DELIVERY OF SERVICES TO PREGNANT WOMEN IN SELECTED HOSPITALS IN NAIROBI, KENYA: A CRITICAL ANALYSIS OF THE LEGAL AND HUMAN RIGHTS IMPLICATIONS

BY

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A Dissertation submitted in partial fulfilment of the requirements for a Masters Degree in Women's Law, Southern and Eastern African Regional Centre for Women's Law, University of Zimbabwe

2012

Abstract

The writer of this dissertation, a lawyer, examines the delivery of services to pregnant women in two selected hospitals (*viz.,* Pumwani Maternity Hospital and Kenyatta National Hospital) in Nairobi, Kenya and attempts to measure the delivery against the standards laid down in legal and human rights instruments which are local, regional and international in nature (e.g., the Constitution of Kenya, CEDAW and the African Protocol on Women's Rights). Interviews were held with a total of 41 respondents, including current and former women patients and service providers at the two hospitals as well as several key informants in the facilities, government and the NGO community. The research was driven by the fact that, despite Kenya being a party to international instruments guaranteeing the rights of women, and as well as having a constitutional dispensation that entrenches the promotion and protection of reproductive rights, women of Kenya women do not apparently enjoy those rights, especially in the field of reproductive health care. The writer utilizes several gender-centred methodologies (especially the Women's Law, Grounded Theory and Human Rights based Approaches) and complementary data collection methods to gather and analyze relevant written and verbal evidence of the deplorable extent to which the State is breaching its duty to realize its patients' right to good health. In unhygienic, overcrowded, grossly underfunded and disintegrating facilities managed by overworked, underpaid and rude staff it comes as no surprise that some breaches are so serious that they even result in death. Having determined the traumatic nature of the lived realities of these poor and mostly ignorant patients, the Women's Law Approach also looks to these same women for their suggestions about possible solutions to their lamentable predicament. Their answers form the basis of a multitude of recommendations and reforms which, the writer finally suggests, should be implemented by the Government in conjunction with the NGO community and in conformity with its obligations under the country's Constitution and several binding/persuasive regional and international Human Rights instruments. These include educating women about their reproductive health rights and putting in place complaints procedures to redress breaches of them; abolishing the illegal practice of detaining poor patients for failing to pay their medical bills; establishing a properly run fee waiver system for poor patients; increasing funding to update equipment, purchase drugs and consumables and improve staff wages and salaries; increasing staff numbers to proper levels and improving their management and treatment of women patients.

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Dedication

I dedicate this work to my late mother Mrs. I. N. Thuo who contributed to what I am today, my father Mr. Paul Thuo , my daughters Wambui and Njeri, my sisters Susan, Lucy, Florence and Victoria my brothers Mark and Vincent, and my grandson Miguel for their support throughout.

You are my heroes.

Acknowledgements

Firstly is to thank my God, the Lord Jesus Christ who has seen me through the experiences of undertaking these studies.

To my father and my late mother who toiled and gave up a lot to enable all his children get an education and encouraged us all to aim high, although my mother has unfortunately been robbed by death of witnessing this milestone in my life.

Thanks indeed to the Norwegian Ministry of Foreign Affairs for generous funding and opening up an opportunity for me to gain deeper insight into the plight of women in Africa and worldwide.

All my interviewees at Pumwani and Kenyatta hospitals in Nairobi, Kenya and all officials at Ministry of Health, at Pumwani and Kenyatta hospitals and City Council of Nairobi. I am indebted to Commissioner Winfred Lichuma of Kenya National Commission on Human Rights and Elise Slattery of the Centre for Reproductive Rights(Kenya) all of who provided vital information that shaped this study. To the women who opened up their hearts to me at the said hospitals shukrani sana.

I sincerely thank Professor Stewart, Dr. Tsanga and R. Katsande as well as all guest lecturers for vital knowledge and information imparted on Women's law. Special thanks to my supervisor, Dr. Tsanga for her unmatched academic guidance and advice throughout my research.

My heartfelt gratitude goes to all the staff at SEARCWL offices and at Basil Fletcher Flats for making my stay in Zimbabwe comfortable and memorable.

To the class of 2011/12 may you continue the journey you have undertaken and keep on fighting for the rights of the voiceless. You were great people; I enjoyed our shared experiences and stimulating intellectual discussions.

May God bless you all.

Abbreviations

CRR (K)	Centre for Reproductive Rights (Kenya)
FIDA (K)	International Federation of Women Lawyers (Kenya)
KNCHR	Kenya National Commission on Human Rights
KNH	Kenyatta National Hospital
MDG	United Nations Millennium Development Goal
MOH	Ministry of Health
NCC	Nairobi City Council
NGO	Non-Governmental Organization
NHP	National Health Policy
PMH	Pumwani Maternity Hospital
TBA	Traditional Birth Attendant
UN	United Nations
USAID	United States Agency for International Development
WHO	World Health Organization
Kshs	Kenyan Shillings
US$	United States Dollars

International Instruments cited

The Convention on the Elimination of all forms of Discrimination against Women (CEDAW)
The Protocol to the African Charter on Human and Peoples' Rights on Rights of Women in Africa ('The African Protocol on Women's Rights')
International Conference on Population and Development (ICPD)
The Beijing Platform for Action
The Universal Declaration of Human Rights (UDHR)
The United Nations International Covenant on Civil and Political Rights (ICCPR)
The United Nations Convention on Economic, Social and Cultural Rights (ICESCR)
United Nations Millennium Development Goals (MDGs)

National Legislation cited

The Constitution of Kenya
The Penal Code, Chapter 63 of the Laws of Kenya

Definition of Terms

Availability of Care means that for functioning health system facilities, goods and services as well as programmes should be available in sufficient quantity and these include trained medical personnel, health facilities and materials needed for the functioning of the health sector.

Accessibility of Care means that the health facilities should be physically accessible by the availability of ambulances and other forms of conveyance to hospital and the availability of road networks linking the health institutions. It also means women do not have to travel long distances to get to a hospital or a clinic, and has too a dimension of non-discrimination in that health facilities, goods and services must be available to all especially the most vulnerable and marginalized.

Affordability of Care means that the services provided by the health providers should not be so expensive that women cannot afford and stay away as a result of the cost.

Acceptability of Care means that the care provided must be respectful of medical ethics and culturally appropriate, taking into account the needs of women and accepting their differences.

Quality Care means that heath facilities, goods and services must be scientifically and medically appropriate and of good quality. This requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water and adequate sanitation.

Midwife - a specially trained nurse who specializes in maternal health or assisting women in giving birth.

State Registered Nurse - a health care professional with basic medical training not specialized training to assist during birth.

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CHAPTER ONE

1.0 INTRODUCTION

1.1 Introduction

There have been many stories in the Kenya media on women being detained in hospitals for their inability to pay hospital bills and having to share beds, as well as human rights abuses suffered by women in the health facilities. Although the Kenya government has taken positive steps to enhance women's health and reproductive rights, the most recent being entrenchment of those rights in the Constitution, the abuses and violations suffered by women still continue. The lack of funding for public health facilities contributes to a great measure to the emergence of a health system in Kenya that discriminates against poor women and prevents or delays access to health care. The government controls almost all health facilities in the country and whilst government facilities cost less money, they tend to be congested, and lack supplies and sufficient staff. Women need to receive quality health care in order for safe motherhood initiatives being promoted by the government to succeed.

Health care providers in public facilities on the other hand are also faced with various challenges in providing quality health care. These include understaffing, lack of institutional support, inadequate supplies and equipment. A staff shortage results in overworked and stressed staff with low morale and also contributes to unhygienic conditions which can threaten lives of mothers and babies.

My research therefore has attempted to unearth the reality on the ground as to whether Kenya is honouring its domestic and global commitments relating to maternal rights. What should Kenya do that it has failed to do in order to honour those obligations? I interviewed women both in and outside hospitals, relevant stakeholders and government officials concerned as well as health care providers. I also looked into whether the government is honouring its international

obligations under the human rights treaties it has ratified and where it is obliged to ensure the quality, acceptability, affordability and access to reproductive health care.

As it is rightly stated in (Kolala, Damaracy 2000, pg.4) women have a different status from men in every society; one of subordination. Women typically have less control over resources and the sexual division of labour burdens women with multiple demanding roles. Equally important is the fact that women and men undergo very different processes of socialization and these give them such disparate identities that they have different perceptions and definitions of good health and ill health. Consequently, not only do women and men have differing health needs and health problems and access to health services, but also varying perceptions of health itself.

Based on my findings, I have then made recommendations that can improve the lives of women and ensure the attainment of the highest standards of health.

1.2 Why This Topic?

I chose this topic following the many complaints aired in the media by women since most women attend the two hospitals that were my research sites as they are public hospitals and therefore less costly than private hospitals. It was my feeling that by researching this topic my understanding and appreciation of problems faced by women when accessing delivery services would be broadened. I would be in a better position make my contribution to the issues of reproductive health from an informed view point, and thus help toward improving the direction of policy and legislation direction to ensure women enjoy their reproductive rights.

1.3 Why Kenyatta and Pumwani Hospitals as the Locations of the Study?

If I looked at all of these health institutions it would give me a diverse view of the problems facing health providers in the country. A number of institutions would also give a comparative analysis of the problems faced by women according to location. For example, Pumwani hospital

is located in the poorer sections of the City of Nairobi, and has some of the poorest women as their clientele dealing with up to 24,000 deliveries per year (FIDA (K) 2007) and is the largest maternity hospital in East and Central Africa, while Kenyatta hospital is a national referral and teaching facility and has a private maternity wing which most women cannot afford. By virtue of being a teaching hospital, it is expected to set standards for other hospitals and my research would benefit from this analysis. Both of these hospitals are public and admit women from all over the country, and most of the women who attend these two hospitals have no prior antenatal check up and thus there is no useful medical information to warn staff of any complications. Some of the common complaints by women who attend these two hospitals are lack of doctors and drugs as well as degrading treatment meted out to them by the medical personnel. Women are physically assaulted, sexually harassed, insulted and jeered at from the time they enter the hospital until they leave. No steps are taken to curb these abuses (FIDA (K) 2007). In addition Pumwani falls under the jurisdiction of the City Council of Nairobi while Kenyatta is under the mandate of the Ministry of Health, became a State Corporation in 1987 and is currently run by board of management. KNH handles between 25-30 deliveries daily according to the assistant chief nurse.

1.4 Statement of the Problem

It appears there is a problem between the existence on paper of human rights on reproductive rights for women and their actual or effective enjoyment of those rights in Kenya. Women's enjoyment of their rights to health care, especially pregnant women, is more of a myth than a reality. Women are most vulnerable during pregnancy and childbirth and their exclusion from policy and decision-making roles marginalizes them further and portrays a systematic lack of adequate government responsiveness to women's conditions and needs. Giving birth in hospitals has become a nightmare for women especially where the quality of care has deteriorated and is no longer acceptable to most women. The government has an obligation in accordance with human rights instruments to protect the rights of women and to improve their quality of life. The standards that were used to analyze the problem have been set in the international instruments and were aptly summarized in the book titled 'Claiming our Rights: Surviving Pregnancy and

Childbirth in Mali' (KatsiveL, Djourte F 2003). The book states the problem and what the government needs to do to guarantee the rights of women. The book analyses the concept of availability, accessibility, affordability and quality of health care that needs to be made available to pregnant women. The availability of health care is the provision of health care facilities with all the essential equipment and materials and trained personnel at birth for pregnant women. It shows how the lack of health facilities has resulted in women not having access to prenatal care as the number of health facilities is inadequate.

In Kenya there are similar problems and yet, under international and regional human rights instruments, international consensus documents and national laws, the government has a legal obligation to address these human and reproductive rights of women. For instance, Kenya having ratified CEDAW should comply with Article12(2) which provides:

> *'States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality with men and women, access to health care services in connection with pregnancy, confinement and post natal period, granting free services where necessary, as well as adequate nutrition during pregnancy.'*

Kenya is also a signatory to The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Article 14(2) of which provides;

> *'States Parties shall take all appropriate measures to:*
>
> *a) provide adequate, affordable and accessible health services including information, education and communication programmes to women especially those in rural areas;*
> *b) establish and strengthen existing pre-natal, delivery and post- natal health and nutritional services for women during pregnancy and while they are breast-feeding;*
> *c) protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus'*

The Covenant on Economic, Social and Cultural Rights at Article 12 (2) provides:

> *'The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'*

The Covenant provides a framework for identifying if governments are implementing the right to health. In the General Comment on the right to the highest attainable standard of health it provides that there are four essential and interrelated elements which are availability, accessibility, acceptability and quality[1] and I used these elements to identify shortcomings of the health system in Kenya and specifically at Kenyatta and Pumwani hospitals.

In the year 2010, Kenya promulgated a new Constitution which entrenches social and economic rights including right to health and reproductive health. Section 43(1) (a) provides:

> *'Every person has the right to-*
>
> *a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.'*

Despite these international and national instruments being so specific, women in Kenya still face major problems when seeking access to delivery services. The maternal mortality rates are very high at 1,000 per 100,000 births (USAID 2008). This is blamed on the lack of access to skilled medical care during labour and delivery. Many more women are maimed and injured as a direct result of negligence of the birth attendants. As much as the government has made commendable efforts to reduce maternal mortality by nationwide campaigns for maternal check-ups, the training of birth attendants, among other measures, and the treatment of pregnant women by medical staff in hospitals lacks dignity.

I met the women involved in this research in and out of the hospitals and heard their lived realities, and was told harrowing stories of gross human rights violations. I also went to my research sites of Kenyatta and Pumwani hospitals in Nairobi and observed how pregnant women

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[1] ICESCR General Comment 14.

accessed delivery services there and was thus able to measure this against the set international and national standards on reproductive rights of women.

1.5 Objectives of the Research

Broad Objective

The overall aim of the research was to identify factors that impede access to delivery services by pregnant women in the two selected hospitals in Nairobi and to examine the findings against a human rights framework, grounded in national and international law. This framework provides the basis for the study's recommendations.

Specific Objectives

These were formulated to help me focus on the main issues in my study as follows:

1. To examine women's reproductive health rights as regards delivery of services to pregnant women in selected hospitals in Nairobi, Kenya in the light of specific human rights provisions as well as constitutional obligations.

2. To unearth women's lived in realities as regards delivery of services to pregnant women and measure them against expected legal and human rights standards.

3. To investigate factors that impact on the delivery of services to pregnant women regarding the access and quality of health care facilities, goods and services.

4. To recommend measures that will enhance and improve delivery of services to pregnant women in order to comply with legal and human rights standards and expectations.

1.6 Research Assumptions

1. Although Kenya has ratified and signed key instruments such as CEDAW and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa and has a Constitution that also recognizes health rights, there is a gap between the existence of women's reproductive rights and their effective enjoyment of them.

2. The services that pregnant women receive do not meet the expected legal and human rights standards.

3. The women do not have access to quality maternity services in the hospitals.

4. The government has not put in place a comprehensive reproductive health policy or laws that, among other things, allocate resources to promote access to delivery of services to pregnant women.

1.7 Research Questions

The study asks the following questions which emanate from the assumptions:

1. Is there a gap between the existence on paper of the reproductive rights and their effective enjoyment?

2. Do the services that pregnant women receive meet the expected legal and human rights standards?

3. What kind of maternity services do the women receive in the hospitals?

4. Does the government need to put in place a comprehensive reproductive health policy or laws that among other things allocate resources to promote access to delivery of services to pregnant women?

1.8 Structure of the Dissertation

The dissertation will be structured as follows:

Chapter One deals with the introduction of the topic and the reason the topic was chosen. It also looks at the statement of the problem faced by women in attaining the right to reproductive health.

Chapter Two deals with the literature used to further the understanding of my research as well as the arguments advanced by different authors. The chapter also deals with the human rights instruments and national frameworks that provide the right to reproductive health.

Chapter Three discusses the methodologies and methods utilized in conducting the research, and the challenges encountered.

Chapter Four deals with the findings as they relate to the initial assumptions that informed the research.

Chapter Five deals with the analysis of the findings and how the State is responding to the situation in the hospitals. It also looks at the responsibilities of the State according to international human rights instruments and how the instruments are being implemented if at all.

Chapter Six is the conclusion and the recommendations that are needed which emerged from the findings.

CHAPTER TWO

2.0 LAW AND LITERATURE REVIEW

2.1 Introduction

This chapter looks at the human rights framework that informed the study and how they capture the rights of pregnant women to maternal health. It also discusses the national framework that promotes and protects those rights.

2.2 Human Rights Framework

The research was premised on a human rights background where I was looking at the delivery of services to pregnant women as provided for in international and regional instruments. Human rights provide for minimum standards of care that are supposed to be implemented by governments so that the care is acceptable, available, affordable and accessible. It was from this premise that I started the research in order to find out to what extent the government is implementing or violating the rights of pregnant women to health care. Women have a right to survive pregnancy and the human rights framework provided me with the opportunity to see how things are done on the ground as compared to what they should be.

The human instruments are designed to give an indication of areas of priority, such as health services, to which resources should be allocated.

The instruments I referred to were:

Article 4 of the African Charter on Human and People's Rights which provides:

> *'Human beings are inviolable. Every human being shall be entitled to respect for his life and integrity of his person. No one may be arbitrarily deprived of this right.'*

This instrument was used in so far as it provides that the lives of women should be respected and women should not lose their lives when giving birth for no justifiable reason and all measures should be taken to save their lives.

The Convention on the Elimination of All Forms of Discrimination against Women provides a basis for rights of women, being the first instrument to expressly guarantee women the right to equality and since Kenya has ratified the Convention, this therefore means that the State is bound to pursue active measures to eliminate discrimination against women in all sectors including the health sector.

Article 12(1) provides that:

> *'States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure on a basis of equality with men and women, access to health care services, including those related to family planning.'*

This article provides for equality of access to healthcare between men and women and can be criticized for not taking into account the fact that women have special needs more than men are ever likely to have.

Article 12(2) provides that:

> *'notwithstanding the provisions of paragraph 1 of this article states parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.'*

This means that states have an obligation to eliminate discrimination and make sure that women enjoy benefits on a basis of equality with men and also take into consideration the special needs of women.

The article deals specifically with the matter of the cost of health care and provides that the State should provide free services where necessary and I felt this has an impact on the situation in the country where women are detained for their inability to pay hospital fees.

In terms of Article 12(1) of the International Covenant on Economic, Social and Cultural Rights:

> *'The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'*

The Covenant provides a framework for identifying if governments are implementing the right to health in terms of General Comment 14 of the ICESCR Committee, which gives the four interrelated and essential elements of availability, accessibility, affordability and quality. These elements were utilized in this study to identify the shortcomings of the health system in Kenya, specifically at Kenyatta and Pumwani hospitals.

The covenant grants women the right to the highest standard of physical and mental health and States Parties who are party to the covenant should uphold this.

The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa provides broad protection for the rights of women, including sexual and reproductive rights thus affirming reproductive choice and autonomy as a key right. Under Article 3 it provides that:

> *'Every woman shall have the right to dignity inherent in a human being and to the recognition and protection of her human and legal rights.'*

This guarantees women the right to be protected and to make sure that their rights are respected and protected by law.

Article 14(2) (b) provides:

> *'States Parties shall take all appropriate measures to establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breastfeeding.'*

The government of Kenya should take all measures to ensure these services to women in accordance with their obligations under this Protocol.

The Millennium Development Goals 4 and 5 are on the reduction of infant mortality and the reduction of maternal deaths by year 2015. Kenya is signatory to the development goals and is therefore committed to do the minimum requirements so as to achieve the goal by 2015.

At the moment, although there are efforts in place such as safe motherhood campaigns by the government being undertaken to reduce incidences of maternal deaths and infant mortality, lack of adequate finances and political goodwill on issues concerning women generally may make it difficult for the goals to be realized by the set dates. Kenya also has in place a National Reproductive Health Policy, 2007 which outlines priority actions for improving maternal health and reducing neonatal and child mortality. More on this will be discussed in the national framework.

Kenya is also a party to politically binding international consensus documents that support a globally recognized reproductive rights framework. These include the ICPD Conference and the Beijing Conference both of which Kenya participated in. The ICPD Conference that was held in 1994 stated that:

> *'Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of all couples and individuals to decide freely and responsibly, the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.'*[2]

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[2] Source: Centre for Reproductive Law and Policy (para.7.3) available online at www.crip.org accessed on 18 January 2012.

The Beijing Conference confirmed and built on the links established between women's reproductive health and human rights. Not only did the Beijing Platform of Action focus on governments' obligations to fulfil and create conditions to enable women and men realize their rights to health, but it also took a holistic view of health and the social, political and economic factors affecting health.

Despite the impressive documents described above and the fact that Kenya has committed herself to improving the state of sexual reproductive health rights, Kenya, like the rest of Africa, is still poor (Maina, B, and Kulane, A, 2011). In the book, 'Sexual and Reproductive Health Rights' in African Sexualities: A Reader', Sylvia Tamale (ed.) it states:

> *'The majority of women lack access to basic sexual and reproductive health services and information, safe labour and delivery services, emergency obstetric care, essential drugs and contraceptive supplies. This scenario is the result of the interplay between gender power imbalances, cultural and religious forces, poverty and deteriorating socio-economic conditions in most African countries. In most of these countries, reproductive rights are within the framework linked to development and human rights. This has created and maintained structural inequalities, resulting in poor countries finding it increasingly difficult to meet their health care obligations and to address the state of sexual and reproductive health.'*

This is the scenario in Kenya and thus there is a need for the Kenya government to find strategies on how to implement the international documents on the rights of women to reproductive health services in the face of the existing challenges.

2.3 National Framework

2.3.1 Constitutional Provisions

The Constitution of Kenya has now explicitly provided for economic and social rights and especially the right to health. Article 43(1) (a) states:

'Every person has the right to the highest attainable standard of health, which includes the right to heath care services, including reproductive health care.'

In Article 21(2) of the Constitution it states:

'The State shall take legislative, policy and other measures, including the setting of standards, to achieve the progressive realization of the rights guaranteed under Article 43.'

Article 22(1) provides:

'Every person has the right to institute court proceedings claiming that a right or fundamental freedom in the Bill of Rights has been denied, violated or infringed, or is threatened.'

Article 27(4) has broadened the grounds that constitute discrimination and reads:

'The State shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth.'

This is very good for women since they have the protection of the supreme law of the land even when they are pregnant. The policy of detaining women in hospital for the failure to pay bills falls neatly into this definition and hospitals guilty of this illegal and unconstitutional practice may be sued for doing so.

The fact that the Constitution provides for the right to health means the State has an obligation to provide health care for its people. If a person has an issue with the health sector, for instance, the wrongful death of a woman while giving birth in a hospital, the person has a constitutional right and can sue the hospital, the doctor responsible, and the State for not making the situation conducive to the provision of quality health care services.

This means that it is now possible for women to have recourse to the law if their rights are violated.

2.3.2 Other Legislative Provisions

The Penal Code criminalizes various forms of assault against the person. Intentional acts that are intended to wound or cause grievous harm to an individual's health are felonies. Health care providers who wound or cause grievous harm to patients may be prosecuted under these provisions. The Penal Code does not provide for protection against psychological harm - a key element of the violation of reproductive rights. However, abusive or neglectful health care may be remedied on the basis that it amounts to inhuman treatment or torture in breach of the Constitution.

2.3.3 Government Policies

Kenya has developed various policies, frameworks, guidelines and action plans in relation to reproductive health rights. These include the 2000 National Population Policy for Sustainable Development, the National Health Policy Framework, the National Health Sector Strategic Plan, the National Reproductive Health Strategy 1997-2010 and the National Reproductive Health Policy 2007. However the effective implementation of these policies remains a major headache, thus limiting their impact and efficacy.

For instance, the NRH Policy 2007 has very noble aims as it has a framework providing for equitable, efficient and effective delivery of quality reproductive health services. The policy is meant to guide the provision of high quality services to those in need and the most vulnerable and to fast track the government's efforts towards realization of the health related Millennium Development Goals (MDGs) and the ICPD Goals. It further incorporates the principles of human rights and freedoms and the promotion of gender equity and equality, empowerment of women and the elimination of all forms of gender-based violence and related harmful practices. Finally it states that implementation of the policy should be guided by adoption of evidence based practices, a human rights approach, quality improvement, standard setting and audit, and application of appropriate and cost free technologies.

This is all fine on paper but the sad truth based on my research is that the policy is far from being implemented. According to one of my key informants from the Division of Reproductive Health the policy was only officially launched in 2010, the same year that Kenya received its new Constitution and therefore the policy is now in the process of being reviewed in order to make it compatible with provisions of the Constitution on reproductive health. It is obvious the government needs to do much more to comply with the Constitution and ensure women's reproductive rights are protected, ensured and promoted both in word and in deed.

2.4 Literature Review

In order to further my understanding of the subject of healthcare I researched relevant books and articles on the subject. The one found most relevant is (Katsive L and Djourte F 2003), 'Claiming our Rights: Surviving Pregnancy and Childbirth in Mali'.

This book revealed and explained the dynamics that are involved in the choices women make about their pregnancies; that indeed most women cannot make that choice independently but do so under duress, even when it is not in their best interest to have another child. The book also helped in understanding that for African states the reality is that for the African woman, pregnancy continues to be a life-threatening condition, notwithstanding the existence of the international human rights instruments. The book notes that the right to survive pregnancy and childbirth is grounded in women's right to life, the most fundamental of all human rights. Several factors have impeded women's enjoyment of their rights to health care that is available, accessible and acceptable and of good quality.

Availability is undermined by the lack of facilities and shortages in material supplies and human resources. Accessibility is hampered by women's lack of information, prevalence of misconceptions and myths surrounding pregnancy and childbirth. Acceptability is compromised by health care workers who treat women, particularly low-income women, with disrespect and

are unresponsive to their needs. Quality of care has suffered as a result of lack of modern health system evaluations and inadequate continuing education and provider regulation.

Discrimination against women in Mali is rampant and takes several forms, all of which contribute to women's vulnerability during pregnancy and childbirth. Formal laws and policies, such as early minimum legal age of marriage and exclusion of women from policy and decision-making roles, marginalizes women and reflect lack of government responsiveness to women's physiological conditions and needs. Female Genital Mutilation affects women's ability to endure childbirth. Women's low status within the family further jeopardizes their lives in a health care context that is poorly equipped to address complications of pregnancy.

Women are seen as nurturers and mothers and lack reproductive self-determination. The law and medical providers further undermine women's autonomy by demanding authorization for certain procedures from husbands. Women's ability to seek care is impeded by their lack of decision-making power in the family. Under international and regional human rights instruments and national laws, the Mali government has a legal obligation to address all factors contributing to women's risk of death during pregnancy and childbirth. Policies and government institutions recognize the need to improve women's status particularly their reproductive health. There is a need to make legal and policy guarantees a reality for women of Mali.

The book recommends that:

- The government invests in maternal and emergency obstetric care.
- Allocate additional funding to health care facilities.
- Address material shortages at hospitals.
- Establish emergency referral and transportation systems.
- Expand family planning services.
- Address unsafe abortions.
- Make women centres health friendly.
- Improve medical training programs.
- Improve health care standards.

- Law reform addressing reproductive health.
- Investigate malpractice.
- Empower women to claim their reproductive rights.
- Champion a concerted approach among government ministries.

Hence this book has given a good exposition on the issues at hand. The book also illustrates how the terms accessibility, acceptability, availability and quality of care are used in the health sector and gives examples of how the Mali government has failed to live up to the standards set by ICESCR and thus failed to guarantee the women's rights to maternal health. This assisted a great deal as it showed women in Africa undergo similar problems in this area and I was encouraged to go out and investigate, using this human rights approach, how these issues affected Kenya women.

During the last decade, a rights based approach to sexual and reproductive health of men and women has evolved (Tamale S (ed.) 2011, African Sexualities: A Reader). This book states that this approach highlights not just the rights but who should implement and safeguard those rights. As individuals we have the right to the highest attainable standard of health, including the right to life and the right to control our reproductive and sexual health, the right to make reproductive decisions including the number and spacing of children without coercion. The rights approach upholds non-discrimination and obligates governments to ensure equal access to health care for everyone. The book questions why despite enhanced articulation of the rights principles, the state of sexual and reproductive health remains poor in Africa and reflects how African feminists, women's movements and human rights advocates are being innovative in their use of the rights based approach.

This book convinced me that this is an opportune time for Kenya to improve its articulation of reproductive health by actively applying the right based approach.

In yet another book (Cook R, Dickens B and Fathalla M 2003, 'Reproductive Health and Human Rights') the authors address relations between men and women by reference to their natural biological differences, and the socially constructed differences. Social structure often rests with

deeply held cultural, religious social and other dispositions that condition attitudes to the point that they make them appear as self-evident truths or laws of nature that do not require analysis. However, social practice sometimes departs from those gendered stereotypes. For instance, many families including those with parties of both sexes depend on women discharge the masculine function of providing family sustenance and guidance, while men discharge the feminine function of providing care. The book however says that the incorporation of human rights principles can facilitate the pursuit of reproductive and social health in circumstances of social justice and equity.

Hence a rights based approach seeks not only to work with and build people's sense of entitlement but also to build the preconditions for accountability and responsiveness within authorities as well as strengthening their capacity to honour their obligations (Cornwall A,Welbourn (eds.) 2002, Realizing Rights: Transforming Approaches to Sexual and Reproductive Wellbeing). As such, it offers powerful possibilities for realizing rights: both in enabling people to become aware of and able to articulate their rights, and in making real entitlements to reproductive and social well being.

In my view this can work well in Kenya as most people are not even aware they have rights which deserve respect and protection by the State and especially the marginalized and 'silenced' majority - the women - by empowering women to fight for their rights.

Women's combined biological and social vulnerability to sexual and reproductive health problems means that they need to be able to exercise choice in their reproductive and sexual lives and it is in this area that human rights instruments relating to reproductive rights play a central role. Improvement in women's health requires more than better science and health care; it also requires state action to correct injustices to women and to help create the enabling conditions necessary for them to exercise these rights. It is the responsibility of the state to ensure that these rights are realized.[3]

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[3] 2000, Health and Human Rights, An International Journal Vol.4 no.2.

The book (Banda F. 2005), 'Women, Law and Human Rights: An African Perspective' guided me in my understanding of the language of rights and the African continent. There are arguments that rights are the language of the West and that they have been imposed on Africa. This statement helped me appreciate the reasons why people in authority at government offices and the hospitals seemed wary and suspicious of my research as maybe they felt I was trying to criticize the government.

Even if the international instruments had been the language of the West, African governments accepted the terms upon their ratification of the international instruments, thereby showing a commitment to the language of rights and agreement to be bound by the provisions. Banda explains further that Africans have attempted to make the conventions more African by having African instruments that reflect values of African people.

There is an African Charter for Human and People's Rights and there is the African equivalent of CEDAW in the Protocol on the Rights of Women in Africa. CEDAW had left out issues that were unique to African women and not experienced by Western women, for example polygyny and widow inheritance. The Protocol on the Rights of women included these and also reinforced the rights that were contained in CEDAW so that African states are still bound.

The governments cannot then argue that the values reflected are Western as they have embraced the language of rights and are therefore bound to implement provisions of those rights.

I also found several internet articles on the state of Pumwani hospital. I believe there are more media reports about it than Kenyatta hospital on this issue of maternal health since it is the largest maternity facility in Kenya and Eastern/ Central African region. One article[4] states that Pumwani is located close to two of the biggest slums in Nairobi and helps 27,000 women give birth every year. Most are poor and young (between the ages of 14 and 18). The hospital strives to provide even the basic services, since it lacks sufficient resources, equipment and staff. Patients have to buy gloves, syringes, needles, cotton wool and maternity pads. According to

[4] Source: available online at http/www/un.org/ecosodew/afric/Vol2/214 accessed on 18/9/2012(article dated January 2008).

WHO, the high service cost, lack of trained staff and supplies, poor transport and patients' insufficient knowledge mean that 60% of mothers in Sub-Saharan Africa do not have a health worker present during birth.

This heightens the risk of complications, contributing to greater maternal and child deaths and disability. However the international community has agreed that bringing down maternal mortality is a priority. The Millennium Development Goals of reducing child and maternal mortality include specific target of reducing the number of women dying during pregnancy and childbirth by three quarters by 2015. At Pumwani hospital, up till May 2007, patients wishing to receive maternal care had to deposit Shs. 1200 and the women without money were turned away. Normal delivery cost Shs. 3000 and caesarean 6000 with Shs. 400 bed charge for the first day. Daily bed charges of Shs. 400 accrue throughout women's stay at the hospital. Though this fee appears low it is a fact that 60% of Kenyans live on less than Shs 140 a day and cannot afford it.

In May 2007, then Health Minister Charity Ngilu abolished maternity fees in public hospitals such as Pumwani. But money had to come from somewhere. Dr. Govedi, in-charge of clinical services at the hospital, pointed out that already the hospital struggles to get the limited subsidy it is entitled to from Nairobi City Council. Without money the hospital cannot run. Dr.Ojwang a member of the task force set up in 2004 by the government to study the running of the hospital says that Nairobi City Council is marked with mismanagement and corruption, hence, Pumwani hospital could not get sufficient funds.

A further fact is that Sub-Saharan countries spend less than US$2 per person on maternal health. Most experts agree that you need to spend at least US$8. A study by WHO entitled, 'Reducing Mortality Rates', reports that some women and birth attendants fail to recognize danger signals and are not prepared to deal with them. The low status of women in society often leaves them with little power to determine if, when and with whom to become pregnant. The women also have little choice in the number and timing of their children.

When I did my research in 2011 the situation was that hospital user fees have been reinstated and most women still find it hard to access delivery services. More of this will be discussed in my

findings. The government also set up yet another task force in July 2011 on the running of PMH, and this will be discussed later in this literature review. But what is emerging is that the government sets up one task force after another and apparently the recommendations of these task forces are slow to be implemented, if at all. What does this portend for women? I believe it is high time the government got seriously engaged with this issue and fulfils its constitutional mandate of ensuring to Kenyan women the highest attainable standard of health.

In another report (FIDA and CRR 2007),[5] where the issues dealt with were access to care, safe and health pregnancy, the highlights were:

Experiences of over 120 women were noted as well as experiences and observation of health care providers and administrators during the period November 2006-May 2007. The report concludes that women's negative experiences in Kenyan health facilities not only have lasting public health implications for the country, but constitute severe violation of human rights that are protected under Kenyan, regional and international laws. The fact-finding, according to Jane Onyango Executive Director, FIDA revealed that women have for decades been subjected to degrading and sometimes even life-threatening treatment when seeking maternity care and services. While this report is specific to Kenya, the problems documented are not. Increasingly, such reproductive rights abuses around the world are being recognized as human rights violations that governments cannot ignore and must address, said Nancy Northup, President of the Centre for Reproductive Rights.

In interviews, focus group discussions and questionnaires, women describe egregious violations of dignity, mutilation, unhygienic conditions, humiliating treatment and lack of medical attention. Shortages of funding, medical staff and equipment plague the health care system, particularly the public sector and interfere with ability of health care staff to provide adequate care. Whilst the report notes positive steps taken by Kenya government to promote safe motherhood and reduce death and injury related to pregnancy. The following recommendations for improvement were made in the report:

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[5]Source: available online at http//reproductiverights.org accessed on 28/1/2012(article dated July 2007).

- Promote and develop policies protecting reproductive rights of women and establish rigorous oversight and regulation in both the public and private sector.
- Ensure supplies and equipment necessary are available and hygienic standards are strictly observed.
- Issue standards and guidelines for medical facilities on patient rights and complaints mechanisms.
- Remove financial barriers that result in the denial or delay in receiving necessary health care services.

The Kenya National Commission on Human Rights has also conducted a study on the status of reproductive health care and violations of citizens' life to quality health care. According to Commissioner Lichuma, one of my key informants, the Commission got reports from Pumwani hospital regarding certain abuses of reproductive health rights. The Commission argues that the government has failed to take responsibility for the reproductive health of its citizens. Due to bad conditions in the health facilities 56% of Kenyan women in slums and rural areas choose to deliver at home rather than hospital. The highlights of the Commission's findings were:

- Violations complained of by women were true and women preferred to deliver at home since in public hospitals they shared beds and got infections.
- In some cases wounds were not stitched properly.
- Tubal ligations were done on women without their consent.
- Road infrastructure was bad thus hindering access to health facilities for many women.
- Most women rely on TBAs (Traditional Birth Attendants) who may not be able to handle complications during delivery as the reality on the ground is that majority of the women cannot reach hospitals.
- The government had not lived up to its commitment of allocating 15% of its budget on health care in line with the Abuja Declaration[6]. Article 43 of the Constitution of Kenya requires the government to have a clear framework of health including reproductive health which is now expressly recognized as a constitutional right.

[6]This was at African Summit in April 2001in Abuja, Nigeria. African Union countries pledged to increase government funding for health to at least 15%.

- At policy level policies are in place but implementation is a major drawback.

The Commission's recommendations were therefore that:

- The government invests more in health especially reproductive health.
- There is need to lobby county governments for money on reproductive health in light of the new constitutional dispensation on devolved government.
- There should be capacity building for women on reproductive rights and services.
- The right to redress is now entrenched in the Constitution and women need to know they can now get redress when their rights are violated.
- Health facilities need to be equipped with modern equipment to enable women to deliver safely.
- Road infrastructure needs to be improved.
- In communities that rely solely on TBAs, skilled health workers should be provided by the government.

This report helped to give me further insights into my research area and will be of great value when I am making my recommendations as one of the thorny issues I encountered during my research for instance was the lack of adequate finances for reproductive health care.

I was fortunate to have an audience with the Africa Regional Director of the Centre for Reproductive Health (CRR), Elisa Slattery, who noted my research was similar to the study done by her Organization in conjunction with FIDA (K) in 2007. Most of their information was obtained from women who had previously delivered in the hospitals, due to the fact that her Organization was denied access to the hospitals and official records. She asked me to verify, through my research, if their report of 2007 had changed anything in the hospitals or whether things had gotten worse.

I shall discuss this in details in my findings chapter as to what I found on the ground.

The CRR, according to her uses various strategies to lobby governments on issues of reproductive health rights listed as under:

- Raise issues before human rights bodies like CEDAW and other relevant UN treaty monitoring bodies as well as with the African Commission.
- In conjunction with FIDA (K) engaged with KNCHR to the holding of a public inquiry on reproductive health rights as it was felt recommendations of KNCHR would hold more weight with the government.
- Pursue litigation on behalf of women whose reproductive rights have been violated. There is currently a constitutional reference case filed in court in a case where tubal ligation was carried out on a woman without her consent.
- The centre is preparing to file another case as concerns detention of women in hospitals over unpaid bills, their contention being that such detention is illegal as it has severe implications on women and their families.

As a feminist lawyer I believe that these two cases will go a long way in improving status of reproductive health in Kenya, in fact one of my respondents at KNH told me she had been detained ever since she gave birth up to the time I spoke with her in January 2012. She gave birth in November 2011 and she confessed to me she had a 2 year old left at home under the care of her husband and relatives.

I had occasion to read the report of a task force set up by government of Kenya in July 2011. The task force was set up following an impromptu visit by the Prime Minster of Kenya to Pumwani hospital on 26 July 2011 where he noted mismanagement, negligence and under- performance of the facility. The Ministry of Medical Services and that of Local Government were directed to constitute a task force and come up with recommendations to reduce maternal mortality and improvement of the facility. The terms of reference were:

- Establish issues that relate to professional negligence and malpractice.
- Audit management systems.
- Find the causes of low staff morale.

- Find the causes of deteriorating hygienic conditions.
- Establish the causes of alleged shortages of drugs, equipment and other essential supplies.
- Investigate any incidental issues relating thereto.

The task force's findings were that there was a lot of negligence and malpractice, that mothers bathed with cold water, the hospital lacked sufficient finances for its daily running and that there was a shortage of staff. Other findings were that there was shortage of drugs, equipment and other supplies, low staff morale, poor work environment with noise and dust pollution, deteriorating hygienic conditions due to inadequate resources to sustain hospital hygiene, no trained nurses on theatre technique, the lack of a perimeter wall and dilapidated roads. A further major finding was that some part of the hospital land had been grabbed (expropriated).

In the circumstances, the task force made recommendations for short-term and long-term interventions as follows:

Short-term Interventions:

- Government should supply drugs to the hospital.
- Perimeter wall be erected to prevent dust and pollution.
- Water heating for patients be revived and sustained.
- Nurses be trained in theatre technique.
- Allocation of grabbed land belonging to PMH be revoked.
- Government to disburse some money to the hospital.
- Recruitment of additional staff be done.
- City Hall and Pumwani address shortcomings and restore public confidence in the hospital.

Long-term interventions suggested were that PMH be totally delinked from City Hall and be run by an autonomous Board, hospital board enters partnerships with local and international funding agencies and well-wishers for funding the hospital and PMH be one out of 10 national referral hospitals.

As good as these recommendations sounded, unfortunately by the time I conducted my research in January 2012, it was apparent that not one of them had been implemented especially the short-term ones which to me were crucial. For instance women were still bathing with cold water, the perimeter wall had not been erected and no additional staff had been recruited. Instead there were media reports of (1) a cash crisis in the hospital[7] and (2) the nurses going on strike as a result of which several babies died.[8] Both of these unfortunate events in my view happened as the government did not act fast enough in implementing the task force recommendations. Commenting on the debt issue the doctor-in-charge attributed the debt to the waiver of delivery charges to poor mothers. Since this money is not reimbursed by the government, great financial strain is placed on hospital which, in turn, cannot pay suppliers. The nurses' reasons for going on strike were, among others, improvement in working conditions and employment of more staff. This bolsters my earlier argument in this review that the government needs to engage more seriously with these issues if women are to truly enjoy their reproductive rights.

[7] Source: The Daily Nation Newspaper, Kenya dated2/2/2012('Sh 50m Debt Throws Hospital into Crisis').
[8] Source: The Daily Nation Newspaper, Kenya dated 30/1/2012('Babies die as Nurses go on Strike').

CHAPTER THREE

3.0 METHODS AND METHODOLOGY

3.1 Introduction

Various methods and methodologies were used during the research and they all worked in different ways in shaping the research and in data collection. I was also able to come up with cogent findings as a result.

METHODOLOGY

3.2 Women's Law Approach

The women's law approach was used as it provides guidelines in capturing women's lived realities and using them as a starting point for the debate on the reproductive and health rights of women.

Women's law is a legal discipline that explores the reality of women's lives and from that perspective interrogates and investigates the law. (Weis Bentzon A et al 1998:pg.26) This approach means that women are the starting point so that one has to first listen to the views of the women on a particular subject. For instance in my research area my first question was *'Did women know they had a right to health and a right to survive pregnancy to begin with?'* It was my finding that women were unaware they had such rights and were willing to take whatever the hospitals did as they felt helpless. Despite the Constitutional provision on right to health being in place most women were unaware of or had never heard of it. Neither were they aware of the international instruments on human rights and the right to health.

The reality of the women was that they do not know they have a right to survive pregnancy and that if they were mistreated at the hospitals they had a right to protest. However, since my mission was not to educate them on their rights, it was not possible then to give them such information. In any event, the women were more concerned with finding ways and money for them to be discharged than learning about instruments on health care.

It became imperative that I find a way connecting with the women and I did that by listening to their experiences in the hospital and guiding them through issues I wanted to raise.

The women's law approach helped me to find out from the women that the fact they were detained for inability to pay hospital fees for instance affected both them and their other children and families left at home. Some women were however not free to tell their stories, and I attributed this to the fact that for those in hospital, they could be worried of a backlash from hospital staff it they told me of their mistreatment. Some women were afraid to talk to me without first obtaining their husbands' consent to do so. I interviewed a total of 24 women inside the two hospitals (KNH and PMH) that were my research sites and 4 women outside the hospitals. Using the women's law approach I was able to formulate questions best suited to the particular woman I was speaking to at the time as I realized that some could have differences in socio-economic backgrounds, and hence could have differences as to what they considered a priority. Some were more concerned about the money, while others expressed concerns like having to bathe with cold water, the state of the hospitals bathrooms and toilets and the attitudes of the nurses. I was able to accommodate the differences between the women and accept that there are social differences even between women themselves. This was of great help since most of the interviews I held with women were individual ones and helped me understand where a particular woman was coming from so that I knew which issues to prioritize. I therefore identified problems at personal and individual level and was able to come up with views of the majority at the end of the day.

3.3 Grounded Theory Approach

Grounded theory approach is an approach that requires that the researcher as far as possible to start with an open mind and one should be aware of the assumptions of the research and take nothing for granted (Weis Bentzon et al 1998 pg 178-9).

I already had my assumptions about how delivery of services to pregnant women at both KNH and PMH did not live up to legal and international standards that are in place regarding reproductive rights of women, and that there was a gap between the existence of the reproductive rights and their effective enjoyment and this helped me as a starting point on what to research.

When I sought for permission to do the research the administrative personnel wanted to know specifically what I wanted to find out and how I would go about it. Thus I had to have defined issues on what was required in my research and also be in a position to explain what I wanted at any moment and to anyone. The people I was dealing with were professionals in their field and I had to bow to their superior knowledge on some of the issues.

When I finally got to the women I was of the view that since the professionals had been preparing me for a situation which was not as bad as my assumptions had shown, the situation would not be as bad as I thought. However, the women painted a different picture based on the reality they were facing, thus I needed to disengage myself from the version of the administrative personnel and look at the reality painted by the women.

As I interviewed the women it emerged that most of them were constantly thankful that they were alive and I asked them why this was so. I asked the women if they knew or had heard of many women dying at the hospitals as a result of pregnancy and while undergoing delivery even though this question was not in my original questionnaire. Even if it had not been my initial assumption I realized that maternal mortality is something that the women were very concerned about and therefore I needed to get more information from the hospital personnel. When I compared the answers I got from the personnel on the ground and those from the administration

building I realized they differed as the administration personnel understated the problem and considered it minor, whereas the nurses and doctors were very vocal and said the problem was weighty and some contributory factors were the lack of sufficient and modern equipment. I thus realized that the problem depends on who one speaks with and since I needed to find out the reality of women patients, there was a need for me to engage more with them. The constant comparative method enabled me to compare what women were saying with what doctors and nurses were saying in order to verify the information gathered and to avoid making unfounded accusations.

3.4 Human Rights Approach

In this study one of the methodological frameworks adopted was the use of the human rights approach. This entailed visiting my two research sites, two public hospitals in Nairobi, and interviewing relevant personnel in order to get an overview of the challenges that they encounter in fulfilling health as a human right, in order to highlight and bring to the fore the human rights issues. The types of questions put forward to health personnel who include doctors, nurses and administrators in the health sector touched on the following:

There were issues of accessibility, availability, acceptability and quality of care that are minimum standards interpreted by the Committee on Economic, Social and Cultural Rights. The minimum standards provided a starting point and served as a basis of what I needed to question the women on and also what to look out for in the hospitals as well. My assumptions and objectives were formulated around these minimum standards that the state had to fulfil in order to grant women the right to health.

The research was on how the failure to meet these minimum standards in the delivery of services to pregnant women has resulted in the violation of the rights of these women at KNH and PMH and what the state needs to do to ensure women realize their human right to health. Observation of the hospitals settings and procedures was also a key tool in assessing human rights compliance

as I was able to observe for myself while in the hospitals most of the interactions between medical staff and the women and the state of the wards among many others.

In total 41 respondents participated in this research, there were 6 men and 35 women.

Table 1: Table of Respondents

Respondents	Male	Female
Doctors	4	2
Nurses	0	5
NGO representatives	0	2
Ministry of Health officials	1	0
Individual women interviewed		28

METHODS OF DATA COLLECTION

The data was collected using various means and they worked in different ways for the research and the findings I came up with.

3.5 In-depth Individual Interviews

The interview method was primarily used during the research. A brief background of the research and who I was started the interview as I realized some women assumed I was a doctor capable of understanding their medical problems. I interviewed the women inside the two hospitals as well as women outside but who had delivered in these hospitals, the interviews were individual ones, and I proceeded in the direction the women wanted to go and only asked questions that had been left out at the end. This helped in that I got more information and also kept the women interested in the discussion, as I listened while they talked. Some women were however not free to talk as they said they needed consent of their husbands. The women to interview were chosen randomly so as to present divergent views on the issues and 28 individual interviews were conducted during the course of the research. The advantage of this method was that it had more privacy and I could question in depth the life situation of a particular woman.

There was need to find out for example how women are actually affected by the issue of the amount of money they have to pay as hospital fees and it was important to ask women individually and to know how they were coping in private.

The disadvantage that I found was that I spent a lot of time with each respondent because I could not rush them through their story so I had to be very patient. Women relished the attention and ability to be able to contribute and wanted to give as much information as possible.

Some of the women needed a lot of probing before they opened up and I gave up on some because they just refused to talk although one could see they were poor.

3.6 Observation

I also used observation as a means of data collection. In other words, I would simply observe the staff and patients as they went about their business. I was able to observe how the nurses and doctors treat the women at the time they are in hospital. I observed the admissions to see how long it took for a woman to be attended to and the amount of attention she got in order to judge if it was adequate. Using this method also enabled me to take note of the infrastructure of the hospitals, the patronage in the hospital wards and the body language of the respondents, for instance some women appeared visibly afraid to talk in the presence of nurses. The advantage was that the nurses continued to do what they always do and I was able to judge for myself if the women were treated with respect or not.

3.7 Questionnaires

Basically these were used for the key informants and the women who had previously delivered in the two hospitals, and to find out if the quality of services was adequate. However they were adaptable depending on the situation, some women were illiterate and thus I had to ask them to tell me of their experiences when they went to deliver and after taking notes would then extract what was relevant to my research. Some officials were too busy and would ask me to leave the questionnaires in which case I would seek another appointment so as to get my questions answered. Samples of the questionnaires I used are contained in the Appendix section at the end of this dissertation. I distributed 8 of them and all were answered in one way or another as I still had to follow up and get the views of the people concerned. The disadvantage of this method was that it was tedious and took a lot of time, but the advantage was that I was able to get very crucial information.

3.8 Key Informants

This method involves collection of data from the insiders, perceived 'knowers', or those with experience on the issue or some people of influence in the community (WLSA, 1997). Appointments were made and given by government officials and NGOs. These were doctors at the Ministry of Health and at the two research sites, nurses at both hospitals and officials of Kenya National Commission on Human Rights (KNCHR) and Centre for Reproductive Rights (Kenya) [CRR (K)]. I also made attempts to see representatives at International Federation of Women Lawyers (Kenya) [FIDA(K)] but I went there many times and could not get the relevant person as they were busy with end-year activities as it was already mid-December and by then I had already talked to 6 doctors, 5 nurses, 1 government official and 2 NGO officials. Talking to the key informants provided insights into my topic at a theoretical and practical level. Since my topic dealt with issues of service delivery to pregnant women and human rights it was important to find out about the government's policy position from those working in the Ministry of Health. It was just as crucial to talk with NGOs who have programs related to reproductive health to understand if and how they liaise with the government.

Table 2: Table of Key Informants

Name	Organization	Position
Dr. Awori	Ministry of Health	Medico-Legal Officer
Dr. Mweke	Ministry of Health	Chief Gynaecologist
Professor Guantai	Kenyatta Hospital/University of Nairobi	Lecturer/Secretary, Research and Ethics Committee
Sister Supaki	Pumwani Maternity Hospital	Assistant Matron
Sister Ojanga	Kenyatta National Hospital	Assistant Chief Nurse
Sister Ireri	Kenyatta National Hospital	Assistant Chief Nurse
Dr. Bibiraranye	Kenyatta National Hospital	Gynaecologist
Mrs. N. Kariuki	Kenyatta National Hospital	Chief Nurse
Mr. D.Nyaberi	Ministry of Health-Division of Reproductive Health	Program Officer
Dr.Omondi	Pumwani Maternity Hospital	Deputy Medical Officer Of Health
Dr. G. Gatembu	Nairobi City Council	Deputy Medical Officer of Health
Sister Atieno	Pumwani Maternity Hospital	Assistant Matron
Winifred Lichuma	Kenya National Commission on Human Rights	Commissioner
Elisa Slattery	Center for Reproductive Rights(K)	Africa Regional Director

3.9 Limitations and Challenges

Bureaucracy at Government Offices

In order to get access to my research sites, I had to follow the guidelines of the Ethics and Research Committee of the University of Nairobi and Kenyatta National Hospital. This Committee is mandated to give clearance on health research in Kenya. It took almost one month after forwarding my research proposal as directed together with other relevant documents for me to get approval to access and interview women. I submitted the documents on 9 November 2011 and got the approval on 14 December by which time there had been a protracted strike by doctors in public hospitals. As a result when I went to seek further approval from the gynaecologist in charge at Kenyatta Hospital so as to access the maternity wards, he informed me he was taking his annual leave and I was to see him after 5 January 2012. In the circumstances due to these delays I got to talk to the women at KNH on 16 January and to the ones at PMH on 26 January 2012. Hence I could not talk to as many women as I would have wished as the time allotted for conducting my research had run out.

The second challenge faced was getting to talk to officials at Ministry of Health, who were said to be in meetings most of the time I went there, even when I had booked appointments with them. There was a time I waited almost the whole day to see a doctor there. I did however manage to see 3 doctors and one of them gave me the National Reproductive Health Policy, 2007 for my review.

Confidentiality

Since my major research sites were hospitals, the Ethics Committee instructed me to prepare consent forms for their approval which I would then use for the women to sign before interviewing them. These forms are to be found in Appendices 5 and 6 at the end of this dissertation.

Hence there were major challenges but I managed to get all my data in the end. Although it was not easy and sometimes I felt like giving up I did eventually persist and overcame these challenges. What these challenges have taught me is that there is a lot of suspicion especially from those within government circles on research that is of a feminist nature. Hence any one undertaking feminist research needs to be positive, proactive and always have an alternative plan of action.

CHAPTER FOUR

4.0 FINDINGS

4.1 Introduction

Kenyatta Hospital is the major referral centre in Nairobi catering for a large number of people and most patients it caters for are poor.

Some of the patients who attend the hospital come from as far away as Mombasa (442 km) from Nairobi and the surrounding areas nearer Nairobi like Thika (39.5km) and also from the slum areas of Kibera and Kawngware within the City. Similarly, although Pumwani is not a referral hospital, by virtue of its being the largest Maternity Hospital in Kenya and East Africa, it receives patients from all over Kenya just like Kenyatta Hospital and the slums of Korogocho and Mathare which are within the vicinity of the hospital. Most of these patients live below the poverty datum line.

Most of the women that are admitted have complications and need special care especially caesarean sections or have high blood pressure, and are sometimes referred from other hospitals. This chapter deals with what was discovered on the ground.

4.2 Congestion in the Wards

This research unearthed that most women at Kenyatta hospital shared beds, while others had to sleep on the cold floor, some without even the comfort of a mattress. One ward visited had over 40 women, some had delivered and were waiting to be discharged while others were admitted waiting to deliver. Six women were interviewed in this ward which was a bee-hive of activity, as women kept on arriving or leaving. There are 3 maternity wards with a total bed capacity of 40 yet here just one ward was accommodating more than 40 women. Out of the four women

interviewed outside the hospital, most of them also said they shared beds when they gave birth at Kenyatta and were not happy about it. Inside the hospital itself, one woman, Natalie Kasika shared her experience:

> "I have been admitted here and am waiting to deliver. I feel uncomfortable as I am sharing a bed with a woman who has undergone caesarean section operation and her baby too has to sleep on the same narrow bed. Further it is unhealthy for us as mothers and more so for the baby as we are all prone to infections."

Two other women, Molyne Ayoo and Veronica Muthoni said they had to sleep on the floor with their babies and for Molyne it was worse as she did not even get a mattress. Another woman, Catherine Njeri, stated that the woman she had to share a bed with had visibly swollen legs (which I observed after she had spent the night seated with her legs dangling over the side of the bed since the bed was too narrow for both of them). The Chief Nurse at KNH, Mrs. N. Kariuki, confirmed that there is congestion but attributed this to the fact that very many women are sent as referral cases from hospitals all over the country to KNH. She was of the view that the government needed to build more referral hospitals all over the country and have them comprehensively equipped to avoid the congestion.

At Pumwani the congestion was not as bad as it had more wards, since this is purely a Maternity hospital. However, one woman revealed that she had shared a bed and that this only happened when there were too many women. Ay the time of my research she was the only woman I found sharing a bed. This was confirmed by Peris Gakii who said:

> "This is my second time to give birth here at Pumwani. My first time was in 2007 and by then it was common to share beds but this time only one or two women shared."

The sharing of beds does not respect the confidentiality of women, nor improve their heath status which is a core element in acceptability of care. International and regional documents recognize the right to the highest attainable standard of health, which standards are now also entrenched in the Constitution of Kenya. Kenya has ratified CEDAW and this obligates the government in

terms of Article 12 thereof, to ensure women receive appropriate services in connection with pregnancy, and sharing beds or sleeping on the floor cannot be said to be appropriate service.

4.3 Shortage of Staff and Equipment

The international human rights standards require that in order for pregnant women to receive quality care, the health facilities must have goods that are medically appropriate and of good quality. This requires skilled medical personnel, drugs, and hospital equipment. In the case of both KNH and PMH it was clear from my observations and interviews that medical staff was insufficient, most women complained of lack of attention as the nurses were too busy. At KNH, Mrs. Ireri, an Assistant Chief Nurse admitted that understaffing was a major problem as the government had frozen employment of civil servants such that when staff members are retrenched or die they are never replaced. There is an urgent need for employment of more staff and who should be well remunerated to keep up their morale. For instance according to Dr. Bibiraranye who was doing the ward rounds in one of the wards visited put it thus:

> ‘The medical staff is inadequate. I am a doctor yet find myself carrying out all manner of tasks even those which are not mine. For example now am collecting laboratory specimens and delivering them personally to the laboratory since there are no staff members to do it.”

The Chief Nurse at KNH told me that according to WHO guidelines, one nurse should attend to six patients and in the labour ward the ratio should be one nurse to two patients which is impossible at KNH due to the staff shortage; there are also too few doctors to cope with the demand and they end up being stressed and overworked. It is the same with the midwives where one mid wife can attend up to ten patients at a time as against the recommended WHO guideline of one midwife to 3 patients.

The same situation prevailed at Pumwani Hospital where there was an acute shortage of doctors and nurses and at the same time the government has put a freeze on employment.

In the wards where women were interviewed it was once again my observation that there were too few nurses and they were overwhelmed by the amount of patients they had to cope with: over 65 women were attended by 2 nurses. Dr. Omondi felt that if the hospital were elevated to handle only referral cases and placed under the Ministry of Health (who would then be responsible for employing the doctors instead of City Council of Nairobi), the services might improve. He also said the hospital urgently needed modern equipment as what is in place is old-fashioned and inadequate, and that the hospital was forced to obtain necessary supplies like drugs and food on credit.

Since women's right to health is guaranteed by the Constitution and international documents listed in Chapter 2 the same should be respected and promoted by the state, which has the obligation to provide public health for its people, including reproductive health care. Thus the state should create conditions that are conducive to the attainment of the highest standard of healthcare. The state is then failing to deliver on the conditions necessary for women to access healthcare as there are insufficient drugs and equipment at PMH as well as an acute shortage of medical staff in both KNH and PMH. It is the duty of the state to make sure the hospital personnel are paid satisfactorily and that their needs are addressed so that women can access the hospitals.

4.4 Funding

At both KNH and PMH it was a major concern that the money allocated to the hospitals was barely enough to run the hospitals. It was the feeling of the medical personnel that reproductive health care especially needs to be allocated sufficient resources as mothers and babies were very vulnerable. On budgetary allocations, KNH receives 7% of the health budget which is a drop in the ocean considering their needs. The case of PMH is even worse as it does not receive the amount it should get from City Council of Nairobi and when coupled with the fact that the hospital grants waivers to poor women sometimes at the rate of Ksh. I million a month (US$82,000,000) the situation is depressing as the hospital is left with no money to run itself. In the words of Dr. Omondi:

> "Most women who deliver here are poor and cannot afford payment of the fees, and the hospital has to waive the same, hence we run at a loss. The hospital budget for a year is approximately Kshs. 147 million (US$179,300) and from the cost sharing (scheme) we only raise Kshs.120 million (US$146,400). We are forced to get supplies like food and drugs on credit; we fuel vehicles for transfer of patients from our own meagre resources and we owe lots of money to suppliers. The City Council of Nairobi is supposed to give us Kshs.2million every month for running expenses which we never receive as the Council only pays salaries and emoluments for staff. The government should reimburse the hospital the money that is waived to enable poor women to get free delivery services."

In his view Pumwani hospital needs to be put directly under the Ministry of Medical Services in order to receive funding directly from the Treasury, if it is to offer quality service. The hospital should also be elevated to deal with referral cases only.

In such circumstances it is the women who are prevented from enjoying their Constitutionally protected right to health. Due to these financial constraints one finds that these women who have just delivered have to bathe with cold water as there is no money to install boilers. One of the women, Catherine Njeri at Kenyatta hospital summed it up for all the women patients:

> "At least give us hot water for bathing immediately after delivery even if we have to contend with cold water for the rest of our stay in hospital."

At Pumwani hospital, Concepta Opiyo expressed the frustrations of the women:

> 'We bathe with cold water and since it is so chilly in the morning here, we postpone our bathing to afternoon by which time we are smelly and uncomfortable.'

Therefore the government should ensure that the health rights of women are realized by making sure that adequate resources are allocated to the health sector and make the health of women a priority. Most of the women who need public service are poor women and the least the government could do is ensure the clinics outside these two major hospitals are adequately funded and staffed.

With the 2 hospitals receiving such small budgets the effect is that women do not get quality service and the staff at the hospitals are unhappy. The nurses and doctors are frustrated at the shortage of equipment and this affects the quality of their work. Indeed the views of the nurses and doctors were heated on this issue. At KNH, the assistant chief nurse, Mrs. Ojanga lamented:

> "The government does not give priority to maternal health. The hospital is only allocated7% of the health budget yet Abuja Declaration states that states commit at least 15% to health. In my view the government should put up a fully fledged maternity hospital on the lines of PMH and provide enough resources, staff and equipment."

Similar views were expressed by the Chief Nurse, Mrs. N.Kariuki:

> "Although nurses are trained to be gentle and kind to patients, sometimes the working environment can cause them stress especially when they are overworked and underpaid. Even though once in a while the hospital gets donor funds to assist in its projects, this is like a drop in the ocean, considering the many unmet needs. I feel that more hospitals should be built by the government in all the provinces of Kenya and that they be fully equipped and staffed. The government also needs to remove the policy that has frozen employment so that more nurses and doctors can be employed. In addition the partnerships between KNH and donors, both individual and corporate need to be cultivated and encouraged."

At the Division of Reproductive Health funds were also a challenge. Mr. Nyaberi, the program officer in the Division said:

> "The main challenge facing the division is lack of finances, as most times the Division depended on donors funds for running of various programs. In order to for women to realize their reproductive rights with dignity, there is an urgent need to put in place legislation that deals with issues of reproductive."

4.5 The Detention of Women for failing to pay their Hospital Bills

During the course of the research, it emerged that many women were or had been detained for failing to pay their hospital bills at KNH and PMH. At both hospitals the nurses confirmed that there were 7 women detained at KNH and 12 women at PMH. One of them detained at KNH for over 2 months since delivery told me even her relatives had given up coming to visit her, they were too poor to afford the fare to come to hospital and she wondered how she would ever pay the bill which was increasing daily. Such detention practices violate a host of fundamental rights, including the right to dignity and the right to be free from discrimination. The illegal detention of women disregards their vulnerability especially at this time when they have recently given birth, as recognized by special protections given to women before, during and after childbirth under international human rights law.

A further finding was that most women found the costs expensive and beyond their means. This led to their inability to pay, and, hence their detention. The detention forcefully separates the women from their families and infringes their right to privacy and family.

Table 3: Cost of Hospital Fees as at January 2012

Kenyatta Hospital	Normal delivery from ksh. 8,000 – 10,000 (US$98-120)	Cesarean delivery from ksh 27,000-30,000 (US$330-366)
Pumwani Hospital	Normal delivery kshs. 3,000 (US$37)	Caesarean delivery kshs.6,000 (US$74)

Added to this were the daily bed charges of kshs 400 (US$5) for Pumwani hospital and kshs. 800(US$10) for Kenyatta which accrue for as long as the women are in hospital. The cost of the hospital was the major issue for the majority of the women whom I interviewed and this affected the affordability of health care for pregnant women.

I found that on this issue of detention, the Division of Reproductive Health within the Ministry of Health is the one that is mandated to ensure that all women have access to delivery services and the Division was alive to the fact that poverty is the root cause that leads to the detention of women in hospitals. In an effort to alleviate the situation, they are in the process of formulating systems where women will be given vouchers from the Division to enable them get free services when they go to give birth.

4.6 Rude and abusive Nurses/Improper Care after Delivery

When women are verbally and physically abused around the time of their delivery (as emerged in course of this study), this constitutes a serious violation of the right to be free from torture, cruel and inhuman treatment. It also amounts to an affront on the dignity of women. At Pumwani hospital, at the post-natal wards, Sarah Mwendwa complained of the nurses' attitudes:

> "The nurses are bad, instead of helping you they abuse you and humiliate you. When I went to deliver my first baby, labour pains intensified before I entered the hospital and I found myself delivering at the hospital's gates. It took more than 20 minutes for nurses to come to my aid yet they were not situated that far from the gate, and meanwhile I was scared as I was alone and a new mother."

Sarah therefore felt aggrieved by the poor service delivery and the humiliation she suffered. Another woman in the same ward, Susan Wambui recounted:

> "I have high blood pressure yet was left unattended in labour ward for a long period of time. I also noticed a nurse being rude to a woman next to me in labour ward who was stitched so badly that she had to be re-stitched. The nurses kept on shouting at us, making my blood pressure rise even more, I did not see why they could not handle us with dignity."

Christine Sabina who was also in the same ward, recounted her own experience:

> "When I came to deliver the nurses were hostile and refused to help me. After the baby was born, the nurses refused to stitch me and I bled for over an hour alone. I was stitched after four hours, I still feel dizzy, in a

> lot of pain and still bleeding. The nurses have refused to give me cotton wool and I have called my husband to bring it. After my discharge, it will need me to go to another hospital to have the stitches checked."

Out of the women interviewed out of hospital, Jackline Achieng had horrible memories of her time when she went to deliver at Pumwani hospital about two years ago:

> "I was a first time mother and did not know what to expect at the hospital. I was traumatized due to the harsh manner in which the nurses handled me as I expected them to be the ones to guide me through labour. Instead they hurled insults at me, telling me not to pretend to be in pain as they were not with me when I was enjoying with my husband."

Jackline told me if she gets pregnant again she would rather deliver at home with some dignity. One other woman who had delivered all her three children at Pumwani hospital was Mary Wambui who on her part stated:

> "Although the treatment from the nurses was abusive all the times I went to deliver, I was afraid of delivering at home and thought it safe to deliver in hospital. But can someone tell the nurses to treat women in a humane manner as it was very depressing to be in an environment where you are constantly humiliated as though you have done wrong to come and deliver."

At Kenyatta hospital it was no different. In the post natal wards all the women had similar complaints. One woman, Molyne Ayoo complained the nurses were generally rude and did not care for the women. Most of the other women as well complained of the rude and abusive attitude of the nurses.

I kept on thinking to myself while listening to these very disturbing experiences, *"Is this truly the kind of care that women deserve? Was the attitude of the nurses fuelled by the fact that there are too few of them and that they are overworked? Is it not time the government addressed these issues?"* In my view, though, the women themselves also need to become empowered in order to take charge of their own reproductive health concerns and to know that they have a right to demand that the violations they suffer must be redressed.

4.7 Infrastructure

One of the core internationally accepted standard for quality reproductive services is accessibility and this requires that health facilities be physically accessible in terms of the availability of ambulances and other forms of conveyances to hospitals. It also requires that women do not have to travel long distances to hospital and that roads be in a good condition.

It was my finding that transport is a major issue. Even Dr. Omondi of Pumwani Hospital admitted that sometimes there is no transport to transfer a woman to Kenyatta and by the time he organizes it from his own resources it may be too late to save the woman's life. The government, as the duty-bearer, should ensure there that there is adequate transport to and from hospitals and that road infrastructure is in good shape to enable easier access to women. For example it was my observation that roads leading to Pumwani were dilapidated, and this by itself could prevent women from accessing the hospital. The dilapidated roads were also one of the findings of the Pumwani taskforce of 2011 and the state has to take urgent remedial measures.

4.8 Summary

The findings show a disregard for women's right to maternal health. The hospitals charge too much and sometimes women prefer to deliver at home, with the help of TBAs. For the women who deliver in hospitals there is the possible indignity of being detained after delivery due to the inability to pay the fees. Most women felt it was better to deliver at home due to the congestion encountered in public hospitals wards like the case of KNH and also the rude and abusive attitude of the nurses. The rights of Kenyan pregnant women will continue to be violated if all these rights violations are not adequately dealt with and addressed by the government with the seriousness they deserve. The findings have buttressed my first assumption that there is an enormous gap between the existence of reproductive and human rights of women and their effective enjoyment.

CHAPTER FIVE

5.0 ANALYSIS

5.1 Human Rights and the State

Human rights are understood as being those rights that are inherent to all human beings by virtue of being human and are founded on the respect for the dignity and worth of the person. Human rights are universal rights that are supposed to be applied equally and without discrimination to all people. They are inalienable, indivisible, inter-related and interdependent. All human rights are of equal importance and no human right should be seen as being more important than others, and must be protected and promoted by national laws and constitutions and guaranteed for the people by the state.

Human rights were used as the starting point for this research because the state has obligations to the world and to its people to ensure the rights of its peoples are guaranteed. The government is signatory to the human rights instruments related to health and has made a commitment to implement provisions of those instruments. The state must therefore be held accountable as the right to health is now entrenched in the Constitution as well. The human rights framework imposes rights and duties on the state and it therefore follows that the state is accountable to its people if it fails to fails to guarantee the rights provided in the human rights instruments and in their Constitution.

Women’s right to health is guaranteed by the conventions and protocols, as well as in the Constitution as listed in Chapter 2 and need to be promoted and respected by the state. The state has the obligation to respect the rights of women and should not restrict the right of women to access health care and should create conditions that are conducive for the attainment of the highest attainable standard of health.

The state is failing to deliver on the conditions necessary for the women to access health care as there are insufficient drugs at the hospitals and the hospital staff is prone to going on strike, and in fact as I was conducting my research there were strikes by nurses and doctors at the public hospitals, their complaints being poor remuneration and unattractive conditions of work. If the nurses and the doctors are on strike this means women cannot access the hospitals.

It is the duty of the state to make sure that the hospital personnel are paid satisfactorily and there is need to address their needs so that women do not suffer for a fault which is not of their own making. The implementation of human rights is subject to available resources, according to Article 2(1) of the ICESCR:

> *'Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.'*

Article 21(2) of the Constitution of Kenya provides:

> *'The State shall take legislative, policy and other measures, including the setting of standards, to achieve the progressive realization of the rights guaranteed under Article 43.'*

Hence even though states may argue they do not have the means at the time to implement the rights like in the case of Kenya, the Constitution grants health as a right hence the state is to be held accountable for its failure to provide health care. The resources needed to correct the situation are not always financial in nature. What is essential but currently missing from the running of the two hospitals investigated is the need to have as a starting point the best interests of women patients; once this is in place the best use may be made of the hospitals' limited resources in helping to realise their patients' right to health.

It was my impression throughout my research that the government was not doing enough as financial constraints are always cited, even for things that are capable of being implemented.

The government should move toward guaranteeing this right by allocating adequate resources to the health sector and making women's health a priority. Pregnant women are not empowered to protect their right to health because they are not aware or informed of those rights and there is a need for non-governmental organizations and the international community to make women aware of those rights. This issue of empowerment was brought to the fore by an Assistant Matron at Pumwani hospital when she said that in her daily interactions with women at the hospital it was her experience that most of the women lacked the vital and independent decision-making capacity concerning the time when they need to come to hospital since most depended on their husbands to make such decisions. Sometimes this leads to dire or fatal consequences for them or their babies. Women have the right to health but their right needs to be implemented fully by the state and if the state has no means of doing so then women's rights will not be respected.

5.2 Women and the Right to Health

International law as currently constructed is men's law especially in its application and the way it affects women. This is because human rights language concentrates on violations by the state and its organs and these occur in the public sphere while the lives of women are in the private sphere and this leads to their exclusion. (Banda F.2005).

The author argues that human rights also concentrate on political rights and less on the economic, social and cultural rights where the rights of women are largely found. This has led to the state not giving them much attention as it should as demonstrated by the way women's health issues have been dealt with in Kenya, since the right to health is not addressed as being paramount for women.

The state as the duty bearer on the provision of health services in public hospitals is not doing enough to improve the situation for women. International standards emphasize the need for equality in their access to health care services, and any differences in health care services that women may receive based on their ability to pay violates their right to equality and non-

discrimination. International and regional equal protection provisions require governments to enact and enforce laws protecting women's physical safety and integrity. To add to this, avoidably high levels of maternal mortality violates women's right to life and compromises the right to the highest attainable standard of health. Breaches of both these rights deny the rights to family life not only of women but of their husbands and often their existing and new born children.

The CEDAW Committee[9] has recognized maternal mortality as a violation of women's right to health and it is the duty of states to ensure women's rights to safe motherhood and emergency obstetric services. The reduction of the maternal mortality rate is one of the Millennium Development Goals agreed to by Kenya and this commitment by the state requires a reduction of the maternal mortality rate to 175 per 100,000 live births by 2015. Yet according to the 2008-2009 Kenya Demographic and Health Survey, the maternal mortality rate was 488 maternal deaths per 100,000 live births for the ten year period prior to the survey. It is therefore imperative that the government takes concrete measures to reduce deaths due to pregnancy. The government owes that much to the Kenyan women.

5.3 Health and the State

The state has the obligation to make sure that the public health system continues to function. The hospital personnel are paid by the state and it is the duty of the state to give them morale boosters so they stay committed to the job. The state seems to have relegated the provision of quality healthcare to private hospitals whereas it is the duty of the state to provide health care in conformity to provisions of regional and international instruments it is party to as well as the Constitution. There is a need for the state to deliver on its responsibilities to women and provide quality service for pregnant women, and it also needs to provide sufficient and good quality equipment to the hospitals if women are to receive quality service.

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[9] CEDAW Committee, General Recommendation 24: Women and Health (1999).

Both Pumwani and the Gynaecology Department at Kenyatta hospital cater exclusively to one gender and there is an acute shortage of medical staff, many financial constraints and detention of women who are unable to pay fees. One is tempted to ask, *"Is it because it is only women who are normally treated as second-class citizens and who patronize these facilities that they have been left to deteriorate to such an extent? Is that the reason they are so poorly funded? Does the government of Kenya really have a commitment to the welfare and health rights of its women?"*

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

This research was meant to identify factors that impede access to delivery of services by pregnant women in two selected hospitals in Nairobi, Kenya and to examine the findings against a human rights framework, grounded in national and international law and to then make recommendations based on those findings. The research was carried out at Kenyatta National Hospital and Pumwani Maternity Hospital. It also included women who were not in hospital but had previously delivered at the two hospitals so as to get an overall picture of women's experiences. In as much as the Constitution of Kenya guarantees the right to the highest standard of health, the reality on the ground is that provision of reproductive health is affected and compromised by the social, economic and political environment in which women live. It is thus the government's obligation to take concrete steps in order for women to enjoy and realize their reproductive rights. With the new Constitution defining discrimination in line with CEDAW and providing stronger guarantees for women's rights, the government should prioritize and focus on ensuring statutory and policy framework that promotes the implementation of the rights in the Constitution.

The Constitution in Article 2(6) states:

> *'Any treaty or convention ratified by Kenya shall form part of the law of Kenya under this Constitution.'*

Therefore the government is duty bound to take measures to implement the provisions of these international documents through enacting legislation to fulfil its international obligations on human rights. The government should address issues of infrastructure and provide training for nurses to be more sensitive to women. Women's access to acceptable, affordable, accessible and

quality health care will to be limited if the state continues to provide minimal resources to reproductive health and instead prioritize other areas of the economy. It is a sad fact that reproductive health eludes most poor women in Kenya as a result of sub-standard quality reproductive services especially delivery care. The government policies that are in place appear to be ineffective and constitute simply well intentioned words on paper: they fail to be meaningfully implemented. In view of this conclusion the following recommendations are made:

6.2 Recommendations

6.2.1 The Government of Kenya

- Take overall responsibility and show commitment towards improving maternal and neo-natal health towards the achievement of Millennium Development Goals Numbers 4 and 5.
- As a matter of urgency de-link Pumwani hospital from City Council of Nairobi and elevate the hospital to a referral facility.
- Enact a law that governs maternal health care and ensure protection of women during childbirth.
- Ensure the availability of adequate numbers of skilled health workers and train more midwives and nurses so that PMH and KNH can be fully staffed.
- Prioritize the health sector in the allocation of resources for buying modern equipment and essential medicines for both PMH and KNH.
- Disseminate relevant health policies and guidelines widely so that women know what to expect from the government and from PMH and KNH.
- Provide many referral centres which are fully equipped so that women do not have to travel long distances to referral centres and thereby reduce congestion in PMH and KNH.
- Devise strategies or policies to prevent the detention of women in these two hospitals due to the inability to pay hospital fees and outlaw the illegal practice of detaining women.

- Reimburse both PMH and KNH for granting waivers and develop clear guidelines and procedures for implementing the waiver system.
- Implement the recommendations of the 2011 task force on Pumwani hospital as a matter of urgency.
- Issue standards and guidelines for these two hospitals on patients' rights and complaint mechanisms; ensure their widespread dissemination and implementation.
- There is a need to make women aware of the international documents that Kenya has signed and ratified and their implications on the rights of women so that they are empowered and can demand their rights.

6.2.2 *United Nations Organizations*

- Support government initiatives in the implementation of policies and strategies to bring about the necessary changes and improve health and quality of life for pregnant women in Kenya.
- Support and provide technical and financial assistance to the Ministry of Health in areas relevant to the attainment of the highest standard of physical and mental health for pregnant women in Kenya.
- Provide financial support to the Ministry of Health for the training of midwives and nurses so that women have trained personnel at the time of birth.

6.2.3 *Non- Governmental Organizations*

- Hold the State responsible to its obligations to the international community by providing shadow reports on the State's failure to implement the provisions of regional and international instruments.
- Help the government disseminate information concerning the health and human rights of women especially reproductive rights.

- Ensure that the government takes legislative, policy and other measures, including the setting of standards to achieve the progressive realization of reproductive rights as human rights for the women of Kenya.
- Champion the implementation of government policies given their strategic position at grassroots level.
- Organize money generating activities for the empowerment of women to enable them to generate incomes so they are able to pay for health services if required to do so.

6.2.4 Kenyatta and Pumwani Hospitals

- Promote the operation of a clean environment at the maternity wards so as not to compromise women's health.
- Monitor and evaluate the services of midwives, nurses and doctors to ensure adherence to acceptable standards of practice.
- Ensure women get an adequate diet for pregnant women and that hot water is provided for their sanitation.
- Prioritize the needs of pregnant women and stop the illegal practice of detaining women who are unable to pay hospital fees.
- Conduct training for all staff members on protecting the rights and dignity of women.
- Make the health facilities women friendly.
- Work with the international organizations and the Ministry of Health in promoting the right of pregnant women to adequate health care and in the reduction of maternal and neonatal mortality.
- Develop clear processes for lodging and redressing complaints and make this information readily available to the women.

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Appendices

Appendix 1: Questions put to Women during Interviews

- Were you asked to pay any fees for maternity services?
- Were you able to pay the fees?
- Were you asked to bring your own supplies-syringes, needles, cotton wool etc.?
- How were you treated by medical staff?
- Did you encounter any abuses and/or humiliation?
- Are there any other challenges you went through to access delivery services?
- What suggestions would you give for improvement of services?
- How would you want to be treated/ handled at maternity hospital?

Appendix 2: Questions put to Service Providers at Hospitals

- Do health service providers conform to human rights standards as to access, quality, availability and acceptability in delivery of services to pregnant women?
- Do they conform to ethical, professional and gender-sensitive standards?
- Do they have a code of ethics on reproductive health?
- At Pumwani Hospital does the City Council of Nairobi allocate adequate funds for the running of the hospital?
- Is there any discrimination against women seeking delivery services?
- At Pumwani hospital have the recommendations of the task force of 2004, whose report was released in July 2011 been implemented?
- Do the hospitals have sufficient equipment and tools to attend the pregnant women?
- Are there adequate medical staff?
- What challenges do they face in carrying out their duties?
- What recommendations do they make for improvement of delivery of services to pregnant women?

Appendix 3: Questions put to Government Officials

- Is there discrimination against women who seek access to delivery services in the 2 hospitals and if so how has it been dealt with?
- What measures has Ministry of Health taken to domesticate CEDAW and the African Protocol on Women's Rights, specifically reproductive health rights (right to life and health, right to equality and non-discrimination, right to be free from torture, cruel, inhuman and degrading treatment, right to dignity, right to information and right to privacy and family)?

Appendix 4: Questions put to NGO Representatives

- How do you assess the government's performance in the fulfilment of its obligations on the realization of reproductive health rights for women?
- How will you ensure that women receive the highest standards of maternal health and specifically that delivery of services to pregnant women meets legal and human rights standards?
- How will you effectively monitor this?
- What is the way forward to improve delivery of services to pregnant women?
- How does the organization support the women in realization of reproductive health rights?
- How does the organization lobby for implementation of laws and policies that will benefit women, specifically on their reproductive health rights?
- What challenges do they face on provision of reproductive health services and in particular delivery of services to pregnant women?
- What recommendations do they have for improvement in the delivery of the services?

Appendix 5: Researcher's Explanation Supporting the Informed Consent Form

I, ELIZABETH WANGARI THUO, wish to explain that this study is purely for academic purposes, in partial fulfilment of my studies at the University of Zimbabwe where I am pursuing a Master of Women's Law Degree. The purpose of this research therefore is to add to scholarly knowledge on this issue and more importantly to analyze how the law and international human rights instruments can be best applied to protect and enhance reproductive rights of women.

You are not obliged to give me information as this is a voluntary exercise. I will only obtain information from you with your consent.

Appendix 6: The Consent Form

I, (name), of (address), hereby confirm that I have voluntarily and without any duress or coercion whatsoever agreed to be interviewed and give relevant information to the researcher. I have understood this research is purely for academic purposes only.

SIGNED: ………………

DATE: ………………