years.⁵⁰⁷ After completing their initial training, clinical officers can pursue an 18-month higher diploma to specialize in a particular medical field.⁵⁰⁸ The first group of clinical officers specializing in reproductive health graduated last year.⁵⁰⁹ These clinical officers are equipped to provide a range of reproductive health care, including family planning services, antenatal care, treatment for sexual transmitted infections, and caesarean sections.⁵¹⁰

Clinical officers are required to observe the same code of conduct as medical practitioners.⁵¹¹ However, the Clinical Council has its own disciplinary committee, which can receive complaints about clinical officers from health facilities or individual complainants. Once a complaint is filed, the Clinical Council holds an inquiry and can call witnesses, but the complainant no longer has a role in the proceedings.⁵¹² If a clinical officer is found guilty, the council may cancel his or her license and registration.⁵¹³ The Clinical Council’s decision can be appealed to the High Court within 30 days.⁵¹⁴

Although clinical officers are responsible for much of the care provided in private facilities, they lack adequate regulatory oversight. An officer of the Clinical Council recently noted that its disciplinary committee does not receive many complaints.⁵¹⁵ A visit to the Clinical Council in February 2007 revealed that it is very inaccessible—it is located on the outskirts of town, it is extremely difficult to find, and the road leading to it is barely passable by vehicles.

Nairobi City Council

PMH falls under the supervision of Nairobi City Council, which is part of the Ministry of Local Government. Dr. Daniel Nguku, the Medical Officer of Health at Nairobi City Council, said a person with a complaint should first seek redress within the facility that provided the medical service.⁵¹⁶ If that does not lead to any results, he suggested the complainant should go to the City Council’s Medical Officer of Health or, if it is serious enough, to the Ministry of Health. However, it was very difficult to obtain specific information about how to file complaints or how such complaints are handled by City Council.

Lack of formalized internal complaint mechanisms

Kenyan law does not require health institutions to establish formal internal complaint mechanisms. The chairman of the Medical Board confirmed that the establishment of a complaint mechanism is not a prerequisite for the registration of a medical facility, and that failure to do so does not result in any penalties.⁵¹⁷ “Patients’ rights are not a well-developed issue,” said Dr. John Nyamu, a leading obstetrician-gynaecologist based in

Nairobi. “There are no communications from the government to private practitioners. There are no guidelines. Even the Board just registers [doctors] and does not give guidelines. Especially for the ones they register, they should have workshops. There is no component of patients’ rights in medical training.”⁵¹⁸

Dr. Shadrack Ojwang, an obstetrician-gynaecologist at Kenyatta National Hospital (KNH), said patients theoretically have “overwhelming rights” to complain to a nurse or even to a government minister about the health services they received.⁵¹⁹ “But if you go to the ground, it might not be what I’m saying,” he acknowledged. “The chief nurse might say, ‘I’m busy, come tomorrow,’ even if she’s free.”

In a first-person *Nation* article, Gilbert Odira, whose wife died during childbirth at PMH in 2000, expressed his frustration with the absence of formalized complaint mechanisms.⁵²⁰ Odira spent four years trying to ascertain how his wife had died and the fate of his newborn infant: “Nobody wanted to talk about this issue and everyone was keen to pass the buck.” [See Structural Barriers section.]

Large hospitals often have suggestion boxes, and patients can also make verbal complaints to staff members, which are then supposed to be addressed by the relevant department head.⁵²¹ However, as the KMA’s Dr. Ochiel noted, “this is an informal process—not formalized.”⁵²² Other leading doctors added that medical and administrative staff members are not given any guidance on how to address complaints. “This is an area where there are no official, clearly put guidelines that spell out how staff and patients are to respond,” said Dr. Karanja, an obstetrician-gynaecologist and professor at the University of Nairobi.⁵²³ He also noted that he does not know what happens to comments placed in the complaint boxes at health facilities because he has never seen anyone collecting them.⁵²⁴ Dr. Helton Jilo, the Director of Maternal Health in the Ministry of Health’s Division of Reproductive Health confirmed: “There is no written procedure. Most [complaints] are handled locally.”⁵²⁵ Although the Ministry of Health has reportedly recently enacted new guidelines on handling complaints, they had not yet been distributed as of May 2007.

Faith-based associations also have failed to implement formalized complaint procedures in their member facilities. CHAK, according to its Quality Assurance Officer, does not handle patient complaints and does not require its member facilities to establish any formal complaint mechanisms, although it encourages them to have suggestion boxes.⁵²⁶ “If patients are not satisfied, they can come to us,” he said. “We have CHAK employees on those hospital boards who will address the issue, or we will take it to the Ministry of Health working group.” The Catholic Secretariat’s facilities have suggestion boxes, but Executive Secretary Dr. Ogola said, “Complaints are a new thing, not very well organized.”⁵²⁷

“The more women who get the complaints in the right ear, the better services will become.”

Effective complaint mechanisms can provide redress to individual victims of rights violations and improve health care by ensuring provider accountability. As a leading midwife noted, “The more women who get the complaints in the right ear, the better services will become.”⁵²⁸ Moreover, complaint mechanisms can serve as tools for measuring and improving quality of care. By studying the nature and frequency of complaints, providers and government officials can identify and address weaknesses and negative trends.

For example, Family Health Options Kenya (FHOK) has implemented a quality-assessment procedure to help improve its services. One out of every 15 patients is selected

for an exit interview, in which they are asked questions to gauge satisfaction with the services received.⁵²⁹ The FHOK facility also has a suggestion box with a label encouraging patients to “tell us” if they did not like the services provided. “Our clients educate us so our changes come from client suggestions,” said an FHOK provider, explaining that many of the facility’s services have been introduced in response to patients’ comments. “Our client forms are detailed; our clients are empowered.”⁵³⁰

FHOK’s procedure can serve as a helpful model for other health care providers and facilities. “We need a formal structure which will investigate and establish process, [and] can record and see a pattern so society can prevent it,” stated the KMA’s Dr. Ochiel. “We need a system to establish why and how. Most causes [of complaints] are preventable.”⁵³¹ According to Dr. Ochiel, although some hospital departments hold meetings to discuss mortalities and near-miss cases, there are many unacknowledged patients who do not meet those criteria but have nonetheless suffered.

“Patients don’t complain because of nothing wrong,” recognized KNH’s Dr. Ojwang. “It is always because they were abused by a nurse or mistreated or have psychological problems. Patients are always right until proven wrong.”⁵³² Dr. Ochiel asserted, “Since the majority of people don’t complain, there should be a system that would bring out the silent majority.”⁵³³

Obstacles to Seeking Redress

Lack of information

A major obstacle to ensuring accountability is the lack of public awareness about patient rights and the mechanisms that do exist to redress violations. Dr. Karanja called for public education on rights, so that people can demand what they are due. “Many times, people don’t even know their rights are being violated,” he commented.⁵³⁴ Dr. Nyamu concurred that patients are unaware of their rights. “They do not have an advocate,” he said. “They do not have the information. It is difficult for clients to be informed. When they come [to seek medical services] they come for specific problems, and they have no time for counselling.”⁵³⁵ Prudence, who works in the maternity ward of a district hospital in Kisumu, confirmed that “mamas don’t know their rights,” and added that nurses prefer it that way. “The nurses also don’t like people who seem to know,” she said. “The thing is to just keep quiet, finish your business, be patient, and then leave. Even if they tell you wrong things, just agree.”⁵³⁶

“I felt angry and desperate. . . . I didn’t know where to go to complain. If I had, I would have complained.”

This holds particularly true for patients in public facilities. “People who go to private hospitals complain much more because of the nature of people who go there—they know their rights; they are paying for the service,” observed Dr. Ochiel. In public hospitals, on the other hand, “the people treating you act as if you are seeking a favour” and patients fear being thrown out or not treated if they voice any complaints.⁵³⁷ “When health care workers think that they are doing a favour [by providing medical services] or that patients are seeking a favour, you have an imbalance of power,” Dr. Ochiel explained.

Even women who knew that their rights had been violated expressed feeling unable to voice their grievances because they did not know how or where to do so. Carole, who

sought contraception at Park Road, a private clinic, was given a form of contraception she did not want, which led to negative side effects.⁵³⁸ When she returned to try, yet again, to change her contraception, she was told that she had to wait several months before switching, and was again made to pay a consultation fee. “I was not happy,” Carole said, adding however, “I could not complain and I just agreed. If I knew where to complain, I would have gone to complain.”

A woman who participated in an April 2007 focus group discussion in Kisumu narrated the story of her friend, who was mistreated for a miscarriage at KNH:

[S]he was told to go home after the cleaning. After one week, she still felt pregnant and had pain in the stomach. She went to the gynaecologist and she was told she was not cleaned properly. She was admitted [again] at Kenyatta. She had a lot of pain, she says Kenyatta was not good to her. They didn't advise her properly. . . . She didn't complain because to whom would she have done so?⁵³⁹

***“You will be told that
‘if you know more
than I do, then why
did you come here?’
[But] it’s good for a
patient to know what
she is suffering from.”***

Similarly, women who had negative experiences with health facilities during delivery explained that they wanted to complain, but did not know how to do so. Betty, who had to beg the attendants to give her anaesthesia for post-delivery stitching after giving birth, said: “I felt angry and desperate. . . . I didn’t know where to go to complain. If I had, I would have complained.”⁵⁴⁰ Similarly, a woman who delivered at PMH in 1993 said, “I would have complained about the neglect and rudeness—the abuse was too much.”⁵⁴¹ This sentiment was echoed by another woman who was mistreated during her 1997 delivery at PMH: “I would have complained about Pumwani; they were very rude.”⁵⁴²

A woman who participated in an April 2007 focus group discussion in Kisumu declared, “We need to empower women to give them the basics. Women suffer because of ignorance. We need to have forums to give them information on where to report. . . . We need forums at the church or community levels to create awareness.”⁵⁴³ This participant, who suffered rights violations at a health care facility over a decade ago, added, “Like in my case, since 1993 I have never reported [what happened to me]. It is only today that I have managed to share my experience. It is just lack of knowledge.”

Other obstacles to complaining about rights violations include displaced files and the inability of patients to gather information because medical providers often do not wear identity tags, do not identify themselves to the patients, and do not explain the procedures they are conducting. Regina wanted to bring charges against a doctor for leaving a rusted surgical blade inside her uterus, which led to years of excruciating pain and devastating health consequences.⁵⁴⁴ “I wanted to get my file because I wanted to sue him, but my file is not there,” she said. “If given an opportunity I would complain. I can’t do any work and I used a lot of money—to date, I still go for check-ups. Imagine, [since] 1993 I can’t bend It really affected my life. I get infections easily. . . . It’s a big scar. This cost me my marriage. Given a chance, I would sue him.”

Hostile responses

Patients reported getting negative responses when they tried to educate themselves about their medical condition and treatment. Jackline, who tested positive for HIV after her delivery—which she believes was due to the nurse’s use of contaminated scissors—felt

she had received insufficient information from the PMTCT (Preventing Mother-to-Child Transmission of HIV) counsellor. The medical staff rejected her attempts to get more information. “You can’t ask a question,” she observed. “The doctor is treating you but you can’t ask how or why you are given a drug. You will be told that ‘if you know more than I do, then why did you come here?’ [But] it’s good for a patient to know what she is suffering from.”⁵⁴⁵ In this context, it is difficult for patients to recognize or gather enough information to demonstrate a violation of their rights.

“Maybe this has happened to women and they just keep quiet. It was a bad experience in a hospital, where you’re supposed to get help—that’s why you go.”

Dr. Karanja further noted that patients are likely to “encounter harassment” if they complain about medical services.⁵⁴⁶ Based on her experience working in a maternity ward, Prudence concurred, saying: “You can complain . . . [you] are given the right, though the nurse will hate you.”⁵⁴⁷ She explained that patient grievances are raised at nurse meetings, and the nurses often harass those patients afterwards for having complained. “Later you see the nurses saying, ‘You are complaining we are beating you—are you children that we can beat you? And even if we beat you, it’s now over.’” Prudence added that if many patients raise complaints against a particular nurse, that nurse is replaced immediately—however, the nurse is simply “taken to another ward, and the problem goes to another ward.”

Another woman who participated in an April 2007 focus group discussion in Kisumu remarked, “Sometimes people don’t complain for fear of victimization. Maybe they should complain when they have left the hospitals. They should mark the nurses and go to the superintendent.”⁵⁴⁸ However, she echoed Prudence’s concern that “they just transfer the nurses [that patients complain about] to other hospitals.”⁵⁴⁹

Josephine, who was abused and mutilated during delivery at a private facility in 2005, stated that she did not know whether any of the men who violated her were doctors.⁵⁵⁰ She determined their names only by hearing them refer to each other. When Josephine returned to the facility to complain about her experience to a doctor, she described his response as follows:

He said, ‘Look, whatever the case has happened to you, it’s unfortunate. Now because we can’t line up these people in the labour wards for you to choose who did this to you—now you just go home, be happy, you have your child. Others don’t. If you speak these things out, you are the one who will be ashamed because now already it is done. . . .’ I tried to ask him, ‘Suppose it was your wife to whom he had done this, would you say like that?’ He just said, ‘Now there’s nothing I can do.’

When Josephine told the doctor about the verbal abuse she had endured during delivery, the doctor replied, “That’s the language they use in the labour ward.” Despite this indifferent response, Josephine decided to pursue a legal case to redress the violations she suffered, but has encountered many obstacles that have prevented her from obtaining restitution, as described in the text box below. “Maybe this has happened to women and they just keep quiet,” she said. “It was a bad experience in a hospital, where you’re supposed to get help—that’s why you go.”

Continued Obstacles Faced by Josephine⁵⁵¹

Following her assault and mutilation during her second delivery at St. Mary's Hospital in Langata in 2005, Josephine obtained an objective evaluation at Nairobi Women's Hospital, where the doctor issued a report confirming that female genital mutilation had been performed. However, Josephine was later called back to the same facility for a second examination, after which a different doctor denied the initial findings and issued a contradicting report. Josephine felt that this second doctor was protecting the practitioner who had mutilated her: "[It was] as if they cooperated in torturing me; it was as if he was hired for such a job."

Josephine also encountered unreasonable obstacles when pursuing the matter with the police. A police officer agreed to take Josephine to a police doctor to fill out the requisite P-3 form, but only if Josephine paid her bus fare. The police P-3 form confirmed that a clitoridectomy had been performed on Josephine, but the police refused to press criminal charges. "They said, 'Even if we take this forward, the papers will be thrown away—there is no case here,'" she recounted. The Penal Code, however, provides that rendering medical or surgical treatment to any person "in a manner so rash or negligent as to . . . be likely to cause harm to any other person," is a criminal offence.⁵⁵²

"If you can't help me, I'll just go home, what can I do—you're in power," Josephine recalled saying to the police officials. "If I took the law in my hands and went to the hospital and stabbed the man to death, you'd be very fast to take me to court and put the chains on me. But now I'm telling you exactly what happened to me. . . . If you can't help I have no choice. I can't take the law on my hands. I just have to go home."

The Medical Board also rejected Josephine's case for a hearing, as noted above, but did not provide a reason for this decision. Josephine is now pursuing other legal options for redress.

Trainings

A key component of quality health care services is ongoing training for service providers. However, although nurses must complete 20 hours of continuing education every three years in order to renew their licenses,⁵⁵³ there are no ongoing training requirements for doctors and clinical officers to expand and update their skills. As a 2004 KIPPRA paper notes:

*Medical knowledge of most practitioners may not be up-to-date due to lack of a legal requirement for continuous updating of medical knowledge and skills. With the challenge of emerging new diseases, a practitioner may easily become limited in application of new methods of diagnosis and treatment and continue using outdated medical technology, leading to errors.*⁵⁵⁴

The Medical Board oversees the training of medical providers only until they obtain their degrees and licenses to practice.⁵⁵⁵ Board officials contended that they are not responsible for formulating guidelines for medical providers or offering continued medical education trainings, because that falls under the mandate of the Ministry of Health.⁵⁵⁶ In contrast, the Nursing Council does regulate the training of nurses,⁵⁵⁷ although it could require more education on behaviour toward patients. As one hospital staff worker observed, "nurses are also ignorant" about patients' rights.⁵⁵⁸

The 2004 Kenya Service Provision Assessment Survey (2004 KSPAS) found that medical providers were lacking in knowledge not only about new methods, but also

about basic information critical to providing quality maternal health care. For example, only 6% of midwives interviewed for the survey could name all four categories of the signs of postpartum haemorrhage and only 12% of midwives were able to name all four expected interventions for postpartum haemorrhage.⁵⁵⁹ Guidelines for managing delivery complications were available in only 7% of delivery-service areas.⁵⁶⁰ Moreover, in fewer than one-third of facilities had the majority of providers received any structured training relating to delivery services during the past year.⁵⁶¹ And only 8% of providers had received routine training on labour care or on lifesaving skills.⁵⁶²

Only 8% of providers had received routine training on labour care or on lifesaving skills.

“People like us working in these areas need a lot of information and education,” said the head of Kasarani Maternity Hospital, Anne Mulinge, referring to the need for more information about service provision and staff management.⁵⁶³ Mulinge noted that this is particularly true for private practitioners, because the government prioritizes training its own medical providers first. Likewise, CHAK’s Joseph Oyongo called for religious associations to be included in the government’s reproductive health trainings—“the Ministry of Health is conducting them, but leaving us out,” he said.⁵⁶⁴ The Ministry of Health recently distributed a circular announcing that every training session should include two people from faith-based organizations, but Oyongo said this is not yet being implemented. The Ministry has also established a working group for faith-based organizations to provide input on public policy, but according to Oyongo, “grass roots implementation is a problem.” Mulinge emphasized, “It’s hard for private practitioners to know more. We want training—that’s what we cry for—so we can get the knowledge.”⁵⁶⁵

THE HUMAN RIGHTS IMPLICATIONS OF VIOLATIONS IN THE HEALTH CARE SYSTEM

The violations described in this report demonstrate that Kenya is not honouring its commitments to respect, protect, and fulfil rights.

The negligence and abuse documented in this report have more than just public health implications; they also constitute serious violations of human rights that are protected under national, regional, and international law. Fundamental human rights that the government of Kenya is obligated to guarantee include the rights to life and health; the rights to equality and non-discrimination; the right to be free from torture and cruel, inhuman, or degrading treatment; the right to dignity; the right to information; the right to privacy and family; and the right to redress. The violations described in this report demonstrate that Kenya is not honouring its domestic and global commitments to respect, protect, and fulfil these rights.

International and Regional Standards

Several regional treaties—the African Charter on Human and People’s Rights (African Charter),⁵⁶⁶ the African Charter on the Rights and Welfare of the Child (Children’s Charter),⁵⁶⁷ and the African Charter’s Protocol on the Rights of Women in Africa (Maputo Protocol)—provide important protections for the rights of women and girls in Kenya. The Kenyan government has ratified the African Charter and the Children’s Charter, and has signed but not yet ratified the Maputo Protocol.⁵⁶⁸ However, even by signing the Maputo Protocol, which offers the most explicit recognition and protection of reproductive rights in the African regional system, Kenya is obligated to refrain from acting in a way that “would defeat the object and purpose of the treaty,”⁵⁶⁹ which includes “the full realisation of the rights” recognized in the treaty.⁵⁷⁰

Kenya has also confirmed its commitment to upholding international human rights standards by ratifying several major global treaties, including the International Covenant on Civil and Political Rights (Civil and Political Rights Covenant),⁵⁷¹ the International Covenant on Economic, Social and Cultural Rights (Economic, Social and Cultural Rights Covenant),⁵⁷² the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),⁵⁷³ the Convention on the Rights of the Child (Children’s Rights Convention),⁵⁷⁴ and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture).⁵⁷⁵ A state that ratifies or accedes to an international convention “establishes on the international plane its consent to be bound by a treaty.”⁵⁷⁶ The government of Kenya is therefore obligated under international law to protect the rights guaranteed by these instruments. However, with the exception of the Children’s Rights Convention, Kenya has failed to domesticate the provisions of these treaties through national-level laws. Furthermore, Kenya has not yet ratified the Optional Protocols to the Civil and Political Rights Covenant, CEDAW, or the Convention against Torture—all of which would permit individuals to submit rights-violation claims directly to the relevant monitoring body, as established by each treaty, after exhausting domestic remedies.

The legally binding provisions of the major human rights conventions are complemented by politically binding international consensus documents that support a globally

recognized reproductive rights framework. These include the outcome documents of international conferences such as the United Nations International Conference on Population and Development (ICPD Conference) and the United Nations Fourth World Conference on Women (Beijing Conference)—both of which Kenya participated in.⁵⁷⁷ Moreover, Kenya has committed itself to attaining the United Nations Millennium Development Goals, which prioritize promoting gender equality, reducing maternal mortality, and combating HIV/AIDS as key development issues for the new millennium.⁵⁷⁸

International and regional conventions repeatedly recognize the fundamental rights to life and to the highest attainable standard of health, and impose an obligation on states to enforce these rights.

Protected Rights

The government of Kenya is legally bound to respect, protect, and fulfil the following rights pursuant to the international and regional conventions that it has signed or ratified.

The rights to life and health

The abuse and negligence endured by women when giving birth in Kenyan health facilities, Kenya's restrictive abortion law, and the barriers to contraceptive access encountered by Kenyan women all constitute violations of the rights to life and health.

International and regional conventions repeatedly recognize the fundamental rights to life and to the highest attainable standard of health, and impose an obligation on states to enforce these rights.⁵⁷⁹

The African Charter, for example, states: "Every individual shall have the right to enjoy the best attainable standard of physical and mental health. States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."⁵⁸⁰ The Maputo Protocol specifically calls upon states to "ensure that the right to health of women, including sexual and reproductive health is respected and promoted."⁵⁸¹ In addition, the Kenyan constitution specifically protects the right to life.⁵⁸²

As indicated above, the right to health encompasses physical, mental, and sexual health.⁵⁸³ Expounding on governments' obligations in this context, the Committee on Economic, Social and Cultural Rights (ESCR Committee) has explained:

The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.⁵⁸⁴

The ESCR Committee further states that an essential component of the right to health is the availability, accessibility, acceptability, and quality of health facilities, goods and services.⁵⁸⁵

The rights to life and health are intrinsically linked to women's right to accessible, quality reproductive health care services—without which women may experience unsafe pregnancies, unsafe abortions, and high rates of maternal mortality and morbidity.

Recognizing the special health needs of women, the ICPD Programme of Action urged:

*States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health care programmes should provide the widest range of services without any form of coercion.*⁵⁸⁶

To this end, international and regional human rights standards require Kenya to eliminate discrimination and all other barriers that women face in accessing health care services.⁵⁸⁷ The Maputo Protocol calls upon states to provide adequate, affordable, and accessible health services to women and to establish and strengthen ante-natal, delivery, and post-natal health and nutritional services for women during pregnancy and while breast-feeding.⁵⁸⁸ Similarly, CEDAW requires states to “ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary,” and to empower women to “decide freely and responsibly on the number and spacing of their children, and to have access to the information, education and means to enable them to exercise these rights.”⁵⁸⁹ The CEDAW Committee has also emphasized the need for governments to monitor the quality of their nations’ health services⁵⁹⁰ and to make sure that such services are “delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.”⁵⁹¹ The Children’s Rights Convention also affirms the right to “necessary medical assistance and health care,” “appropriate pre-natal and post-natal health care for mothers,” and “family planning education and services.”⁵⁹²

The abuse and negligence that women endure when giving birth in Kenyan health facilities constitute egregious violations of the rights to life and health. [See Delivery section.] The widespread delays and neglect in providing medical services; lack of assistance before, during, and immediately following labour; rough and degrading treatment during examinations; physical and verbal abuse; lack of basic infrastructure and supplies; inability to handle complications; and delivery in unhygienic conditions endanger the health and lives of the women and their babies. Furthermore, the trauma of these negative experiences can discourage women from seeking reproductive health care services in the future, which has an ongoing, adverse long-term impact on their health and lives.

The barriers that women encounter when trying to access contraception also violate their right to health. [See Contraception section.] Delays and financial obstacles, misinformation about family planning, stockouts of preferred methods, lack of necessary equipment to insert family planning devices, and inability to access emergency contraception at many facilities lead to unwanted pregnancies, which can have negative and far-reaching consequences on women’s health and wellbeing. Furthermore, Kenya’s restrictive abortion law leads women with unwanted pregnancies to seek unsafe illegal abortions, which can result in serious illness, sterility, or death. [See Abortion section.]

The rights to equality and non-discrimination

The abuses that women encounter in health facilities constitute discrimination on the basis of gender, because only women require health care services for pregnancy and childbirth, and the rights violations have a disparate adverse effect on women’s health. Differences in health care services that women receive based on their ability to pay also violate the rights

to equality and non-discrimination, as does disparately harsh treatment of younger women.

The rights to equality and non-discrimination—regardless of gender, age, or financial resources—are bedrocks of human rights doctrine and fundamental principles of international and regional law.⁵⁹³ Every human right discussed in this section must be exercised without discrimination.⁵⁹⁴

The African Charter not only declares that all individuals are “equal before the law,” but also specifically requires states parties to “ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions.⁵⁹⁵ Similarly, the Maputo Protocol calls upon states to reform laws and practices that discriminate against women.⁵⁹⁶ On the national level, the Kenyan constitution also contains a provision that protects the right to be free from discrimination.⁵⁹⁷

International standards emphasize the need for equality in “access to health care services, including those related to family planning.”⁵⁹⁸ The right to health is subject to progressive realization and resource availability,⁵⁹⁹ but states must take “deliberate, concrete and targeted” steps towards the realization of this right, and some obligations are immediate and not subject to resource availability.⁶⁰⁰ The minimum core government obligations that the ESCR Committee has recognised include the duty to ensure reproductive, maternal (ante-natal as well as post-natal), and child health care.⁶⁰¹ Similarly, in its 2007 Concluding Observations, the Children’s Rights Committee recommended that the Kenyan government give all pregnant women health and social services free of charge.⁶⁰²

The rights to equality and non-discrimination are bedrocks of human rights doctrine.

With regard to economic access, the ESCR Committee has stated:

“Health facilities, goods and services must be affordable for all. Payment for health care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, *whether privately or publicly provided*, are affordable for all, including socially disadvantaged groups.”⁶⁰³ Thus, the governmental obligation to protect health includes taking measures to ensure that private health care facilities provide services that meet the state’s human rights obligations.⁶⁰⁴ Kenya must “ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services.”⁶⁰⁵

The abuses that women encounter during delivery in health facilities have a disparate adverse effect on women’s health. [See Delivery section.] This disparity is heightened by the amplified vulnerability of women who are pregnant or have recently given birth, as recognized in international human rights law by the provision for special protection of mothers during and for a reasonable period before and after childbirth.⁶⁰⁶ Abuses that take place around delivery thus prevent women “from accessing and benefiting from health care on a basis of equality.”⁶⁰⁷ Abuse motivated by or related to one’s gender also violates the rights to equality and non-discrimination, which means that international and regional equal-protection provisions require governments to enact and enforce laws protecting women’s physical safety and integrity.⁶⁰⁸ The increased neglect and abuse encountered by young women who deliver in health facilities constitutes added discrimination on the basis of age. The government is required to remedy all such discrimination in both the public and the private sectors.⁶⁰⁹

Any differences in health care services that women receive based on their ability to pay also violate the rights to equality and non-discrimination. [See Discrimination section.] Women delivering in public facilities reported enduring longer waits, poorer-quality services, a greater dearth of basic supplies, and inappropriately levied costs due to high rates of corruption—and they frequently stated that they would rather seek maternal health services in a private facility if they could afford to do so. User fees that prevent people from obtaining certain services, like reproductive health check-ups, and result in women being turned away from hospitals as they are about to give birth also violate the right to non-discrimination. The inconsistent and ineffective implementation of fee exemptions and the degrading and lengthy fee-waiver process have done little to remedy this inequality.

The right to be free from torture and cruel, inhuman, or degrading treatment

The verbal and physical abuse around delivery, inappropriate stitching practices, and detention in health facilities documented in this report all constitute serious violations of the right to be free from torture and cruel, inhuman, or degrading treatment.

The right to be free from torture and cruel, inhuman, or degrading treatment is not only specifically protected by several international and regional conventions that Kenya has ratified,⁶¹⁰ but is now arguably a facet of customary international law.⁶¹¹ The Kenyan Constitution also safeguards the right to protection from inhuman treatment.⁶¹² According to the African Charter, “All forms of exploitation and degradation . . . particularly . . . torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.”⁶¹³ Cruel, inhuman, and degrading treatment is not restricted to acts that cause physical pain; it also encompasses actions that result in mental suffering.⁶¹⁴ The Human Rights Committee has clearly stated that the protection against cruel, inhuman, and degrading treatment applies to medical institutions.⁶¹⁵

Verbal and physical abuse in health care facilities—especially during the particularly vulnerable periods before, during, and after childbirth—infringes upon women’s physical and psychological integrity, thus violating the right to be free from torture and cruel, inhuman, or degrading treatment.⁶¹⁶ Similarly, the extended delays that women endure before receiving medical attention during labour or while waiting for stitches after delivery—as well as being stitched without anaesthesia—cause women a great deal of physical and emotional suffering. [See Delivery section.] The practice of detaining women in medical facilities because they cannot pay their medical bills is also a violation of the right to be free from torture and cruel, inhuman, or degrading treatment. [See Detention inset.]

Detention in health facilities, abusive treatment, and difficulties seeking redress for rights violations all infringe upon the right to dignity.

The right to dignity

Detention in health facilities, abusive treatment, and difficulties seeking redress for rights violations all infringe upon the right to dignity.

The right to dignity is recognized and protected by international and regional instruments.⁶¹⁷ The African Charter states, “Every individual shall have the right to the respect of the dignity inherent in a human being.”⁶¹⁸ The Maputo Protocol calls upon states to “adopt and implement appropriate measures to ensure the protection of

every woman's right to respect for her dignity."⁶¹⁹ The Children's Charter makes several references to the governmental obligation to protect dignity.⁶²⁰

The abusive treatment that women face during delivery in Kenyan health facilities and the practice of detaining patients who are unable to pay their medical bills violate the right to dignity. [See Delivery and Discrimination sections.] Breaches of this right are also evident in the obstacles that people report encountering when seeking redress for rights violations in hospitals or in their quests for information about loved ones who died during delivery. [See Structural Barriers section.]

The right to information

Insufficient family planning information, failure to follow informed-consent procedures, and lack of transparent record-keeping are all examples of violations of the right to information.

The right to information about health is a critical component of reproductive rights; failure to provide such information can threaten the rights to life, health, and autonomy in decision making, and all other reproductive rights of women and girls. The African Charter recognizes that every individual has "the right to receive information" and "the right to education."⁶²¹ The Maputo Protocol specifically includes "the right to have family planning education" and further obligates governments to "provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas."⁶²²

International treaties and consensus documents also strongly endorse the right to full and accurate information about one's health, particularly in matters of family planning.⁶²³ The ICPD Programme of Action calls for ensuring "that comprehensive and factual information . . . [is] accessible, affordable, acceptable and convenient to all users."⁶²⁴ The ESCR Committee "interprets the right to health . . . as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to . . . health-related education and information, including on sexual and reproductive health."⁶²⁵ Information accessibility consists of "the right to seek, receive and impart information and ideas concerning health issues."⁶²⁶ CEDAW requires states to take measures to guarantee access to "information to help to ensure the health and well-being of families, including information and advice on family planning"; to protect rural women's "access to adequate health care facilities, including information, counselling and services in family planning"; and to ensure access to the "information, education and means" that would enable women to exercise their right to decide the number and spacing of their children.⁶²⁷ Similarly, the Children's Rights Convention requires states to "develop preventive health care, guidance for parents and family planning education and services."⁶²⁸

Moreover, international law recognizes that the right to information includes an individual's right to access her medical files—which is essential to autonomy and informed decision-making.⁶²⁹ As the World Health Organization Declaration on Patients' Rights states, "Patients have the right of access to their medical files and technical records and to any other files and records pertaining to their diagnosis, treatment and care and to receive a copy of their own files and records or parts thereof."⁶³⁰

Kenyan medical facilities violate this right to information in myriad ways—from the lack of transparent record-keeping, to the failure of staff members to wear badges or clearly identify themselves, to the inability of patients to obtain clear information about their treatment. [See Structural Barriers and Delivery sections.] The fact that these facilities often do not obtain informed consent for medical procedures, such as tubal ligation, is also a serious rights violation. Furthermore, failing to provide comprehensive, accurate information to women seeking family planning services and delivery care violates the right to information. [See Delivery and Contraception sections.]

The right to privacy and family

The right to privacy also finds support in both international and regional law.⁶³¹ The Civil and Political Rights Covenant states, “No one shall be subjected to arbitrary or unlawful interference with his privacy, family, [or] home,” and recognizes the family as “the natural and fundamental group unit of society [that] is entitled to protection by society and the State.”⁶³² Similarly, the Economic, Social and Cultural Rights Covenant recognizes that “[t]he widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit [of] society,” and that, accordingly, “[s]pecial protection should be accorded to mothers during a reasonable period before and after childbirth.”⁶³³

The widest possible protection and assistance should be accorded to the family.

The Human Rights Committee has also recognized a state’s obligation to protect the right of privacy against interferences from both public and private entities, including private hospitals, stating:

*[T]his right is required to be guaranteed against all such interferences and attacks whether they emanate from State authorities or from natural or legal persons. The obligations imposed by this article require the State to adopt legislative and other measures to give effect to the prohibition against such interferences and attacks as well as to the protection of this right.*⁶³⁴

The right not to be subjected to unlawful interference with one’s privacy also supports the right to access files concerning one’s medical treatment and status. In addition, informed consent is a key component of the right to privacy. The Maputo Protocol and the Civil and Political Rights Covenant prohibit performing medical experimentation on women without their informed consent.⁶³⁵

The right to privacy of Kenyan women is violated when they are not treated with respect and confidentiality when seeking reproductive health services, when they are not given access to their files, when medical procedures are performed upon them without informed consent, and when they are detained in hospitals and thereby forcefully separated from their families. [See Delivery and Discrimination sections.]

The right to redress

The lack of adequate complaint procedures and mechanisms and the many barriers to seeking redress documented in this report demonstrate clear violations of the right to redress.

Regional and international treaties establish the basic right of individuals to an effective remedy when their human rights have been violated.⁶³⁶ The Maputo Protocol specifically

recognizes women's right to redress, requiring states to "provide for appropriate remedies to any woman whose rights or freedoms . . . have been violated."⁶³⁷ Similarly, the Human Rights Committee has established that "a failure by a State Party to investigate allegations of violations could in and of itself give rise to a separate breach of the Covenant."⁶³⁸

Several international treaties specifically require that an effective remedy exist with respect to violations of the right to health. The CEDAW Committee has stated that in order for states to demonstrate that they "respect, protect and fulfil" a woman's right to health care, they must "ensure that legislation and executive action and policy comply with these three obligations" and also "put in place a system that ensures effective judicial action," indicating that a failure to provide such a remedy would "constitute a violation of article 12 [right to health]."⁶³⁹ The ESCR Committee has also emphasised that states must establish remedies and ensure that individuals have effective access to these remedies when their right to health is violated.⁶⁴⁰

The lack of effective complaint procedures and mechanisms for patients who suffer rights violations in Kenyan health facilities constitutes a violation of their right to redress. [See Complaints section.] International law requires the government to provide effective redress mechanisms for these violations, as indicated in the Remedies text box below.

National Law and Policy

Some protections for the rights set forth above are included in Kenya's existing national laws and policies. However, as discussed in the Complaints section, neither adequate protections nor complaint mechanisms exist to address the types of violations identified in this report.

The Constitution

The existing Constitution protects many of the rights that this report outlines, but the new Constitution will hopefully provide even more explicit protections for economic and social rights, such as the right to health. The 2005 Draft Constitution expanded the definition of discrimination to include categories such as pregnancy, marital status, and health status (relevant to HIV/AIDS);⁶⁴¹ empowered the state to undertake affirmative action programmes where necessary for the benefit of disadvantaged groups;⁶⁴² specifically required that the state provide reasonable facilities and opportunities to enhance the welfare of women;⁶⁴³ provided for the right to health (including the right to health care services and reproductive health care);⁶⁴⁴ and clearly stated that the state must protect, promote and fulfil all human rights including "its international obligations in respect of human rights."⁶⁴⁵ Although the Draft Constitution was rejected in a national referendum, the issues in contention leading to its rejection did not include the recognition of economic and social rights. The process of constitutional review is currently ongoing.

Legislative provisions

Penal Code

The Penal Code⁶⁴⁶ criminalizes various forms of assaults to the person. Whether or not an assault causes bodily harm, it is a misdemeanor offence;⁶⁴⁷ intentional acts that are intended to wound or cause grievous harm to an individual's health are felonies.⁶⁴⁸ Health

care providers who wound or cause grievous harm to patients may be prosecuted under these provisions. Moreover, medical practitioners may be held liable for a misdemeanor if they provide rash or negligent medical or surgical treatment that endangers human life or is likely to cause harm.⁶⁴⁹

The Penal Code does not provide for protections against psychological harm—a key element of the violation of reproductive rights. Unless abusive or neglectful health care services amount to inhuman treatment or torture, thereby bringing them under the scope of the Constitution, there is little recourse under the Penal Code for the mental harm they might cause.

Governmental policies

In the last decade, Kenya has developed and adopted various policies, frameworks, guidelines, and action plans in relation to reproductive health and rights, including the 2000 National Population Policy for Sustainable Development, the 2003 Adolescent Reproductive Health and Development Policy, the National Health Policy Framework, the National Health Sector Strategic Plan, the National Reproductive Health Strategy 1997-2010, the Family Planning Guidelines, and the HIV/AIDS Strategic Plan 2001-2005. However, effective implementation of these policies remains a significant problem, which dramatically limits their impact and efficacy.

The Right to an Effective Remedy

Effective remedies to rights violations are vital: they do more than simply *protect* human rights, they can also *promote* them.⁶⁵⁰ However, the complaint mechanisms discussed in this section fall short of the steps that international law requires the Kenyan government to take in order to ensure that individuals can seek redress when their rights are violated. Key elements in making the right to redress a reality include:

Mechanisms to ensure effective remedies for rights violations

The Civil and Political Rights Covenant, which Kenya has ratified, requires states to ensure that any person claiming a remedy for a rights violation is heard by “competent judicial, administrative or legislative authorities” or another competent authority established by the state.⁶⁵¹ The treaty’s monitoring body, the Human Rights Committee, has particularly emphasized the need to establish “independent and impartial bodies,” such as national human rights institutions, which can “investigate allegations of violations promptly, thoroughly and effectively.”⁶⁵² Remedies issued by administrative bodies must be “accessible, affordable, timely and effective,”⁶⁵³ and individuals should have the option of pursuing a judicial appeal of administrative decisions.⁶⁵⁴ International law also calls for states to establish competent authorities to enforce the remedies that are granted.⁶⁵⁵

Appropriate compensation for rights violations

Full realization of the right to an effective remedy includes providing compensation to individuals whose rights have been violated.⁶⁵⁶ This may take the form of legal action against the perpetrators, changes in relevant laws and practices, money payments, additional health services to treat medical problems, and public apologies.⁶⁵⁷ Remedies should also include specific measures to stop ongoing rights violations.⁶⁵⁸ The Human Rights Committee has noted that “remedies should be appropriately adapted so as to take account of the special vulnerability of certain categories of persons.”⁶⁵⁹

RECOMMENDATIONS

The following recommendations are based upon the findings of this report and input from the women, health care providers, and officials with whom FIDA Kenya/CRR spoke in the course of its research.

To the Government of Kenya

Address problems in the delivery of maternal health care.

- Implement and enforce the Ministry of Health’s Maternal Care Standards, which protect women’s rights and health.
 - Meet the recommended ratios for staffing in medical facilities.
 - Ensure that the supplies and equipment necessary to maintain hygienic conditions are available and that hygiene standards are strictly enforced.
 - Provide adequate equipment for women in labour and newborn infants, including incubators.
- Develop a protocol for post-delivery stitching and train providers to follow the protocol.
- Enact a law that would govern maternal health care and ensure the protection of women during childbirth.
- Ensure that only qualified health care personnel attend to expectant mothers and that medical trainees are closely supervised.

Develop a comprehensive strategy to address the problems identified by the 2004 Kenya Service Provision Assessment Survey, including equipment and supply shortages.

Distribute government guidelines addressing reproductive health services to all facilities and encourage their use; emphasize the importance of informed consent in these guidelines.

Provide continuous training for reproductive health care providers in both public and private facilities.

Improve contraceptive access.

- Develop comprehensive guidelines on the obligations of all health care facilities, including those run by faith-based organizations, to provide accurate and comprehensive family planning services and information. Develop a clear referral policy for facilities that cannot or choose not to provide certain family planning information or services.
- In light of the Ministry of Health’s Guidelines on the Medical Management of Sexual Violence, insist that all health facilities, regardless of their religious affiliation, provide emergency contraception to survivors of sexual violence.
- Assure equal and consistent contraceptive distribution to non-public institutions.

Reduce incidents of unsafe abortion, which is one of the primary causes of maternal mortality for women in Kenya.

- Review and update current reproductive health policies and guidelines, including training for health providers, to guarantee access to safe abortion services within the existing law.
- Ensure that women who develop abortion-related complications are not doubly victimized by both the health care and the criminal justice system.
- Take measures to make certain that medical professionals who may provide or advocate for safe abortion are not harassed or unjustly targeted for criminal prosecutions.

Remove financial barriers that result in the denial of or delays in receiving necessary health care services.

- Publicize which services are cost-exempt and ensure that they are actually free in practice.
- Monitor practices in facilities to ensure that informal and inappropriate fees are not levied.
- Ensure that women in need of delivery services are not turned away because they cannot pay a fee or deposit.
- Implement the Ministry of Health's stated commitment to free maternity services in public facilities by providing the finances and staffing necessary to make it a reality; define explicitly what is included in maternity services.

Fix the waiver system in public health facilities.

- Develop clear guidelines and procedures for implementing the waiver system.
- Publicize the existence of a waiver system and its eligibility criteria. Institute protections so that determining waiver status does not delay access to care.
- Reimburse public facilities for administering and granting waivers.

Explicitly outlaw at all health facilities the practice of detaining patients who cannot pay their medical bills.

Address the longstanding violations of women's rights at Pumwani Maternity Hospital (PMH).

- Release the 2004 PMH Task Force Report, fully implement its recommendations, and allow for its review and the development of further recommendations.
- Remove PMH from the supervision of the Ministry of Local Government and place it under the supervision of the Ministry of Health.
- Appoint an independent ombudsperson to investigate current and past violations.
- Develop mechanisms, such as public hearings, to redress past violations.
- Release information on staffing levels, operating procedures, and the tender process at PMH.

Strengthen structures to protect patients' rights.

- Conduct public-awareness programs to educate patients about their rights.
- Require all public and private health care facilities to establish formalized complaint mechanisms as part of their licensing requirements.
- Issue standards and guidelines for medical facilities on patients' rights and complaint mechanisms; ensure their widespread dissemination and implementation.
- Strengthen the complaint mechanisms of the Medical Board, the Nursing Council, and the Clinical Council. Establish formal guidelines for complaint-screening procedures and take measures to reduce delays in the complaint process. Establish a patients' advocate on each board and ensure that patients have legal representation in the complaint process. Require these bodies to release annual accountings and statistics on the cases that they have heard and their outcomes. Institute an internal appeals system.
- Develop a clear complaint process to be adopted by all health facilities, regardless of type of management.
- Improve the regulation and training of clinical officers; include these personnel in the Medical Board's oversight.
- Conduct mandatory trainings for doctors, nurses, and clinical officers in both public and private facilities in order to continually educate them on medical advances, best practices, and patients' rights.
- Provide information to judges and legal professionals on rights violations in the health care context.

Improve access to information within the health care system.

- Enact a comprehensive Freedom of Information bill that includes whistleblower protections and encourage public employees to report incidences of wrongdoing.
- Release the findings of task force reports documenting conditions in health care facilities, including the 2004 PMH Task Force Report.
- Make public the operating guidelines, standards, and procedures that govern public health facilities.
- Develop a policy to ensure that patients can easily obtain their comprehensive medical records from private and public health facilities.

Strengthen Kenya's human rights framework.

- Ratify the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol).
- Domesticize international treaties and implement them at the national level.
- Create a constitutional framework that recognizes key human rights, such as the right to health. Provide accountability and complaint mechanisms to protect and realize those rights.

To all public and private health care facilities

Protect patients' rights and promote accountability.

- Conduct trainings for all staff members on protecting the rights and dignity of patients; encourage health care staff to report rights violations.
- Post patients' rights and provide complaint boxes. Develop clear processes for lodging and redressing complaints and make this information readily available to patients.
- Ensure that all health care staff members wear badges with their names and positions.

Establish payment policies that are fair and transparent, and that safeguard patients' health.

- Immediately stop the practice of detaining patients who cannot pay their medical bills; release all patients who are currently detained.
- Do not turn away women seeking delivery care because they cannot pay a fee or deposit.
- Ensure that women and their families are not required to bring supplies for delivery or other reproductive health services. Post the fee schedule for services in a prominent location and ensure that patients understand these fees.

Remove financial incentives for unnecessarily cutting women during childbirth for the purpose of forcing them to undergo post-delivery stitching. Stitch women promptly and with adequate anaesthesia.

Implement an effective identification process for newborns to prevent possibilities of, and fears about, baby-stealing and swapping.

To Associations of Health Care Professionals in Kenya

Revise ethical codes to provide sanctions for all violent and discriminatory practices against women and ensure that these provisions are widely publicized.

Emphasise the importance of respecting patients' rights in trainings and other activities for members.

To The World Bank and International Monetary Fund

Examine the human rights consequences of conditions placed on funding and take necessary steps to ensure that these conditions do not result in rights violations, such as detention for inability to pay medical bills; ensure that these conditions do not weaken the health care system in other ways, such as by making it impossible to hire sufficient medical staff.

To the International Donor Community

Organizations financing public and private reproductive health and family planning programs should ensure that such programs are designed to improve health care and promote the exercise of women's rights, and should establish indicators for evaluating these projects, based on the criteria of efficiency, quality, and respect for women's human rights.

To International and African Human Rights Bodies

Use the occasion of Kenya's periodic reports to the treaty-monitoring bodies to issue strong concluding observations and recommendations in order to reinforce Kenya's obligations to protect the rights of women seeking reproductive health care services and to provide redress and remedies for violations of these rights.

Endnotes

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- ³⁴ Interview with Anne Mulinge, Nurse/Administrator - Kasarani Maternity Hospital, Kasarani, Nov. 16, 2006.
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- ¹²⁹ Focus group discussion with unnamed participant, Nairobi, Apr. 20, 2007.
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- ¹³¹ 2004 KSPAS at 139.
- ¹³² *Id.* at 148. Basic emergency case includes administration of parenteral antibiotics, oxytocic drugs and anticonvulsants; manual removal of placenta; removal of retained products of conception; and assisted vaginal delivery. Comprehensive emergency care includes all of the above, as well as blood transfusions and surgery (caesarean delivery). *Id.* at 146-147.
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- ¹³⁷ *Id.*
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- ³⁸⁷ *Id.*
- ³⁸⁸ *Id.*
- ³⁸⁹ One woman detained at Pumwani told the *Standard* that her husband had never come to visit her after she gave birth, so she has not been able to get the money to pay the fees. The article quotes her as saying, "He claims to be sick...No one comes to visit me...I'm like a reject. They have dumped me here." *Id.*
- ³⁹⁰ Interview with health care user, Nairobi, Jan. 22, 2007.
- ³⁹¹ Interview with Dr. Joseph Karanja, Professor - University of Nairobi and Obstetrician-Gynaecologist, Nairobi, Nov. 24, 2006.
- ³⁹² Interview with Dr. Shadrack Ojwang, Professor

- University of Nairobi and Obstetrician-Gynaecologist - Kenyatta National Hospital, Nairobi, Apr. 17, 2007.
- ³⁹³ Human Rights Committee, *General Comment No. 20: Replaces general comment 7 concerning prohibition of torture and cruel treatment or punishment*, para. 5 (Mar. 10, 1992) [hereinafter CCPR General Comment No. 20].
- ³⁹⁴ Universal Declaration of Human Rights, Art. 23, *adopted* Dec. 10, 1948, G.A. Res. 217A (III), at 71, U.N. Doc. A/810 (1948) [hereinafter Universal Declaration]; International Covenant on Economic, Social and Cultural Rights, Art. 6, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, U.N. Doc A/6316 (1966), 999 U.N.T.S. 3 (*entered into force* Jan. 3, 1976) [hereinafter Economic, Social and Cultural Rights Covenant].
- ³⁹⁵ Universal Declaration, Art. 27; Economic, Social and Cultural Rights Covenant, Art. 15.
- ³⁹⁶ Universal Declaration, Art. 13; International Covenant on Civil and Political Rights, Art. 12, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) [hereinafter Civil and Political Rights Covenant]; Human Rights Committee, *General Comment No. 27: Freedom of movement*, U.N. Doc CCPR/C/21/Rev. 1/Add. 9 (Nov. 2 1999) [hereinafter CCPR General Comment No. 27]. Article 12 of the Civil and Political Rights Covenant guarantees protection “not only from public but also from private interference.” CCPR General Comment No. 27 at para. 6.
- ³⁹⁷ Human Rights Watch, *A High Price to Pay: Detention of Poor Patients in Burundian Hospitals* 71 (Sept. 2006).
- ³⁹⁸ Human Rights Committee, *General Comment No. 28: Equality of rights between men and women*, para. 15, U.N. Doc. CCPR/C/21/Rev. 1/Add. 10 (Mar. 29, 2000).
- ³⁹⁹ Committee on Economic, Social and Cultural Rights *General Comment No. 14: The right to the highest attainable standard of health*, para. 43, U.N. Doc E/C.12/2000/4 (Aug. 11, 2000) [hereinafter CESCR General Comment No. 14]. While the Committee on Economic, Social and Cultural Rights has recognized that some elements of the right to health are subject to progressive realization and resource availability [Committee on Economic, Social and Cultural Rights, *General Comment No. 3: The nature of States parties obligations*, para. 2 (Dec. 14, 1990)], some obligations, such as equal treatment for men and women, give rise to immediate effect. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, para. 63, U.N. Doc A/HRC/4/28 (Jan. 17, 2007) (“Equal treatment of women and men ... is not subject to progressive realization and resource availability. A State may not argue that presently it has insufficient resources to provide equal services for women and men and so, for the time being, it is going to focus on services for men.”).
- ⁴⁰⁰ CESCR General Comment No. 14 at para.12.
- ⁴⁰¹ Human Rights Committee, *General Comment No. 19: Protection of the family, the right to marriage and equality of the spouses*, para. 5 (July 27, 1990).
- ⁴⁰² *Contra*, Convention on the Rights of the Child, Art. 3(2), *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, UN Doc. A/44/49 (1989), reprinted in 28 I.L.M. 1448 (*entered into force* Sept. 2, 1990) [hereinafter Children’s Rights Convention].
- ⁴⁰³ *Contra* to Children’s Rights Convention, Art. 27.
- ⁴⁰⁴ CCPR General Comment No. 20 at para. 2 (emphasis added).
- ⁴⁰⁵ Questionnaire respondent, Kisumu, Apr. 4, 2007.
- ⁴⁰⁶ Interview with health care user, Nairobi, Jan. 14, 2007.
- ⁴⁰⁷ Interview with Teresa Kanjigi, Nurse/Administrator - St. Theresa Clinic, Nairobi, Feb. 5, 2007.
- ⁴⁰⁸ Questionnaire respondent, Nairobi, Mar. 21, 2007.
- ⁴⁰⁹ Questionnaire respondent, Nairobi, Mar. 13, 2007.
- ⁴¹⁰ Focus group discussion with unnamed participant, Nairobi, Feb. 9, 2007.
- ⁴¹¹ Focus group discussion with unnamed participant, Kisumu, May 30, 2007.
- ⁴¹² Interview with health care user, Kasarani, Nov. 29, 2006.
- ⁴¹³ *See e.g.*, Nairobi Focus Group Discussions, Feb. 2, 2007, Feb. 9, 2007, Apr. 13, 2007; Kisumu Focus Group Discussions, Apr. 5, 2007, May 39, 2007.
- ⁴¹⁴ Interview with health care user, Nairobi, Jan. 22, 2007.
- ⁴¹⁵ *See e.g.*, Questionnaire respondent, Nairobi, Mar. 13, 2007.
- ⁴¹⁶ Questionnaire respondent, Kisumu, Apr. 4, 2007.
- ⁴¹⁷ Interview with Dr. Daniel Nguku, Medical Officer -Nairobi City Council, Nairobi, Feb. 2, 2007.
- ⁴¹⁸ David I. Muthaka et al., Kenya Inst. for Pub. Pol’y Res. and Analysis, *A Review of the Regulatory Framework for Private Health care Services in Kenya 10* (KIPPRA Discussion Paper No. 35, Mar. 2004) [hereinafter Muthaka]. The public health care sector is comprised of a large number of health posts, mobile clinics, and dispensaries at the community level; health centers, sub-district, district, and provincial hospitals at the regional level; and two national level hospitals—Kenyatta National Hospital in Nairobi and Moi Teaching and Referral Hospital in Eldoret. *Id.* at 10.
- ⁴¹⁹ *Id.* at 7, 10.
- ⁴²⁰ *Id.* at 63.
- ⁴²¹ The Penal Code § 243(e), Cap. 63 of the Laws of Kenya, (Revised ed. 1985) [hereinafter The Penal Code].
- ⁴²² The Penal Code § 218.
- ⁴²³ Tudor Jackson, *The Law of Kenya: An Introduction* 208 (2nd ed. 1978) [hereinafter Jackson]. To succeed in an action for negligence, the plaintiff must prove that the defendant was in breach of the duty of care owed by medical practitioners toward their clients, and that, as a result of the breach of that duty, the plaintiff suffered harm.
- ⁴²⁴ *Id.* at 185.
- ⁴²⁵ *Id.*
- ⁴²⁶ *See Id.* at 197 (discussing “trespass to the person” generally).
- ⁴²⁷ Muthaka, at 59 fn. 17 and 60.

- ⁴²⁸ *Id.* at 60.
- ⁴²⁹ *Id.* at 59.
- ⁴³⁰ *Id.* at 55.
- ⁴³¹ *Id.* at 27-28.
- ⁴³² Ministry of Local Government (Kenya), www.localgovernment.go.ke/ (last visited June 15, 2007).
- ⁴³³ Muthaka at 31.
- ⁴³⁴ *See, e.g.*, The Medical Practitioners and Dentists Act, § 4, Cap. 253 of the Laws of Kenya (Revised ed. 1983) (stating that the Medical Board will be chaired by an appointee of the Minister of Health) [hereinafter The Medical Practitioners Act]; The Nurses Act, § 4, Cap. 257 of the Laws of Kenya, (Revised ed. 1985) (providing that the Nursing Council will consist, in part, of the Director of Medical Services or her representative and nine persons appointed by the Minister of Health) [hereinafter The Nurses Act].
- ⁴³⁵ The Public Health Act § 3, Cap. 242 of the Laws of Kenya (Revised ed. 1986).
- ⁴³⁶ *Id.* at 28.
- ⁴³⁷ The Medical Practitioners Act § 11(1)(c); *see also*, §§ 15, 17.
- ⁴³⁸ The Medical Practitioners Act § 20.
- ⁴³⁹ The Nurses Act § 9.
- ⁴⁴⁰ The Nurses Act §§ 12-17.
- ⁴⁴¹ The Clinical Officers (Training, Registration and Licensing) Act, § 5, Cap. 260 of the Laws of Kenya (Revised ed. 1990) [hereinafter The Clinical Officers Act].
- ⁴⁴² Kenya Medical Association, <http://www.kma.co.ke/>.
- ⁴⁴³ Kenya Medical Association, <http://www.kma.co.ke/>; Interview with Rose Kioko, Executive / Program Officer - Kenya Medical Association, Nairobi, Nov. 20, 2006.
- ⁴⁴⁴ Muthaka at 21.
- ⁴⁴⁵ Interview with Margaret Ogola, National Executive Secretary, and other members of the Catholic Secretariat - Kenya Episcopal Conference, Nairobi, Apr. 10, 2007; Interview with Joseph Oyongo, Quality Assurance Officer - Christian Health Association of Kenya, Nairobi, Nov. 20, 2006.
- ⁴⁴⁶ Interview with Margaret Ogola, National Executive Secretary, and other members of the Catholic Secretariat - Kenya Episcopal Conference, Nairobi, Apr. 10, 2007.
- ⁴⁴⁷ *Id.*
- ⁴⁴⁸ *Id.*
- ⁴⁴⁹ Interview with Joseph Oyongo, Quality Assurance Officer - Christian Health Association of Kenya, Nairobi, Nov. 20, 2006.
- ⁴⁵⁰ *Id.*
- ⁴⁵¹ Muthaka at 7, 18.
- ⁴⁵² *Id.* at 13.
- ⁴⁵³ *See also, Id.* at 12.
- ⁴⁵⁴ *Id.* at 7, 8.
- ⁴⁵⁵ *Id.* at 35.
- ⁴⁵⁶ *Id.*
- ⁴⁵⁷ *Id.* at 8.
- ⁴⁵⁸ *Id.* at 7, 23.
- ⁴⁵⁹ *Id.* at 25.
- ⁴⁶⁰ Interview with Dr. Stephen Ochiel, Obstetrician-Gynaecologist and Chairperson - Kenya Medical Association, Nairobi, Nov. 24, 2006.
- ⁴⁶¹ Interview with Rose Kioko, Executive/Program Officer - Kenya Medical Association, Nairobi, Nov. 20, 2006.
- ⁴⁶² Muthaka at 52.
- ⁴⁶³ Interview with Dr. Chris Wagaiyu, Chair, and Stella Mwihaki, Legal Advisor - Kenya Medical Practitioners and Dentists' Board, Nairobi, Mar. 13, 2007.
- ⁴⁶⁴ The Medical Practitioners and Dentists' Board, The Code of Professional Conduct and Discipline 7 (para. 16), MPDB Circular No. 4/79 (5th ed., May 2003).
- ⁴⁶⁵ Interview with Dr. Chris Wagaiyu, Chair, and Stella Mwihaki, Legal Advisor - Kenya Medical Practitioners and Dentists' Board, Nairobi, Mar. 13, 2007.
- ⁴⁶⁶ *Id.*; Telephone Interview with Mr. Kierini, Administrator - Kenyatta National Hospital, Nairobi, Apr. 18, 2007; Interview with Rose Kioko, Executive/Program Officer - Kenya Medical Association, Nairobi, Nov. 20, 2006.
- ⁴⁶⁷ Interview with Dr. Chris Wagaiyu, Chair, and Stella Mwihaki, Legal Advisor - Kenya Medical Practitioners and Dentists' Board, Nairobi, Mar. 13, 2007.
- ⁴⁶⁸ *Id.*
- ⁴⁶⁹ *Id.*
- ⁴⁷⁰ The Medical Practitioners Act § 20(2)-(3).
- ⁴⁷¹ Consultant's Interview with Stella Mwihaki, Legal Advisor - Kenya Medical Practitioners and Dentists' Board, Nairobi, May 17, 2007.
- ⁴⁷² Interview with Dr. Chris Wagaiyu, Chair, and Stella Mwihaki, Legal Adviser - Kenya Medical Practitioners and Dentists' Board, Nairobi, Mar. 13, 2007.
- ⁴⁷³ *Id.*
- ⁴⁷⁴ *Id.* Ms. Mwihaki suggested that the majority of complaints stemmed from the public's lack of understanding about medical practice.
- ⁴⁷⁵ *Id.*
- ⁴⁷⁶ Interview with Dr. Stephen Ochiel, Obstetrician-Gynaecologist and Chairperson - Kenya Medical Association, Nairobi, Nov. 24, 2006.
- ⁴⁷⁷ Interview with Dr. Chris Wagaiyu, Chair, and Stella Mwihaki, Legal Advisor - Kenya Medical Practitioners and Dentists' Board, Nairobi, Mar. 13, 2007.
- ⁴⁷⁸ The Medical Practitioners Act § 20(6).
- ⁴⁷⁹ Consultant's Interview with Stella Mwihaki, Legal Adviser - Kenya Medical Practitioners and Dentists' Board, Nairobi, May 17, 2007.
- ⁴⁸⁰ *Id.*
- ⁴⁸¹ Muthaka at 52.
- ⁴⁸² Interview with Dr. Chris Wagaiyu, Chair, and Stella Mwihaki, Legal Adviser - Kenya Medical Practitioners and Dentists' Board, Nairobi, Mar. 13, 2007.
- ⁴⁸³ *Id.*
- ⁴⁸⁴ *Id.*
- ⁴⁸⁵ *Id.*
- ⁴⁸⁶ The Medical Practitioners Act § 4(1). The Medical Board is comprised of the Ministry of Health's Director and Deputy Director of Medical Services; a chairman appointed by the Minister of Health;

- four medical practitioners nominated by the Minister; a representative of the University of Nairobi's Faculty of Medicine; and five elected medical practitioners and two elected dentists.
- ⁴⁸⁷ Muthaka at 37.
- ⁴⁸⁸ *Id.* at 38.
- ⁴⁸⁹ Interview with Elizabeth Oywer, Registrar-Nursing Council of Kenya, Feb. 7, 2007.
- ⁴⁹⁰ Nursing Council of Kenya, Code of Ethics and Professional Conduct for Nurses 5 (Mar. 2006) [hereinafter Nurses Code of Ethics].
- ⁴⁹¹ *Id.*
- ⁴⁹² Interview with Elizabeth Oywer, Registrar-Nursing Council of Kenya, Feb. 7, 2007.
- ⁴⁹³ *Id.*
- ⁴⁹⁴ Consultant's Interview with Elizabeth Registrar-Nursing Council of Kenya, May 17, 2007.
- ⁴⁹⁵ Interview with Elizabeth Oywer, Registrar-Nursing Council of Kenya, Feb. 7, 2007.
- ⁴⁹⁶ Consultant's Interview with Elizabeth Oywer-Registrar, Nursing Council of Kenya, May 17, 2007.
- ⁴⁹⁷ *Id.*
- ⁴⁹⁸ Interview with Elizabeth Oywer, Registrar-Nursing Council of Kenya, Feb. 7, 2007; Sec. 9 of Nurses Act, Cap. 257, Laws of Kenya, Sec. 25.
- ⁴⁹⁹ Nurses Code of Ethics at 20.
- ⁵⁰⁰ The Nurses Act § 25(5).
- ⁵⁰¹ Consultant's Interview with Elizabeth Oywer, Registrar- Nursing Council of Kenya, May 17, 2007.
- ⁵⁰² The Nurses Act § 5(1)(b) of Nurses Act (providing that a person who is not currently registered or licensed cannot be appointed to the Nursing Council).
- ⁵⁰³ Consultant's Interview with Elizabeth Oywer, Registrar- Nursing Council of Kenya, May 17, 2007.
- ⁵⁰⁴ *Id.*
- ⁵⁰⁵ Interview with Elizabeth Oywer, Registrar-Nursing Council of Kenya, Feb. 7, 2007.
- ⁵⁰⁶ Interview with Clinical Officers Council official, Nairobi, Feb. 7, 2007.
- ⁵⁰⁷ *Id.*
- ⁵⁰⁸ *Id.*
- ⁵⁰⁹ *Id.*
- ⁵¹⁰ The Clinical Officers Act at First Schedule; Interview with Clinical Officers Council official, Nairobi, Feb. 7, 2007.
- ⁵¹¹ The Clinical Officers Act § 15.
- ⁵¹² *Id.*
- ⁵¹³ *Id.* at §§ 15(2), 15(6).
- ⁵¹⁴ *Id.* at § 15(7).
- ⁵¹⁵ Interview with Clinical Officers Council official, Nairobi, Feb. 7, 2007.
- ⁵¹⁶ Interview with Dr. Daniel Nguku, Medical Officer of Health - Nairobi City Council, Nairobi, Feb. 2, 2007.
- ⁵¹⁷ Interview with Dr. Chris Wagaiyu, Chair, and Stella Mwhaki, Legal Advisor- Kenya Medical Practitioners and Dentists' Board, Nairobi, Mar. 13, 2007.
- ⁵¹⁸ Interview with Dr. John Nyamu, CEO/Consultant Gynaecologist - Reproductive Health Services, Nairobi, Feb. 5, 2007.
- ⁵¹⁹ Interview with Dr. Shadrack Ojwang, Professor - University of Nairobi and Obstetrician-Gynaecologist - Kenyatta National Hospital, Nairobi, Apr. 17, 2007.
- ⁵²⁰ Odira, *Mystery of wife's death* at 12.
- ⁵²¹ See Interview with Dr. Stephen Ochiel, Obstetrician-Gynaecologist and Chairperson of the Kenya Medical Association, Nairobi, Nov. 24, 2006; Interview with Dr. Shadrack Ojwang, Professor - University of Nairobi and Obstetrician-Gynaecologist - Kenyatta National Hospital, Nairobi, Apr. 17, 2007; Interview with Dr. Joseph Karanja, Professor - University of Nairobi and Obstetrician-Gynaecologist, Nairobi, Nov. 24, 2006.
- ⁵²² Interview with Dr. Stephen Ochiel, Obstetrician-Gynaecologist and Chairperson - Kenya Medical Association, Nov. 24, 2006.
- ⁵²³ Interview with Dr. Joseph Karanja, Professor - University of Nairobi and Obstetrician-Gynaecologist, Nov. 24, 2006.
- ⁵²⁴ *Id.*
- ⁵²⁵ Dr. Helton Jilo, Director of Maternal Health - Ministry of Health, Division of Reproductive Health, Nairobi, Feb. 7, 2007.
- ⁵²⁶ Interview with Joseph Oyongo, Quality Assurance Officer- Christian Health Association of Kenya, Nairobi, Nov. 20, 2006.
- ⁵²⁷ Interview with Margaret Ogola, National Executive Secretary, and other members of the Catholic Secretariat - Kenya Episcopal Conference, Nairobi, Apr. 10, 2007.
- ⁵²⁸ Interview with experienced midwife, Nairobi, Feb. 2, 2007.
- ⁵²⁹ Interview with Rose Njoki Ngahu, Matron - Family Health Options Kenya, Nairobi, Feb. 1, 2007.
- ⁵³⁰ *Id.*
- ⁵³¹ Interview with Dr. Stephen Ochiel, Obstetrician-Gynaecologist and Chairperson - Kenya Medical Association, Nairobi, Nov. 24, 2006.
- ⁵³² Interview with Dr. Shadrack Ojwang, Professor - University of Nairobi and Obstetrician-Gynaecologist - Kenyatta National Hospital, Nairobi, Apr. 17, 2007.
- ⁵³³ Interview with Dr. Stephen Ochiel, Obstetrician-Gynaecologist and Chairperson - Kenya Medical Association, Nairobi, Nov. 24, 2006.
- ⁵³⁴ Interview with Dr. Joseph Karanja, Professor - University of Nairobi and Obstetrician-Gynaecologist, Nairobi, Mar. 24, 2006.
- ⁵³⁵ Interview with Dr. John Nyamu, CEO/Consultant Gynaecologist - Reproductive Health Services, Nairobi, Feb. 5, 2007.
- ⁵³⁶ Focus group discussion unnamed participant, Kisumu, Apr. 5, 2007.
- ⁵³⁷ Interview with Dr. Stephen Ochiel, Obstetrician-Gynaecologist and Chairperson - Kenya Medical Association, Nairobi, Nov. 24, 2006.
- ⁵³⁸ Interview with health care user, Nairobi, Nov. 28, 2006.
- ⁵³⁹ Focus group discussion unnamed participant, Nairobi, Apr. 20, 2007.
- ⁵⁴⁰ Interview with health care user, Nairobi, Nov. 28, 2006.
- ⁵⁴¹ Focus group discussion unnamed participant,

- Nairobi, Apr. 20, 2007.
- ⁵⁴² Focus group discussion unnamed participant, Nairobi, Apr. 20, 2007.
- ⁵⁴³ Focus group discussion unnamed participant, Kisumu, Apr. 5, 2007.
- ⁵⁴⁴ Focus group discussion unnamed participant, Kisumu, Apr. 5, 2007.
- ⁵⁴⁵ Focus group discussion unnamed participant, Kisumu, May 30, 2007.
- ⁵⁴⁶ Interview with Dr. Joseph Karanja, Professor - University of Nairobi and Obstetrician-Gynaecologist, Nairobi, Mar. 24, 2006.
- ⁵⁴⁷ Focus group discussion unnamed participant, Kisumu, Apr. 5, 2007.
- ⁵⁴⁸ Focus group discussion unnamed participant, Kisumu, Apr. 5, 2007.
- ⁵⁴⁹ Focus group discussion unnamed participant, Kisumu, Apr. 5, 2007.
- ⁵⁵⁰ Interview with health care user, Nairobi, Apr. 11, 2007.
- ⁵⁵¹ *Id.*
- ⁵⁵² The Penal Code § 243(e).
- ⁵⁵³ Interview with Elizabeth Oywer, Registrar - Nursing Council of Kenya, Feb. 7, 2007.
- ⁵⁵⁴ Muthaka at 51.
- ⁵⁵⁵ *Id.*
- ⁵⁵⁶ Interview with Dr. Chris Wagaiyu, Chair, and Stella Mwihaki, Legal Advisor - Kenya Medical Practitioners and Dentists' Board, Nairobi, Mar. 13, 2007; Muthaka at 51.
- ⁵⁵⁷ The Nurses Act § 9.
- ⁵⁵⁸ Focus group discussion unnamed participant, Kisumu, Apr. 5, 2007.
- ⁵⁵⁹ 2004 KSPAS at 138.
- ⁵⁶⁰ *Id.* at 132.
- ⁵⁶¹ *Id.* at 145.
- ⁵⁶² *Id.*
- ⁵⁶³ Interview with Anne Mulinge, Nurse/Administrator - Kasarani Maternity Hospital, Kasarani, Nov. 16, 2006.
- ⁵⁶⁴ Interview with Joseph Oyongo, Quality Assurance Officer - Christian Health Association of Kenya, Nairobi, Nov. 20, 2006.
- ⁵⁶⁵ Interview with Anne Mulinge, Nurse/Administrator - Kasarani Maternity Hospital, Kasarani, Nov. 16, 2006.
- ⁵⁶⁶ African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, O.A.U. Doc. CAB/LEG/67/3, rev.5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986) [hereinafter *Banjul Charter*]. The Banjul Charter obliges state parties to "ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions." Article 18(3) of the Banjul Charter.
- ⁵⁶⁷ African Charter on Rights and Welfare of the Child, (*adopted* July 1990) O.A.U. Doc. CAB/LEG/24.9/49 (*entered into force* Nov. 29, 1999) [hereinafter *African Charter on Children*].
- ⁵⁶⁸ African Commission on Human and Peoples' Rights, Status of Ratification/Accession to OAU/AU Human Rights Treaties, http://www.achpr.org/english/_info/index_ratifications_en.html (last visited June 13, 2007).
- ⁵⁶⁹ Vienna Convention on the Law of Treaties art. 18(a), May 23, 1969, 1155 U.N.T.S. 331, 8 I.L.M. 679 (*entered into force* Jan. 27, 1980), available at http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf [hereinafter *Vienna Convention*].
- ⁵⁷⁰ Maputo Protocol at art. 26.
- ⁵⁷¹ International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) [hereinafter *Civil and Political Rights Covenant*].
- ⁵⁷² International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, U.N. Doc A/6316 (1966), 999 U.N.T.S. 3 (*entered into force* Jan. 3, 1976) [hereinafter *Economic, Social and Cultural Rights Covenant*].
- ⁵⁷³ Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) [hereinafter *CEDAW*].
- ⁵⁷⁴ Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, UN Doc. A/44/49 (1989), *reprinted in* 28 I.L.M. 1448 (*entered into force* Sept. 2, 1990) [hereinafter *Children's Rights Convention*].
- ⁵⁷⁵ Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *adopted* Dec. 10, 1984, G.A. Res. 39/46, U.N. GAOR, 39th Sess., Supp. No. 51, at 197, U.N. Doc. A/39/51 (1984), 1465 U.N.T.S. 85 (*entered into force* June 26, 1987) [hereinafter *Convention against Torture*].
- ⁵⁷⁶ Vienna Convention at art. 2.1(b). *See also*, *Vienna Declaration and Programme of Action*, *World Conference on Human Rights*, para. 1, Vienna, Austria, July 14-25, 1993, U.N. Doc. A/CONF 157/23 (1993) (reaffirming "the solemn commitment of all States to fulfil their obligations to promote universal respect for, and observance and protection of, all human rights and fundamental freedoms for all in accordance with the Charter of the United Nations, other instruments relating to human rights, and international law.") [hereinafter *Vienna Declaration and Programme of Action*].
- ⁵⁷⁷ *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*]. The consensus documents that emerged from these conferences are not legally binding on states. However, by setting forth a detailed, global mandate, these documents contribute to advancing and interpreting the human rights standards contained in human rights treaties.
- ⁵⁷⁸ UNITED NATIONS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 8-9, 12-15 (2006), available at <http://unstats.un.org/unsd/mdg/Resources/Static/Products/Progress2006/MDGReport2006.pdf>.
- ⁵⁷⁹ *See, e.g.*, Universal Declaration at arts. 3, 25; CEDAW at arts. 10(h), 12, 14.2(b); Economic,

- Social and Cultural Rights Covenant at art. 12; Civil and Political Rights Covenant at art. 6(1); ICPD Programme of Action at Principle 8; Beijing Declaration and Platform for Action at para. 89, available at www.un.org/womenwatch/daw/beijing/platform/health.htm; Convention Children's Rights Convention at arts. 6(1), 24(1); Banjul Charter at arts. 4, 16; African Charter on Children at arts. 5(1), 14; Maputo Protocol at arts. 4(1), 14.
- ⁵⁸⁰ Banjul Charter at art. 16.
- ⁵⁸¹ Maputo Protocol at art. 14.
- ⁵⁸² Constitution, Art. 71 (1992) (Kenya).
- ⁵⁸³ Economic, Social and Cultural Rights Covenant at art. 12.1; Maputo Protocol at art. 14. The UN Declaration on Violence against Women defines violence as including "physical, sexual and psychological violence." Declaration on the Elimination of Violence against Women, G.A. Res. 48/104, at art. 2(c), U.N. Doc. A/RES/48/104 (Dec. 20, 1993).
- ⁵⁸⁴ CESCR General Comment No. 14 at para. 8.
- ⁵⁸⁵ *Id.* at para. 12 (stating that accessibility consists of non-discrimination, physical accessibility, affordability, and access to information). The U.N. Special Rapporteur on the right to health has recently affirmed these necessary components of the right to health. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, paras. 68, 71, U.N. Doc. A/HRC/4/28 (Jan. 17, 2007).
- ⁵⁸⁶ *ICPD Programme of Action* at principle 8.
- ⁵⁸⁷ Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and health*, paras. 21, 31 (Feb. 2, 1999) [hereinafter CEDAW General Recommendation 24]; CESCR General Comment No. 14 at para. 21; Maputo Protocol at art. 2.
- ⁵⁸⁸ Maputo Protocol at art. 14.
- ⁵⁸⁹ CEDAW at arts. 12(2), 16(1)(e). The CEDAW Committee has further urged governments to take measures "to prevent coercion in regard to fertility and reproduction, and to ensure that women are not forced to seek unsafe medical procedures... because of lack of appropriate services in regard to fertility control." Committee on the Elimination of Discrimination against Women, *General Recommendation 19: Violence against women*, para. 24(m), U.N. Doc. A/47/38 (Jan. 29, 1992).
- ⁵⁹⁰ CEDAW General Recommendation 24 at para. 31(d).
- ⁵⁹¹ *Id.* at para. 22.
- ⁵⁹² Children's Rights Convention at art. 24(2).
- ⁵⁹³ Civil and Political Rights Covenant at art. 2, 3; Economic, Social and Cultural Rights Covenant at art. 2, 3; Banjul Charter at arts. 2, 3, 18(3); Committee on Economic Social and Cultural Rights, *General Comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights*, para 1, U.N. Doc. E/C.12/2005/4 (Aug. 11, 2004) [hereinafter CESCR General Comment No. 16].
- ⁵⁹⁴ *See, e.g.*, Article 2 of the UDHR; Article 2(1) of the ICCPR; Article 2(2) of the ICESCR; African Charter art. 2.
- ⁵⁹⁵ Banjul Charter at arts. 3, 18.
- ⁵⁹⁶ Maputo Protocol at art. 2.
- ⁵⁹⁷ Constitution, Art. 82 (1992) (Kenya).
- ⁵⁹⁸ CEDAW at art. 12(1). *See also*, Children's Rights Convention at art. 24(2)(f).
- ⁵⁹⁹ Economic, Social and Cultural Rights Covenant at art. 2(1); Children's Rights Convention at art. 4.
- ⁶⁰⁰ CESCR General Comment No. 3 at para 2; Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, para. 63, U.N. Doc. A/HRC/4/28 (Jan. 17, 2007) [hereinafter Report of the Special Rapporteur on the right to health].
- ⁶⁰¹ CESCR General Comment No. 14 at para. 44; CESCR General Comment No. 3 at para 29.
- ⁶⁰² Concluding Observations of the Committee on the Rights of the Child: Kenya, paras. 48, 52, U.N. Doc. CRC/C/KEN/CO/2 (Feb. 2, 2007).
- ⁶⁰³ CESCR General Comment No. 14 at para. 12 (emphasis added).
- ⁶⁰⁴ *Id.* at para 35.
- ⁶⁰⁵ *Id.*
- ⁶⁰⁶ Economic, Social and Cultural Rights Covenant at art. 10(2).
- ⁶⁰⁷ CESCR General Comment No. 16 at para. 29.
- ⁶⁰⁸ *See, e.g.*, CEDAW General Recommendation No. 19 at paras. 1, 24(b) (stating that "Gender-based violence is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men."); CESCR General Comment No. 16 at para. 19 (stating that states parties obligations under the convention include "the adoption of legislation to eliminate discrimination and to prevent third parties from interfering directly or indirectly with the enjoyment of this right.")
- ⁶⁰⁹ CESCR General Comment No. 14 at paras 15, 19; Committee on the Rights of the Child, *General Comment No. 4: Adolescent health and development*, paras. 6, 41, U.N. Doc. CRC/GC/2003/4 (July 1, 2003) [hereinafter CRC General Comment No. 4].
- ⁶¹⁰ Universal Declaration at art. 5; Civil and Political Rights Covenant at art. 7; Convention against Torture at arts. 2, 16; Banjul Charter at art. 5; African Charter on Children at art. 16. In addition, the Maputo Protocol prohibits "[a]ll forms of exploitation, cruel, inhuman or degrading punishment and treatment," and requires state parties to take measures to protect women from all forms of sexual violence. Maputo Protocol at arts. 3, 4.
- ⁶¹¹ Mark W. Yanis, *An Introduction to International Law*, 259-60 (2003).
- ⁶¹² Constitution, art. 74 (1992) (Kenya).
- ⁶¹³ Banjul Charter at art. 5.
- ⁶¹⁴ CCPR General Comment 20 at para. 5.
- ⁶¹⁵ *Id.* at para. 5.
- ⁶¹⁶ The CEDAW Committee defines gender-based violence as "acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty," stating that such acts of gender-based violence impair or nullify women's fundamental rights, including "[t]he right not to be subject to torture or to cruel,

- inhuman or degrading treatment.” CEDAW General Recommendation No. 19 at paras. 6, 7.
- ⁶¹⁷ Universal Declaration at art. 1; Civil and Political Rights Covenant at preamble; Banjul Charter at art. 5; African Charter on Children at art. 11(5).
- ⁶¹⁸ Banjul Charter at art. 5.
- ⁶¹⁹ Maputo Protocol at art. 3.
- ⁶²⁰ African Charter on Children at arts. 11, 17, 20.
- ⁶²¹ Banjul Charter at arts. 9(1), 17(1).
- ⁶²² Maputo Protocol at art. 14.
- ⁶²³ CESCR General Comment No. 14 at para. 11; *ICPD Programme of Action* at paras. 7.2-7.3; *Beijing Platform for Action* at paras. 94-95.
- ⁶²⁴ *ICPD Programme of Action* at para. 7.5(a).
- ⁶²⁵ CESCR General Comment No. 14 at para. 11.
- ⁶²⁶ *Id.* at para. 12(b).
- ⁶²⁷ CEDAW at arts. 10(h), 14(2)(b), 16(1)(e). Further elaborating on these rights, the CEDAW Committee has stated: “In order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services.” Committee on the Elimination of Discrimination against Women, *General Recommendation 21: Equality in marriage and family relations*, para. 22 (Feb. 4, 1994).
- ⁶²⁸ Children’s Rights Convention at art. 24(2)(f). In numerous concluding observations, the Committee has recommended that states strengthen their reproductive health education programs for adolescents in order to combat adolescent pregnancy and the spread of HIV/AIDS and other STIs. *See, e.g.*, Concluding Observations of the Committee on the Rights of the Child: Egypt, para. 44, U.N. Doc. CRC/C/15/Add.145 (Feb. 21, 2001); Concluding Observations of the Committee on the Rights of the Child: Georgia, para. 51, U.N. Doc. CRC/C/15/Add.222 (Oct. 27, 2003); Concluding Observations of the Committee on the Rights of the Child: Latvia, para. 45, U.N. Doc. CRC/C/LVA/CO/2 (June 28, 2006). Further the Committee has suggested that girls should have access to information on the harm that early pregnancy can cause, and that those who become pregnant should have access to services sensitive to their particular needs. CRC General Comment No. 4 at 31.
- ⁶²⁹ *See, e.g.*, Human Rights Committee, *General Comment 16: The right to respect privacy, family, home and correspondence*, para. 10 (Apr. 8, 1988), (affirming the right of individuals to access files containing their personal data) [hereinafter CCPR General Comment No. 16].
- ⁶³⁰ World Health Organization, *A Declaration on the Promotion of Patient’s Rights in Europe* art. 4.4 (Mar. 1994).
- ⁶³¹ Universal Declaration at art. 12; Civil and Political Rights Covenant at art. 17; Children’s Rights Convention at art. 16; African Charter on Children at art. 10.
- ⁶³² Civil and Political Rights Covenant at arts. 17(1), 23(1).
- ⁶³³ Economic, Social and Cultural Rights at art. 10.
- ⁶³⁴ CCPR General Comment No. 16 at para. 1.
- ⁶³⁵ Maputo Protocol at art. 4(h); Civil and Political Rights Covenant at art. 7. *See also*, CCPR General Comment No. 20 (explaining that “Article 7 expressly prohibits medical or scientific experimentation without the free consent of the person concerned.”). Similarly, the CEDAW Committee has affirmed a woman’s right to information regarding health care and treatment options, stating that the government has an obligation to prohibit “forms of coercion ... that violate women’s rights to informed consent and dignity.” CEDAW General Recommendation No. 24 at paras. 20, 22.
- ⁶³⁶ *See, e.g.*, Universal Declaration at art. 8; Civil and Political Rights Covenant at art. 2(3)(a); Maputo Protocol at art. 25. In explaining the right to an effective remedy, the Human Rights Committee states that not only does the Civil and Political Rights Covenant establish that states must protect individuals from rights violations, but states must also take positive steps towards ensuring that, when violations do occur, “accessible and effective remedies” are available in order to “vindicate those rights.”
- ⁶³⁷ Maputo Protocol at art. 25(a).
- ⁶³⁸ Human Rights Committee, *General Comment No. 31: Nature of the General Legal Obligation Imposed on States Parties to the Covenant*, para. 15, U.N. Doc. CCPR/C/21/Rev.1/Add.13 (May 26, 2004).
- ⁶³⁹ CEDAW General Recommendation No. 24 at para. 13.
- ⁶⁴⁰ CESCR General Comment No. 14 at para. 59 (“Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels.”).
- ⁶⁴¹ The Proposed New Constitution of Kenya (2005), Kenya Gazette Supplement No. 63, at art. 37 (Aug. 22, 2005) [hereinafter referred to as the Draft Constitution]. While prohibiting, abortion, the draft did make room for abortion to be legal where an act of parliament so stipulates, leaving it to the legislature to determine when and if abortion would be permissible rather than outlawing it absolutely. Draft Constitution at art. 35(3).
- ⁶⁴² Draft Constitution at art. 37(4).
- ⁶⁴³ *Id.* at art. 38(4).
- ⁶⁴⁴ *Id.* at art. 61.
- ⁶⁴⁵ *Id.* at art. 31(1).
- ⁶⁴⁶ The Penal Code, Cap 63 of the Laws of Kenya, (Revised ed. 1985) [hereinafter The Penal Code].
- ⁶⁴⁷ The Penal Code §§ 250, 251.
- ⁶⁴⁸ The Penal Code §§ 231, 234.
- ⁶⁴⁹ The Penal Code § 243(e).
- ⁶⁵⁰ Committee on Economic, Social and Cultural Rights, *General Comment No. 3: The nature of States parties obligations*, para. 5 (Dec. 14, 1990) (hereinafter CESCR General Comment No. 3).
- ⁶⁵¹ Civil and Political Rights Covenant at art. 2(3)(b).

- ⁶⁵² CCPR General Comment No. 31 at para. 15.
- ⁶⁵³ Committee on Economic, Social and Cultural Rights, *General Comment No. 9: The domestic application of the Covenant*, para. 9, U.N. Doc. E/C.12/1998/24 (Dec. 3, 1998).
- ⁶⁵⁴ *Id.* at para. 9. The Committee further states that “whenever a Covenant right cannot be made fully effective without some role for the judiciary, judicial remedies are necessary.”
- ⁶⁵⁵ Civil and Political Rights Covenant at art. 2(3)(c).
- ⁶⁵⁶ CCPR General Comment No. 31 at para. 16 (stating that the state’s obligation to provide an effective remedy “is not discharged” if the state fails to provide reparations to individuals whose rights have been violated).
- ⁶⁵⁷ CCPR General Comment No. 31 at para. 16; Committee on Economic, Social and Cultural Rights *General Comment No. 14: The right to the highest attainable standard of health*, para. 59, U.N. Doc E/C.12/2000/4 (Aug. 11, 2000).
- ⁶⁵⁸ CCPR General Comment No. 31 at para. 15.
- ⁶⁵⁹ *Id.* at para. 15.