REALISING THE RIGHT TO REPRODUCTIVE HEALTH: AN ANALYSIS OF MATERNAL HEALTH CARE CHALLENGES IN INTERNALLY DISPLACED PERSONS (IDP) CAMPS IN NAKURU COUNTY, KENYA

BY
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Abstract

The internally displaced persons (IDPs) phenomenon has been of increasing concern not only in Kenya but also to the international community due to their growing numbers and an increasing awareness of their vulnerability. The pernicious effects on those displaced are wide ranging and include impoverishment and exclusion from basic and social amenities like water, food, shelter, education and health. Various international and regional instruments on internal displacement recognize the right to reproductive health and enjoin member states to ensure that women have access to affordable quality maternal health services. Conversely, at the national level of many developing countries, comprehensive reproductive health care in the context of displacement is still insufficiently understood or applied. A great majority of the world's IDPs are in developing countries where health facilities are either inadequate or essentially unavailable. Internal displacement therefore brings with it additional burdens in an already resource poor environment. This study was carried out in Nakuru County, Kenya targeting four internally displaced persons camps, namely, Pipeline, Vumilia, Ebenezer and Githima. The core objective of the study was to find out whether there are challenges facing internally displaced women in accessing quality affordable maternal health care. The methodological framework was informed by the understanding that experiences of pregnancy and child delivery pre-exist in the social, political and cultural contexts in which women live. Consequently, the women's law, human rights and the grounded theory approaches were instrumental in underscoring the women's experiences and lived realities. A qualitative data collection method that allowed for a focus on the whole research topic was embraced. A total of 46 interviews were conducted and four focused group discussions held. The study revealed that a majority of pregnant women neither attend ante natal clinics nor deliver in health facilities. The health facilities are economically and geographically inaccessible to the women. The cost of medical care is unaffordable to the women taking into consideration their economic vulnerability. There are no health facilities within the camps and the ones within the women's reach are not adequately equipped to provide maternal health services. It is concluded that the maternal health care challenges in the camps are as a result of failure on the part of the government to adopt and implement policies that acknowledge the special status and concomitant vulnerabilities of the internally displaced women. In order to address this, it is recommended that the government should not only take appropriate legislative measures but also administrative, social and educational measures to give effect to its constitutional and international human rights commitments.

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Declaration

I, JUDITH A. NYAGOL, do hereby declare that this dissertation is my original work and has not been presented or submitted anywhere else before.

SIGNATURE DATE

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Judith A. Nyagol

Dedication

To my late mum and dad,
Thank you for instilling in me the virtue of hard work and a motivation to strive for excellence in all my endeavours.

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I would like to express my sincere gratitude to my supervisor, Dr. Amy Tsanga for her patience as I burnt my 'brain cells' throughout this piece of work. Her guidance in the early stages of this work was critical to developing the sound research design on which this study is based. Her continual guidance made this piece of work interesting and insightful. I appreciate her interest in enhancing my skills as a researcher, through discussions and critical analysis.

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I am equally indebted to the various authors from whose work I extracted very valuable information to make the study complete.

Last but not the least I am grateful to my friends Elita and Phyllis for motivation throughout my stay in Zimbabwe. Their generosity has not gone unnoticed.

List of Abbreviations

ANC	Ante Natal Care
APHIA	AIDS, Population and Health Integrated Assistance Project
IDMC	Internal Displacement Monitoring Centre
IDPs	Internally Displaced Persons
IOM	International Organization for Migration
KDHS	Kenya Demographic and Health Survey
KHRC	Kenya Human Rights Commission
LDHS	Liberia Demographic and Health Survey
MERLIN	Medical Emergency Relief International
MOSSP	Ministry of State for Special Programmes
MMR	Maternal Mortality Ratio
TBA	Traditional Birth Attendant
UNOCHA	United Nations – Office for the Coordination of Humanitarian Affairs
WHO	World Health Organization

List of Statutes, Policies And Guidelines cited

Constitution of Kenya, 2010
National Reproductive Health Strategy, 1997 – 2010
National Reproductive Health Policy, 2007

International Conventions, Protocols, Declarations and Consensus Documents cited

African Union Convention on the Protection and Assistance to IDPs (Kampala 2009)
African Charter on Human and Peoples' Rights (Banjul Charter)
Beijing Declaration and Platform for Action of the Fourth World Conference on Women adopted in Beijing, China, 1995
Convention on Elimination of All Forms of Discrimination Against Women (CEDAW)
Declaration of Alma-Ata in International Conference on Primary Health Care, Alma-Ata
International Covenant on Economic, Social and Cultural Rights (ICESCR)
Programme of Action of the International Conference on Population and Development, Cairo, Egypt, (ICPD-PA 1995)
The Protocols and Pact to the International Conference on the Great Lakes Region (IC/GL-2006)
United Nations Guiding Principles on Internal Displacements (UNGIP 1998)

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CHAPTER ONE:

1.0 INTRODUCTION

> *In the year 2006, I conceived my first pregnancy. I attended the antenatal clinic regularly with a visit in every two months and in the third trimester the visits increased to monthly basis. The doctor had projected that I would deliver on or about the 27th December, 2006. On the 25th November, 2006 I woke up at 7 am ready to go to work. I took a shower and dressed. No sooner had I sat down to take my breakfast than I felt like going to the toilet. In the toilet, I realized that I had a discharge which was unusually thicker than urine. I got very nervous as thoughts of a miscarriage crossed my mind. This prompted me to call my doctor who advised me to get to the hospital quickly. While in the car I would feel like the baby was coming out. My neighbour who had accompanied me encouraged me to hold on as we made our way to Provincial General Hospital (PGH), the referral hospital in this study. As soon as I got out of the car, the baby thrashed out at around 8 am and lucky enough, my neighbour held him before he hit the ground. The medics explained that I had experienced a precipitate labour*[1].

My experience demonstrates the exigencies of pregnancy and delivery that most women go through in order to discharge their reproductive roles. The unpredictable nature of pregnancy raised my interest in the research topic. Of particular concern was how the *wanjikus* (ordinary women) coped with issues of accessibility to quality maternal health services, especially in emergency situations. Having had my own unpleasant experience I was curious to find out how the other women were coping especially women who have little or no means. That is why I chose the internally displaced women whom I perceived had unique needs that are distinct from the general population and who require special attention that arise as a result of displacement.

This work is presented in five parts; the first chapter lays the background to the study by highlighting the internally displaced persons phenomenon and the state of maternal health care, problem statement, objectives, assumptions and research questions. The second chapter reviews related literature and laws (international human rights laws and national legislations and policies) on maternal health care in the context of displacement as has been found by other authors and

[1] Precipitate labour in medical parlance, is the expulsion of the fetus within less than three hours of the commencement of contractions. It is associated with higher rates of maternal complications.

organizations worldwide. Chapter three reveals the methodological process of obtaining information and ensuring the quality of information. Chapter four and five demonstrate the findings of the study and the penultimate chapter, chapter six details the conclusion and recommendations of the study.

1.1 Background to the Internally Displaced Persons (IDPs) Phenomenon

Millions of people in Africa have been forced to flee their homes and communities as a result of conflict, situations of generalized violence, human rights violations, natural disasters and environmental degradation. Once it happens, internal displacement brings about a set of circumstances that render those affected highly vulnerable.

In the early 1990s, a number of factors focused global attention on the provision of reproductive rights, health and services to refugees and displaced populations. Crises in the former Yugoslavia and Rwanda heightened awareness of the specific reproductive health needs of refugee and internally displaced women (UNHCR, 2004).

The concept of internally displaced persons has been defined comprehensively by various international laws. The study adopts the definition set out in the 1998 Guiding Principles on Internal Displacement (the Guiding Principles) which describes 'internally displaced persons' (IDPs) as:

> *Persons or group of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of, or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human made disasters, and who have not crossed an internationally recognized State border.*

While displacements have taken the manifestations captured above from the colonial to post-independence eras in Kenya, it is the politically instigated violence which has taken a centre stage from 1991 to 2008. The focus of this study is on the politically instigated displacement as was witnessed in Kenya in the year 2007/08. In the year 2007/08 Kenya witnessed the worst

form of politically instigated violence as a result of disputed presidential elections results. The violence caused the displacement of over 650,000 persons who took refuge in makeshift camps. The government has embarked on a resettlement process but it has been very slow.

According to a February report from the UN Office for the Coordination of Humanitarian Affairs (OCHA) hundreds of displaced Kenyans are still living in squalid conditions. Tents intended for temporary shelter are now torn and unusable, especially during the rainy season. Poor housing conditions are exposing the IDPs to health and social problems within the camps. The report further explains that coupled with adverse weather conditions, this has led to respiratory complications like asthma and pneumonia among both the adults and children.

A report by Kenya Human Rights Commission (KHRC) 2011, revealed that most of IDPs have complained about either lack of access to and /or unaffordable health services within their camps. An audit commissioned by the Panel of Eminent African Personalities[2] reported in January, 2010 that hundreds of displaced people in camps continue to face serious health and shelter problems especially when it rains. An example was given of a diabetic woman who was detained in hospital owing to the inability to pay the hospital bill after undergoing an operation.
Women in situations of displacement are particularly vulnerable especially with regard to their reproductive roles as they are obliged to settle in isolated camps away from affordable government run health facilities. Further, the reproductive health needs of women are exacerbated by the likelihood that the health services are extremely limited or essentially unavailable. Consequently, complications of pregnancy and child birth are not addressed appropriately. It is estimated that about 15% of pregnant women in emergency situations experience complications during pregnancy or delivery that are life-threatening and require emergency obstetric care (WHO, 2005). When such care is not available, the likelihood of maternal death increases.

[2] As a result of the violence that pervaded in Kenya due to the disputed presidential elections result, the African Union, the UK, the USA and the EU supported efforts by Kofi Annan and his colleagues on the AU panel of Eminent Personalities to mediate between the ruling party and the opposition. The intervention led to the signing in February, 2008 of the Kenya National Dialogue and Reconciliation Accord.

In addition, internally displaced women have usually been cut off from their land, traditional livelihood and means of generating an income, and compelled to leave all but a few possessions behind, they suddenly find themselves stripped of their economic means of survival. As a result they have lost their livelihoods and the means of generating an independent income which means that they cannot afford health care fees and medication.

The Kenya Human Rights Commission (KHRC), (2011) notes that while the government has made some effort to protect and assist the IDPs, (for example the Ministry of Finance has embarked on providing funds for resettlement), the government has not put in place adequate measures and resources to foster the protection and assistance of IDPs. The human rights of the IDPs, in the context of this study the reproductive health rights of the internally displaced women, are inadequately addressed at policy level. The needs of the IDPs are addressed on an *ad hoc* basis through the line ministries concerned. With regard to maternal health services, the internally displaced women have to compete for services that are already inadequate and, in some situations, essentially unavailable (WHO, 2005).

1.2 Background to Maternal Health Care

A full and detailed outline of the reproductive rights (for all human beings, including refugees and the internally displaced) was first set forth in 1994 at the International Conference on Population and Development (ICPD) in Cairo. The conference called for universal access to basic reproductive health services and specific measures for fostering human development and the social, economic and health status of women. Despite sound arguments based on public health concerns, human rights and social justice, comprehensive reproductive health care is still insufficiently understood or applied in many developing countries. The situation is even worse in conflict and post conflict situations.

The 1998 United Nations Guiding Principles on Internal Displacement provides that national governments have the primary duty and responsibility to provide protection and humanitarian

assistance to internally displaced persons within their jurisdictions[3]. In the context of this study and, as in many developing countries, the internally displaced women are obliged to compete with local residents for health services that are already over stretched.

According to the World Health Organization (2005), up to 15% of all births are complicated by a potentially fatal condition. Despite the fact that these complications are unpredictable, they are largely preventable. Skilled health providers are trained to recognize and manage the complications or to stabilize the condition and refer the patient to a higher level of care if required. Yet, in the developing world, only about 58% of all deliveries are reported as being attended by skilled health services providers. Access to maternal health services remains a challenge, especially in developing countries.

Maternal health services are not only bedeviled with accessibility and quality issues but also availability and affordability. WHO (2005) opined that the exposure of poor and vulnerable women to crude means of delivery at home and by untrained birth attendants poses a great danger to the health of women, hence a major concern. In light of this, the United Nations identified the need to reduce maternal mortality by three – quarters by the year 2015 (MDGs). Even though this objective in the Millennium Development Goals has been well lauded, relatively little progress has been made.

In Kenya, according to the 2008/2009 Kenya Demographic Health Survey (KDHS), Kenya's maternal mortality ratio (MMR) is high, at 488 maternal deaths per 100, 000 live births, well above the 2015 MDG target of 147 per 100, 000. The National Coordinating Agency for Population and Development (NACPD)[4] revealed that only 18% of maternity facilities provide for both ante-natal care, normal and emergency delivery services countrywide. About 60% of Kenyan women deliver at home without assistance from a health provider.

[3] Principle 1

[4] National Coordinating Agency for Population and Development (NACPD) and ORC Macro 2006 Kenya Service Provision Assessment Survey 2004, Maternal Health Findings, Nairobi, Kenya.

According to the Demographic and Health Survey of 2008/09 a vast majority of women were reported to have received some antenatal care (ANC) from a skilled provider, only 15% reported that they had made the recommended ANC visit by their fourth month of pregnancy. In addition, only 43% had learned about the signs of pregnancy complications during an ANC visit. More than half of Kenya's births occur at home. The most commonly given reasons for not going to a health facility to give birth were cost, distance and a lack of transportation (KDHS, 2008/09).

From the foregoing discussion, it is patently clear that the internally displaced women are in a situation where the health facilities goods and services are already inadequate. Internal displacement therefore carries an additional burden as, within an already resource poor environment, the women are pushed into even more deprived circumstances, where health services are lacking or where they must compete with local residents for limited supplies and assistance.

1.3 Statement of the Problem

Women bear the greatest burden of reproductive health problems and their vulnerability to reproductive ill-health is increased by biological, cultural, social and economic factors. While their need for comprehensive reproductive health care and services remains, refugees and internally displaced persons (IDPs) often have limited access to such care.

This research focuses on the maternal health care (antenatal care and delivery services), which is an aspect of reproductive health, in situations of displacements. It is only relatively recently that several events drew attention to internally displaced persons' need for reproductive health care. At the 1994 International Conference on Population and Development (ICPD) a full and detailed outline of reproductive rights (for all human beings, including refugees and the internally displaced) was set forth. The African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa of 1998 also recognizes the right to health which includes maternal health care in situations of displacement.

The primary responsibility for the provision of the maternal health care needs in camps lies with national governments. The Constitution of Kenya has impressive provisions under Article 43(1) on the right to the highest attainable standard of health which includes the right to health care services, including reproductive health care. Kenya has also ratified the core international and regional human rights instruments pertaining to right to health in situations of internal displacement.

According to the Committee on Economic, Social and Cultural Rights, General Comment 14, health services should be available, affordable accessible and of quality. However, in the context of the present study, the standards are far from being realized as the Kenyan health sector grapples with its own challenges and displacement brings with it a new challenge in already overstretched resources.

This research seeks to analyze maternal health care challenges in internally displaced persons camps in Nakuru County. The research seeks to evaluate the affordability, accessibility and the quality of maternal health services available to the women. It attempts to assess the measures taken by the government towards achieving its constitutional and human rights obligations and the possible interventions necessary to improve the maternal health care needs of the women in situations of displacement.

1.4 Objectives of the Research

In coming up with my objectives and assumptions, my yardstick were the international right to health principles of availability, accessibility, quality and affordability as set out in the General Comment No. 14 of ICESCR. My main objectives were:-

1. To find out whether there are challenges facing internally displaced women in accessing quality maternal health care.

2. To assess women's access to ante natal and delivery services in internally displaced camps.

3. To evaluate the affordability of the requisite maternal health care services by women in internally displaced camps.

4. To evaluate the availability of the ante natal and delivery health care services to the internally displaced women.

5. To find out to what extent the government complies with its obligation to ensure that the women attain the highest standard of health (which includes the right to health care services including reproductive health care) as recognized and enshrined in the Constitution[5] and international and regional human rights instruments[6].

6. To find out the possible interventions that can be employed to ensure that the women in displacement camps in Kenya attain the highest standard of maternal health care as enshrined in the Constitution and human rights instruments.

To achieve these objectives, I was guided by the following assumptions and research questions.

1.5 Research Assumptions

1.a There are maternal health care **challenges** experienced by women in the camps because the pregnant women do not attend antenatal clinics.

[5] Article 43 (1) of the Kenyan Constitution.
[6] Article 25 of the Universal Declaration of Human Rights, Article 12 of the International Covenant on Economic, Social and Cultural Rights, Articles 1(k-l) & 7 (5c) of the Africa Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa (Kampala Convention) and Principle 18 of the UN Guiding Principles on Internal Displacement of 1998.

1.b Child births are attended to by unskilled birth attendants from within the camps who cannot identify and address appropriately complications of pregnancy and labour, for instance, obstructed labour, retained placenta and still births.

2. Internally displaced women cannot access appropriate medical attention in cases of problems associated with their pregnancy and childbirth because the health facilities are far away from the camps.

3. Internally displaced women cannot **afford** appropriate health care because they do not have the resources necessary to pay for the health care and medication due to loss of livelihoods and the means of generating an independent income.

4. The health care facilities are not **available** within the camps and this hampers the women's access to emergency health needs.

5. The government has a constitutional and human rights **obligation** to ensure that the displaced women have access to quality and affordable maternal health care as enshrined in the human rights instruments it has ratified, yet it has failed to bring its national reproductive health policy, budgets and programs in line with those commitments.

6. The government's failure to meet its constitutional and human rights obligation is as a result of **inadequate focus** on the health needs of the internally displaced women and lack of commitment on the part of the government to provide resources, both manpower and financial, to facilitate the implementation thereof.

1.6 Research Questions

The following research questions arose from the above assumptions.

1. Are there challenges experienced by the internally displaced women which prevent them from accessing quality maternal health care services?

2. How far away from the camps are the health facilities? Does the distance hinder the women's access to the facilities in cases of emergencies?

3. Can the internally displaced women afford appropriate health care?

4. Are health care facilities available in camps?

5. What are the reasons for the government's failure to honour its constitutional and human rights obligations to realize the women's right to the highest standard of maternal health care?

6. What measures is the government putting in place to facilitate the implementation of the constitutional and human rights provisions in addressing the maternal health care needs of internally displaced women?

1.7 Demarcation of Research

This study was carried out in Nakuru County. Nakuru is approximately 200 kilometres from the capital city of Kenya, Nairobi. It is the provincial headquarters of Rift Valley Province. It was one of the counties most affected by post election violence (PEV) and ended up harbouring many of the IDP from different parts of the country. According to Kenya National Bureau of Statistics, March and July, 2010, Report, a total of 350, 000 IDPs sought refuge in 118 camps across the country. A considerable number of IDPs have since been resettled while some have either gone back to their ancestral homes or from where they were displaced. The rest are still in the camps.
The study focused on four IDP camps; Pipeline with a capacity of approximately 530 households, Ebenezer with a capacity of 150 households, Vumilia with a capacity of 280 households and Githima residential estate where integrated IDPs, namely IDPs in urban or peri-

urban areas, who took up residence with friends or relatives, or rented accommodation. The camps are located in the margins of the society away from basic infrastructure like roads, water and electricity. The camps have symbolic names for instance; Ebenezer (*"Thus far the Lord has brought us*) and Vumilia (*endure*) are symbolic names, possibly pointing to both the miseries and inspirations of the IDPs in life.

The focus was also on health providers in Nakuru County. The main referral hospital in Nakuru is the Provincial General Hospital (PGH). The government run Mirugi Dispensary and Gilgil District Hospital.

Figure 1: Photograph of a woman and children at Pipeline Camp, Nakuru.

CHAPTER TWO:

2.0 LAW AND LITERATURE REVIEW

Good health is an essential component of human dignity and a foundation upon which full and productive human lives are built [7].

2.1 Introduction

This chapter contextualizes the present study within existing literature and studies on maternal health care in situations of displacement as experienced within the global communities and related obstacles. By discussing the international human rights instruments and national laws dealing with maternal health care, the international human rights standards are viewed as the yardstick against which national laws and policies are measured. The gaps arising from the laws are further highlighted and discussed.

The chapter focuses on; right to the highest attainable standard of health, international right to health principles, state responsibility with regard to the internally displaced persons and national legislative and policy interventions in maternal health services.

2.2 Right to the Highest Attainable Standard of Health

It is only relatively recently, that several events drew attention to internally displaced persons' need for reproductive health care. At the 1994 International Conference on Population and Development (ICPD) a full and detailed outline of reproductive rights (for all human beings including refugees and the internally displaced) was set forth.

[7] LO Gostin, 2004

The 1998 United Nations Guiding Principles on Internal Displacement provides specifically for protection and assistance to especially vulnerable populations required by their condition and to treatment which takes into account their special needs[8]. This takes cognizance of the internally displaced women's unique needs and heightened vulnerabilities, which arise directly from their forced displacement, distinct from those of the general population and which therefore require special attention.

In particular, the Guiding Principles provide explicitly that special attention should be paid to the health needs of women, including access to female health care providers and services, such as reproductive health care[9]. Principle 18 states that all IDPs have the right to an adequate standard of living and that at the minimum, regardless of the circumstances and without discrimination, competent authorities shall provide internally displaced persons with and ensure safe access to essential medical services and sanitation.

Principle 29 which relates to access to public services after displacement, does not make explicit reference to health and basic services but it does assert the right of IDPs to have equal access to public services which could implicitly include any health care that would be available through public services and facilities.

Based on the 1998 Guiding Principles, the African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa of 1998, also recognizes the right to health which includes maternal health care in situations of displacement[10]. The Convention further seeks to protect the fundamental rights and freedoms of internally displaced persons, facilitate durable solutions to their displacement, and ensure that these individuals have an opportunity to lead dignified and productive lives. It also focuses on preventing situations of mass displacement and resolving the vulnerabilities and needs of those who have been displaced.

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[8] Principle 4 states that "Certain internally displaced persons … shall be entitled to protection and assistance required by their condition and to treatment which takes into account their special needs."

[9] Principle 19

[10] Articles 1(k-l) & 7(5c)of the African Union Convention on the Protection and Assistance of Internally Displaced Persons was adopted by African heads of state and government to address the root causes and challenges of forced displacement on the Continent of Africa at a special Summit in Kampala, Uganda on October 22-23, 2009.

Numerous provisions of regional and international human rights treaties also set out the right to health.

The World Health Organization constitution in 1948[11] defined the Right to Health as the right of all people *"to the enjoyment of the highest attainable standard of physical and mental health"*. According to General Comment 14, the right to the highest attainable standard asserts the right to the highest possible level of health, which is a relative level dependent on individual biology, socio-economic conditions and available resources. The International Covenant on Economic, Social and Cultural Rights spells out the obligations of UN member states to commit to the highest attainable standard of health.

The Covenant on Elimination of All Forms of Discrimination Against Women (CEDAW)[12] affirms the importance of meeting women's unique health needs. The Committee on the Elimination of All Forms of Discrimination against Women's General Recommendation No. 24 expands upon the right to health in a variety of respects, including asserting that special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women.

The Alma Ata Declaration in 1978[13] was the first document to emphasize the value and necessity of advancing universal primary health care. In this document, the scope of essential primary health care was defined as including, at the very minimum, where the underlined phrase is of particular interest to this study:-

> *…education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.*

[11] Preamble to the Constitution of the World Health Organization. In: International Health Conference,New York, 19-22 June, 1946, entered into force on 7 April 1948. Available at www.who.int/governance/
[12] Convention on Elimination of All Forms of Discrimination Against Women, art. 12
[13] Declaration of Alma-Ata, art 7(3). In: International Conference on Primary Health Care, Alma-Ata, 6-12 Sept 1978

Regional treaties also reaffirm the commitment to health rights, for example, the Banjul Charter[14] proclaims the right to the highest attainable standard of physical and mental health.

However the reproductive health rights of women in the context of displacement are inadequately addressed in policy at the national level of many countries and the provisions applicable for the general population applies equally to IDPs.

2.3 International Right to Health Principles

Human rights affect the relationship between states and individuals, giving state duties and individual entitlements. Human rights aim to empower individuals and are thus based on the general principles of equality, participation, accountability, attention to vulnerable groups and the interdependence of human rights (Muli E. 2008).

In 2000 the Committee on International Covenant on Economic Social and Cultural Rights (ICESCR) outlined international right to health principles in General Comment 14 with particular emphasis on the principles of availability, quality, affordability and accessibility. The Committee asserted in the pertinent part that:

> *State parties recognize the right to the enjoyment of the highest attainable standard of physical and mental health through the provision of health care services as well as the safeguarding of the underlying preconditions for health.* ***They shall ensure the availability, accessibility, affordability and quality of such services and pay commensurate attention to the position of vulnerable groups in this regard. Irrespective of their available resources, states shall ensure a right to basic health services, including;***
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> *i. Maternal and child health care,…(emphasis mine)*

[14] African Charter on Human and Peoples' Rights, art 16. In: *Organization of African Unity, Banjul,* 27 June 1981.

2.3.1 Quality of Antenatal and Delivery Services

According to the recommendations set out in the General Comment No. 14, health facilities, goods and services must be scientifically and medically appropriate and of good quality. Good quality means that providers are able to manage an individual's or a population's health care by timely, skilful application of medical technology in a culturally sensitive manner within the available resource constraints.

According to World Health Organization (WHO, 2005), all pregnant women need to have access to skilled care throughout pregnancy, delivery, postpartum and postnatal periods. World Health Organization defines 'a skilled attendant' as a health professional such as a midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns. In this context, skilled attendance implies access to appropriately trained health providers whether in a health facility or through domiciliary care, and having access to a rapid means of referral in case of emergency.

Focused antenatal care requires at least four visits; the first one should be as soon as a woman learns that she is pregnant (Lederman, 2001:54). These visits enable the health care providers to assess health safety of the pregnant woman; HIV status, nutrition and danger signs of pregnancy, including bleeding and anaemia.

In a case study carried out in Gereida IDP camp, in Sudan, by Merlin's revealed that many women lacked access to quality health care which contributed to the dangers associated with pregnancy and child birth. In 2004, the Government of Sudan introduced a series of measures to reform its health system and strengthen maternal health care. Henceforth, maternal health care would be addressed at the community level through village midwives with twelve months training, national examination and national certification.

Despite the government stopping the training of TBAs, in practice, many continue to attend births. Most women in Gereida IDP camp attend an antenatal clinic during their pregnancy specifically in their 2nd trimester, but deliver in the community assisted by a TBA. Many TBAs are unable to identify labour complications, many of which are linked to cultural issues or practices (such as Female Genital Mutilation). Complications of pregnancy and childbirth experienced in this context include prolonged or obstructed labour; post-partum sepsis and hemorrhage; retained placenta; stillbirth, severe anaemia and (pre)-eclampsia. Although the antenatal care visits in the IDP camp is high, the greatest challenge remains convincing mothers to seek a clinic delivery. Merlin's team, therefore, ensures that all women visiting the clinic in their 3rd trimester receive a clean delivery kit to be used at home (in the event that they do not attend a health facility for the birth) (Merlin, 2008).

Liberia is one of the countries in Africa that also grapples with the problem of IDPs. According to the Liberia Demographic and Health Survey 2007 (LDHS), the vast majority of births in Liberia are carried out in the community, usually attended to by a traditional practitioner, and currently 63% of deliveries take place outside of a health facility. Even within health facilities there is a startling lack of trained midwives. Facilities with no formal trained staff usually use traditional practitioners, who are often illiterate. This is most common in the rural areas. Only 32% of mothers living in rural areas can expect a medically assisted delivery (Liberia DHS 2007).

Various factors prevent the women from utilizing skilled services, for example, in a study carried out in the Ahafo-Ano South district, Ghana, it was revealed that inaccessible roads to health facilities and the lack of access to vehicles account for the low utilization of skilled attendants (Nai- Adjei, 2008).

2.3.2 Availability

According to the recommendations by the committee on International Covenant on Economic Social and Cultural Rights (ICESCR), functioning public health and health-care facilities, goods

and services, as well as programs, have to be available in sufficient quantity within the State party. The great majority of the world's IDPs are in developing countries where health facilities, goods, and services are inadequate or essentially unavailable. Internal displacement can carry an additional burden as, within an already resource poor environment, it can push populations into even more deprived circumstances where health services are lacking or where they must compete with local residents for limited supplies and assistance (International Organization for Migration, 2007).

For instance, in Iraq, January 2007 a study by International Organization for Migration (IOM) noted that already poorly equipped and inadequately staffed health centers, located in areas of high IDP concentration, are unable to cope with the increased caseloads. There is a chronic shortage of medication, lab materials and X-ray films in the country, which renders many health facilities useless.

In order to manage pregnancy and delivery complications, a facility must have trained staff and a functional operating theatre, and it must be able to administer blood transfusions and anaesthesia. In most of the developing countries where the internally displaced women depend on existing health facilities, the district hospitals and health centres can often become capable of providing emergency obstetric care by improving the health facilities that already exist to enable them to manage pregnancies.

A national level study conducted in Egypt discovered that avoidable factors associated with women's deaths were due to substandard delivery care. In many cases, no standard referral system was in place and no protocols were available for obstetric emergencies (MOH – Egypt 1998). As a result of the study findings, the Egyptian Ministry of Health worked to define a set of health facilities and community based interventions to address the available factors identified. Among the interventions were protocols for delivery care, standard of quality of care and special training courses for maternity care providers (USAID, 2008).

2.3.3 Accessibility

According to the recommendations by the committee on ICESCR, health facilities, goods and services must be accessible to everyone. Health facilities should be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, including those in rural areas. A multi-country study of displacement in the Balkans found that the displaced populations reported excessive distances to health facilities as a hindrance toward utilization of skilled services (UNDP, 2006).

According to UNFPA Report (2004), difficult geographic terrain and limited transportation may present obstacles to reaching a skilled attendant. Tsanga (2011:216) opined that the main challenges for poor rural women in accessing health care include transportation difficulties, poverty, lack of access to health care information and lack of access to health care in relation to HIV/AIDs.

A Nepal study found that living more than one hour away from a health facility is eight times more likely to lead to non use of the health facility for delivery (Wagle, et al. 2004). Claeson, et al. (2001) agrees that if services are not accessible, then the issue of whether they are properly staffed or not is irrelevant.

In remote areas, where vehicles are often scarce and in poor condition, the cost of arranging emergency transportation can be daunting. The same applies to internally displaced persons situations where the camps located as they are in remote places where the health facilities, goods and services are inadequate or essentially unavailable, are likely to prevent the women from accessing health care.

2.3.4 Affordability

According to the recommendations set out by the committee on ICESCR, the costs for health care services, whether privately or publicly provided, should be affordable to all, including socially disadvantaged groups. Many factors complicate women's access to skilled care in most regions in Africa. The UNFPA, (2004) report, explains that women often give birth at home because of the prohibitive cost of medical care or cultural beliefs that promote home based delivery.

According to United Nations Office for the Coordination of Humanitarian Affairs (2004) report, it was noted that quality health care services are largely inaccessible to internally displaced persons, mainly because of the high cost involved. There are unexpected costs associated with obstetric emergencies. In most developing countries a significant percentage of people who used public services incurred substantial costs even though the user fees are supposed to be low in public facilities (UNOCHA, 2004).

In a study carried out in the Ahafo –Ano South district, Ghana, it was revealed that cost can be a significant barrier to the decision to seek lifesaving care in many settings. For most women, cost was a major barrier to obtaining appropriate medical care; those delivering in a public facility had to pay medical fees, anaesthetic and antibiotic costs and the cost of surgical supplies, such as gloves and surgical drapes (Nai- Adjei, 2008).

In Colombia, for instance, an IDP Law (387/97, passed in 1997) established that IDPs should have access to health services to the maximum of the funds available and a 2000 regulation guaranteed that registered IDPs would have free and unlimited access to health care and medicines.

Mrisho, et al. (2007:10) assert that women still deliver at home despite the availability of maternity services and cite fees and low income as reasons for not using the health facility in Nigeria. According to UNFPA reports (2004) from Bangladesh, wealthy women are more likely to deliver in a facility than poor women. The report further stated that women face barriers to skilled care at different levels. At the individual level, women avoid institutional delivery due to

shame, fear of caesarean sections and death. At the family level, economic constraints are a major barrier.

In order to curb the non affordability of maternal health services in Zambia, maternal health policy provides that maternal health services such as focused antenatal care, child birth, post natal care, family planning and basic emergency should be provided free of charge in all public health facilities (Ministry of Health, Zambia 2008).

2.4 International Human Rights Law: Reproductive Rights and State Responsibility

The regional and international human rights and humanitarian laws[15] espouse both the specific and general safeguards on the rights and needs of IDPs in all phases of displacement. According to the 1998 United Nations Guiding Principles on Internal Displacement (Guiding Pinciples) for instance: Internally displaced persons shall enjoy, in full equality, the same rights and freedoms under international and domestic law as do other persons in their country. They shall not be discriminated against in the enjoyment of any rights and freedoms on the ground that they are internally displaced. These Principles shall be observed by all authorities, groups and persons, irrespective of their legal status, and applied without any adverse distinction[16].

The African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa of 1998 affirms the leading role and responsibility of national governments to protect and assist IDPs and prevent situations of internal displacement in the region and within their individual countries.

Of significance is that the Convention requires that national authorities make funding available to assist IDPs and designate institutional focal points in each of their countries to facilitate coordination among relevant government agencies and with local and international partners on

[15] United Nations Guiding Principles on Internal Displacements(UNGIP 1998), The Protocols and Pact to the International Conference on the Great Lakes Region(IC/GL-2006) and the African Union Convention on the Protection and Assistance to IDPs (Kampala 2009).
[16] Principles 1, 2 & 3.

issues related to internal displacement. National authorities may, for instance, designate an existing government ministry or agency to take responsibility of IDPs or create a special commission or working group to coordinate government activities.

National authorities carry primary responsibility for ensuring the highest attainable standard of health for everyone within their jurisdiction, including internally displaced persons. This obligation requires States to take progressive steps, to the maximum of their available resources, towards the full realization of the right to health by all appropriate means, including legislative, administrative, financial, educational and social. In particular, national authorities must aim to ensure that health-care facilities, services and supplies are available, accessible, culturally acceptable, and of good quality.

These obligations are set out in General Comment 14 on the right to the highest attainable standard of health, issued by the UN Committee on Social, Economic and Cultural Rights thus;-

> *1. State parties recognize the right to the enjoyment of the highest attainable standard of physical and mental health through the provision of health care services as well as the safeguarding of the underlying preconditions for health. They shall* ***ensure the availability, accessibility, affordability and quality of such services, and pay commensurate attention to the position of vulnerable groups*** *in this regard. (emphasis mine)*
>
> *2. Irrespective of their available resources, states shall ensure a right to basic health services, including:*
>
> *(i) Maternal and child health care, including family planning;*

It is in this light that the Committee on Economic, Social and Cultural Rights, General comment 14 set down the obligations on the part of the State to ensure progressive realization of the right to health thus;-

> *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*[17].

The phrase "with a view to achieving progressively the full realization of rights" conveys the need for continuous progressive action rather than inaction or regression (Chapman A. A., 1996). State responsibility towards realization of the internally displaced women's right to health begins with the entrenchment of the right to health concept and components within constitutional frameworks. Constitutional text is then interpreted and contextualized by legislators and policy makers to produce national health policies and legislation that identify the state's responsibilities to health and the targeted steps it should take to fulfil them. These legal instruments are translated into action by, for example, allocating national resources towards health initiatives or creating national health programs.

While it is not possible to recommend uniform bench marks applicable to all states, the states are mandated to ensure resource commitment in order to make relative advancements of the right to health in diverse political circumstances, social conditions and available resources.

In order to address maternal health care needs of the internally displaced women, national authorities are developing legislation aimed at translating the provisions of the regional and international instruments on displacement into directives at the national level. For example, Sudan has developed a National Policy on Internal Displacement (2009). Sudan's national policy recognizes the civil and political, as well as economic, social and cultural rights of the IDPs.

In Kenya, just like in most developing countries, the health facilities, goods and services are inadequate or essentially unavailable. Internal displacement therefore imposes upon the national authorities an additional responsibility of ensuring that their public service utilities, in this case the health facilities, are adequately equipped to handle the additional burden brought about by internal displacement.

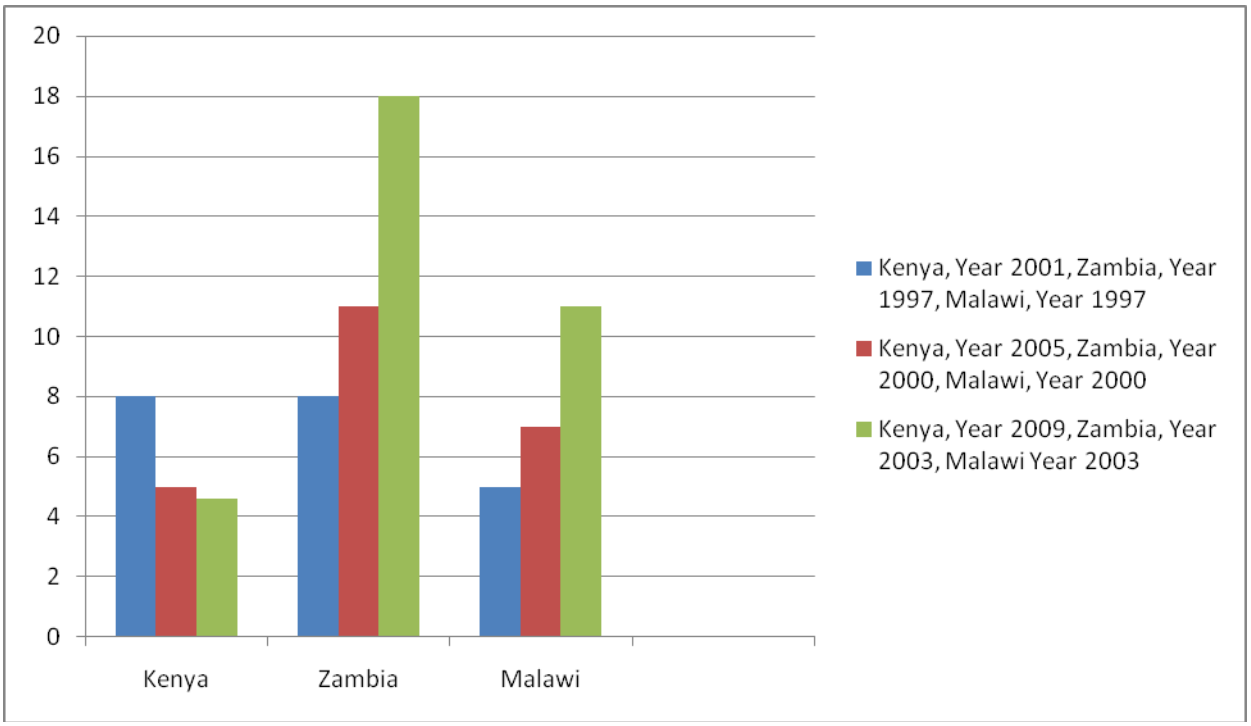
[17] International Covenant on Economic, Social and Cultural Rights, art 2(1). In: United Nations General Assembly, Geneva, 16 Dec 1966.

In this vein, the heads of States of the African Union member states in Abuja, Federal Republic of Nigeria, on the 27th April 2001 committed to allocating at least 15% of annual budgets to the improvement of the health sector. They further resolved to take immediate action to use tax exemptions and other incentives to reduce the prices of drugs and all other inputs to health care services for accelerated improvement of population health in Africa (Govender V, McIntyre D, Loewenson R, 2008).

In a study carried out in various Southern and East African countries to assess the progress which they have made towards the Abuja target, Govender V, McIntyre D, Loewenson R (2008) observed that of the countries reviewed, only Zambia and Malawi have made considerable progress towards the Abuja target, with the health sector's share of total government expenditure increasing consistently from 8% and 5%, respectively, in 1997 to nearly 11% and 7% in 2000 and almost 18% and 11% in 2003 (thus, in Zambia's case exceeding the Abuja target). See Figure 2 below.

Kenya is the furthest from the Abuja target, with only 5% of government resources going to health services in 2006 and 4.6% in 2008/09 and with no consistent increase in government spending. This is illustrated in figure 2 below:

Figure 2: Government Health Expenditure in selected Countries in Eastern and Southern Africa



2.5 National Legislative and Policy Interventions in Maternal Health Care in Kenya

The regional and international legal and policy frameworks[18] enjoin Kenya to protect, promote and respect the IDPs rights to land, food, shelter, health/sanitation and other support to IDPs, particularly support to Inherently Vulnerable Groups (IVGs)[19]. Consequently, Kenya is required to develop legislation or policies aimed at translating the aforesaid provisions into directives at the national level for their implementation.

On a positive note, the government working with a broad range of national and international stakeholders including UN agencies, the Ministry of State for Special Programmes (MOSSP) and

[18] The regional and international human rights and humanitarian laws espouse both the specific and general safeguards on the rights and needs of IDPs in all phases of displacement. The United Nations Guiding Principles on Internal Displacements(UNGIP 1998), The Protocols and Pact to the International Conference on the Great Lakes Region(IC/GL-2006) and the African Union Convention on the Protection and Assistance to IDPs (Kampala 2009) are critical instruments in this initiative.

[19] Inherently Vulnerable Groups comprise of women, older members of the society, youth, children, persons with disabilities, the sick, persons living with HIV/AIDs.

the Ministry of Justice, National Cohesion and Constitutional Affairs launched a draft version of National Policy on IDPs in March 2010. This draft is expected to be approved by the Cabinet and the Parliament before it is adopted. The draft policy has direct positive implications for the protection, assistance and justice for IDPs.

However, according to Kenya Human Rights Commission (KHRC), 2011 report, the policy still awaits adoption and implementation. Consequently, there are no effective means of identifying and supporting the inherently vulnerable groups within the camps, in this respect, the internally displaced women. As such, the internally displaced women rely on protection and assistance from the general entitlements to citizens without consideration to their special status.

The Constitution of Kenya enshrines such fundamental rights and freedoms as the rights to life, security, human dignity, effective administrative action, property, land, education, housing, health, sanitation, food, water, social security, among others. These are integral to the protection of and assistance to IDPs. Of particular significance to the present study is the right to health as espoused in the Constitution and the Draft National IDP Policy[20].

Kenya is a signatory to the Platform of Action of the International Conference on Population and Development (ICPD) of 1994, and the Millennium Development Goals (MDGs) approved by the World Summit on Sustainable Development (WSSD) in September 2000. In order to give effect to the ICPD Programme of action, Kenya developed a consensus policy document titled, The National Population Policy for Sustainable Development, which was approved by Parliament as a Sessional paper No. 1 of 2000. The sessional paper sets out strategies and objectives in the areas of fertility, mortality, family planning, reproductive health and reproductive rights, gender perspectives and HIV/AIDS.

As a follow up to the recommendations of the ICPD Platform of Action, the National Reproductive Health Strategy (NRHS, 1997-2010) was developed as a guide to the implementation of the reproductive health agenda as recommended by the ICPD. The National

[20] See Article 43 of the Constitution and Page 34 of the Draft IDPs Policy.

Reproductive Health Strategy faced a number of challenges the most significant of which was inadequate funding that led to the deterioration in the quality of health service delivery resulting in negative health indicators.

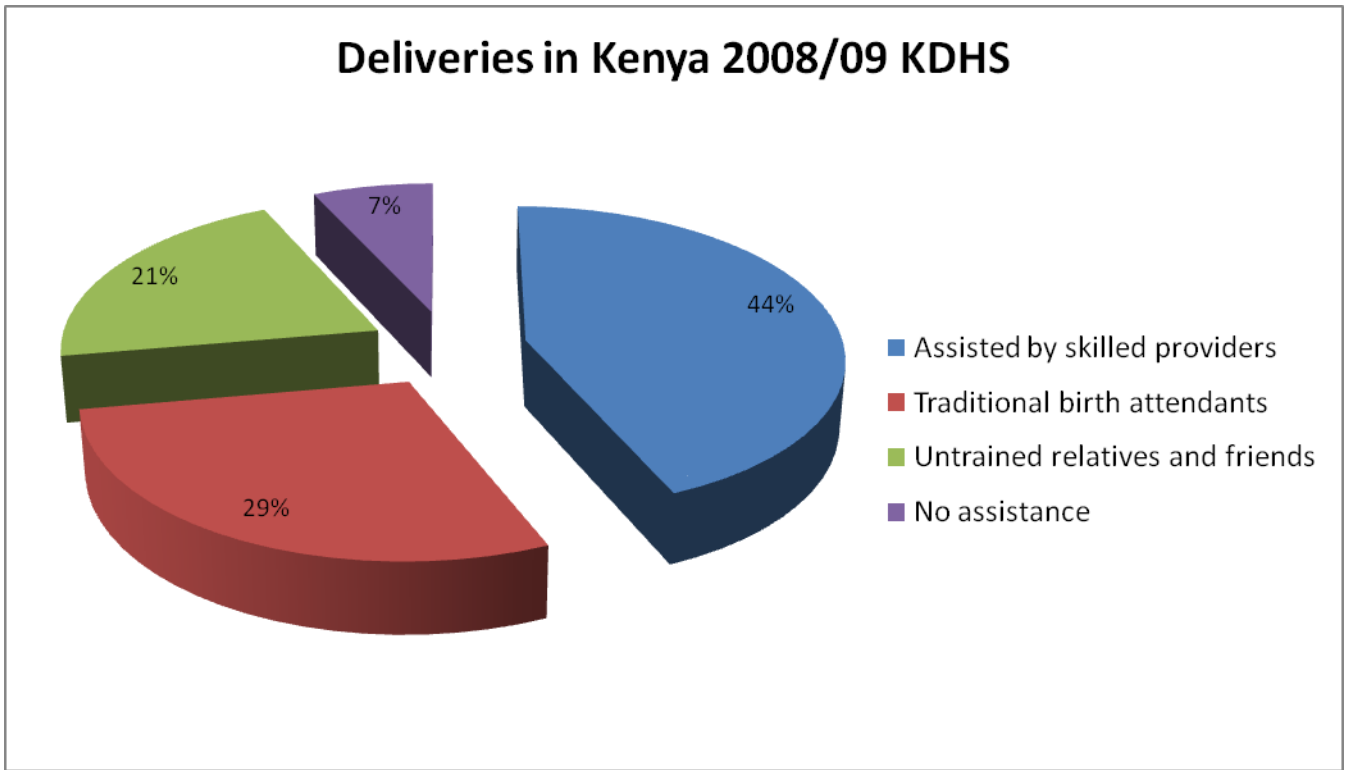
In October 2007, Kenya's Ministry of Health (MOH) formally approved and adopted the country's first ever National Reproductive Health Policy to provide a framework for the review and revision of the strategy towards addressing the challenges experienced by the National Reproductive Health Strategy. With the theme "Enhancing the Reproductive Health Status for All Kenyans", the policy provides a framework for equitable, efficient, and effective delivery of high-quality reproductive health (RH) services throughout the country, and emphasizes reaching those in greatest need and most vulnerable[21]. The goal of the National Reproductive Health Policy (NRHP) is to improve the reproductive health of all people in Kenya by increasing equitable access and improving quality, efficiency and effectiveness of service delivery at all levels.

In spite of these impressive initiatives, the implementation of the policy is still plagued by inadequate funding. According to National Reproductive Health Policy (NRHP), a majority of levels 2 and 3 health facilities which comprise of the dispensaries and the health centres are not adequately equipped to provide antenatal and delivery services. As such a majority of women cannot access affordable quality maternal health services.

The country continues to grapple with the challenge of increasing the proportion of women receiving antenatal care and delivering with a skilled attendant. According to the 2008/09 KDHS, more than half of Kenya's births occur at home and 43% occur in a health facility. Only 44% of births in Kenya are assisted by a skilled provider (i.e., a doctor, nurse or midwife); 28% are assisted by a traditional birth attendant; 21% by untrained relatives or friends; and 7% occur with no assistance at all. More than half of the women surveyed did not have a post natal checkup. This is illustrated below:

[21] Preamble to the National Reproductive Health Policy, October, 2007.

Figure 3: Deliveries in Kenya 2008/09 (Kenya Demographic and Health Survey, KDHS)



The situation is grimmer where displacement has occurred. Internal displacement unloads an additional burden on an already resource poor environment. It pushes populations into even more deprived circumstances where health services are lacking or where the internally displaced women have to compete with local residents for limited supplies and assistance.

The KHRC, 2011 report opined that many IDPs can neither access nor afford the cost of health care facilities. The KHRC report further notes that the government lacks concrete mechanisms to support the inherently vulnerable groups, including the maternal health care needs of the internally displaced women.

2.6 Conclusion

Internally displaced persons (IDPs) have the right to health and other basic services, including the right to a standard of living adequate to maintain health and well-being. However, despite the

development at the international and regional levels, the reproductive health and rights of women in the context of displacement are inadequately addressed at the national policy level of many African states. Considering that a majority of the world's IDPs are women in developing countries where health facilities, goods and services are inadequate or essentially unavailable, internal displacement carries with it an additional burden in an already resource poor environment.

The global consensus fostered by the 1978 Alma Ata Conference[22] for achieving "health for all" therefore remains intangible for most African families. Not only are the United Nations Millennium Development Goals (MDGs) for child and maternal mortality reduction unmet by many developing countries, the recently promulgated target of establishing accessible reproductive health services for all is a challenging prospect not only in Kenya but throughout the region.

The concerns about reproductive health and rights raised by the 1994 Cairo International Conference on Population and Development (ICPD) have also been inadequately addressed and donors and governments are looking for sustainable approaches to reduce persistently high maternal morbidity and mortality which is a manifestation of poor maternal health services.

WHO estimates that globally, only 43% of women have access to skilled care during deliveries and the rest are exposed to unskilled delivery service (WHO, 2005). In effect, this is a hindrance towards improving the health of women especially during delivery.

[22] Declaration of Alma – Ata In: International Conference on Primary Health Care, Alma – Ata, 6-12 Sept. 1978.

CHAPTER THREE:

3.0 THE METHODOLOGICAL FRAMEWORK

3.1 Introduction

This chapter describes the various methodological approaches that were employed in this work, the accompanying methods of data collection and the challenges encountered in the field. The methodologies used to collect and analyze data were dependent on the research assumptions, research questions and the objectives. In order to test my assumptions, I adopted the women's law, grounded theory and human rights approaches to ensure that sufficient and relevant data is collected.

A qualitative data collection method that allowed for a focus on the whole research topic was embraced. Accompanying techniques employed to collect the desired data were mainly focused group discussions, in- depth interviews and observation. A total of 46 in-depth interviews were conducted in the course of the research period. These comprised of 14 key informants and 32 general respondents.

The research journey was not, however, smooth. A few challenges were experienced here and there in particular entry into the research field was not easy. There is a lot of bureaucracy in obtaining research permissions. In order to carry out research in the province it is imperative that a researcher obtains a research permit from the Ministry of Internal Security. The Deputy Provincial Commissioner was of the view that the permission can only be issued from the headquarters, Nairobi which is approximately 200 kilometres from Nakuru. Further enquiry revealed that the process of obtaining such permission is very hectic and time consuming.

Considering the limited time that I had for the research, my authority as an employee of the government, personal contacts and acquaintances were used to circumvent this barrier. Instead of

starting with the Ministry of Internal Security, I changed tack and secured entry into the field through the Ministry of Health.

3.2 The Women's Law Approach

The Kenyan Constitution provides that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. In addition the National Reproductive Health Policy seeks to enhance the reproductive health status of all Kenyans by increasing equitable access to reproductive health services and by improving quality, efficiency and effectiveness of services provided at all levels.

My objective as I proceeded to the field was to explore whether the internally displaced women through their experiences and realities are able to realize their constitutional right to the highest attainable standard of health. The yardstick in assessing this law was the international right to health principles of accessibility, quality, affordability and availability. In order to do this, the women's law approach was employed.

The approach was instrumental in examining and understanding the lived realities of the internally displaced women in as far as access to quality affordable maternal health care is concerned. The approach is a woman centered legal discipline which takes women's actual lived experience and life situations based on sexuality, birth, care and domestic work as a starting point for the analysis of the position of women in law and society, (Bentzon et al 1998).

On the first day of my research, on my way to Pipeline camp, I met a school girl who had been sent home for school fees in a *matatu* (a public service vehicle). My interaction with her from where we alighted to the camp was very insightful to my research topic because it predisposed me to the socio – economic realities of my respondents. It also emerged that following protocol in the camp would not yield much because the camp leadership would restrict my interaction with the respondents.

This made my work easier because instead of using the leaders of the camp for introduction to the respondents, the school girl introduced me to her mother who was very resourceful in the camp.

Using experience gained from the visit to Pipeline camp, the same strategies were applied to Vumilia and Ebenezer camps in that in both camps leadership protocol was ignored choosing instead to make personal introduction and contacts on the ground. Winning the confidence of at least one woman in a camp is a positive starting point towards reaching the other women.

A total of four group discussions were held in the four camps (Vumilia, Ebenezer, Pipeline and Githima).

Table A: Focused Group Discussions

Group Discussions	Female	Male	Total Number
Pipeline camp (2)	9	3	12
Vumilia camp(1)	4	0	4
Githima camp(1)	5	2	7
Totals	18	5	23

Group discussions were held to get the general perception of the respondents with regard to my area of study. The use of this method was helpful in gathering data on collective perceptions and views on maternal health care challenges in situations of displacement as participants refined each others input into the discussions by citing examples of incidents and individuals they had collectively heard involving maternal health care. In line with my assumptions, putting in mind my respondents and what they had been through during the post election violence (PEV), the group discussion provided a flexible method to interact with the women.

Through this method, general consensus on the challenges that internally displaced women experience with regard to access, availability, affordability and quality of maternal health service was unearthed. The issues of costly maternal health services, lack of stable employment, lack of health services providers within the camps and lack of transport were very prominent.

During the group discussions, the participants were comfortable telling stories about other persons not present in the discussions. As much as it limited the collection of first hand information, it was crucial in identifying the individual interviewees because as they mentioned their names I took notes. I also noticed that some of the women in the group especially the young ones were not willing to speak freely about their experiences. This is mainly because this topic is shrouded in secrecy hence it was uncomfortable for some respondents to open up and recount their experiences. Individual interviews with the respondents were therefore imperative in order to elicit what was not freely forthcoming.

Focus therefore shifted to individual women's lived realities and experiences for a better analysis of the position of women in law as propounded by Bentzon, et al, (1998). A total of 30 women and 2 men were interviewed.

Table B: General Respondents

Camps	Female	Male	Total Number
Pipeline camp residents	12	0	12
Vumilia camp	8	1	9
Ebenezer camp	10	1	11
Totals	30	2	32

The interviewees were selected based on their experiential data in as far as maternal health care was concerned. I approached the women in private by making personal visits to their tents and broaching the subject from a non threatening angle. My contact persons in the camps were very instrumental in introducing me to some of the women and telling them that I could be trusted with information. This way they opened up and narrated their experiences to me.

The use of unstructured interviews allowed the respondents to express ideas and thoughts in their own words rather than the words of the interviewer (Fontana and Finey, 1994:210). It was an effective way of gathering information because the respondents' facial expressions, gestures and

the body language could be observed. It also provided the opportunity to clarify any issues and make follow ups on the spot.

This method was effective in that I received first hand information from the respondents. The research topic is quite sensitive and it was only this method that ensured mutual trust with the women who had poor experiences with pregnancies and had even lost their children. I witnessed deep revelations of the magnitude of maternal health care challenges in the camps. I had a chance to witness the despair, tears and hopelessness on most of the women's faces as they narrated their painful experiences. The despair and hopelessness was also evident as they recounted their losses during the PEV and the on- going uncertainty that mars the resettlement process.

The individual experiences were more nuanced. As the women recounted their experiences, my consciousness was raised with regard to the interrelatedness of the maternal health care challenges. In their own simple words, the women explained how, for instance, they lacked money to pay for transport and medical care because they did not have any source of livelihood and that they could not deliver in the health facilities because they are far away from the camps.

The women's situations and dynamics of maternal health care was therefore analyzed from the women's perspective (Bentzon, et al. 1998:93). This gave me deeper insight into the ineffectiveness of laws and policies which are not informed by grounded issues and, in the present study, the laws and the policies in place were not developed in the context of internal displacement. The vulnerabilities and uniqueness of the internally displaced women's needs are therefore not addressed in the National Reproductive Health Policy.

From a feminist perspective, this approach enabled me to identify areas of strong and weak legal support and the legal voids and, hence, the need for expansion, contraction or replacement of the said laws (Dahl 1987:20). For instance, there is comprehensive legal framework on maternal health care although the implementation thereof is hampered by inadequate resources, both human and financial, that weaken their capacity to provide maternal health services. On the other

hand, there is no policy framework on internal displacement and this hampers effective provision of maternal health services to the internally displaced women.

When some of the in depth interviews and group discussions were inordinately delayed I took time to observe the camp settings and surroundings. For instance, the squalid conditions of the camps came out clearly through observation. The field research was carried out during the rainy season, and the deplorable state of life in the camps was witnessed first- hand. When it rained, for instance, the tents made of torn polythene paper would leak thereby wetting the bedding and fire places making living in the tents almost as unbearable as living outside in the open.

Figure 4: Photograph of a tent at Pipeline camp made of gunny bags

3.3 Grounded Theory

The research process involved employing the dung beetle approach as espoused by Bentzon et al (1998: 18) thus;

> *The dung beetle method… is grounded research process in which the researcher collects data, sifts and analyses it, considers the implications of her findings, determines what to collect next to meet her needs, and continues the collection and analysis cycle. Through this process new methodologies, perspectives are hatched.*

The challenges that emerged from women's lived realities pointed to the need to interrogate the role of ministries as well as health services providers. For example, following the disclosure in one interview that child deliveries are attended to by unskilled attendants because there are no health facilities in the camps meant that if this challenge was to be fully understood the Ministry of Health officers had to be interviewed to get a fuller picture.

Bentzon et al (1998: 18) opine that this approach allows a researcher to consider the implications of the findings and to determine what to collect next. As such it emerged from one of the group discussions that the internally displaced persons were not given any special consideration in the health facilities as they have to pay for the services just like the common citizens. In order to clarify this issue, the administration at the Provincial General hospital had to be interviewed. The approach further led me to the department of social welfare to get a clearer picture of the hospital's administration on the waiver of hospital fees for the needy in society.

Other categories that emerged for further investigation stemming from interviews included the inability by the Ministry of Health to employ more staff, to buy supplies and to equip the health facilities. The health services providers exposed the underlying causes of the challenges facing the Ministry, the main one being the lean budgetary allocation by the central government.

A lack of protection and assistance to the internally displaced persons and a lack of consideration of the uniqueness of reproductive health needs of the internally displaced women also emerged from the interviews held. In order to clarify these issues, I had to interview the officers at the

Ministry of State for Special Programs whereby it further emerged that there was no policy framework for internal displacement.

3.4 The Human Rights Approach

This approach involves an analysis of a problem or situation from a holistic perspective of human rights and corresponding obligations of government according to international human rights standards (Goonesekere, 2000:2). The effect of using human rights as a methodological tool to analyze a social problem is that it ensures that every individual is recognized as a person and as a rights holder under the framework of standards and principles, duties and obligations (Bartlett, 1989:2)

From this understanding, a desk review was carried out of literature around the area of my research topic and relevant human rights instruments and the obligations set out therein for member states to comply with, with regard to maternal health care in situations of internal displacement. Library and internet sources played an important role in this regard. In the field, I came across policy documents which also added insights into my field of study. Relevant newspapers also added value to this discourse.

Kenya is a signatory to a plethora of international human rights instruments[23] which provide for the right to the highest attainable standard of health including reproductive health and the protection and assistance to IDPs[24]. Human rights obligations require that actions of a legislative, administrative or policy be assessed in the light of the obligation to protect, promote and fulfill the human rights. They create obligations for duty holders to act and enable rights holders to exercise the rights to which they are entitled (Goonesekere, 2000). Government as primary duty

[23] See Article 25(2) Universal Declaration of Human Rights and Article 12(1) International Covenant on Economic, Social and Cultural Rights.
[24] 1998 United Nations Guiding Principles on internal displacement.
See Articles 1(k-l) & 7(5c) of the Africa Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa.

bearers must take all appropriate legislative, administrative and other measures to ensure that the internally displaced women have access to quality affordable maternal health care.

It is against this backdrop that the extent to which Kenyan legislation, policies and practices on the ground conformed to the international standards were assessed.

A total of 14 key informants were interviewed.

Table C: Key Informants

Interviewees	Female	Male	Total Number
Provincial Director of medical services	0	1	1
Provincial Reproductive health coordinator	1	0	1
District Reproductive health coordinator	3	0	3
District Medical officer of health	0	1	1
District Public health nurse	1	0	1
Nurse	2	0	2
Social worker	1	0	1
Community health worker	1	0	1
Division officer	0	1	1
Chief	0	1	1
Ministry of Special Programmes Officer in Charge Nakuru	0	1	1
Totals	9	5	14

The key respondents were selected based on their technical expertise on the subject and they provided immense information which was significant to the study. The field research period coincided with the public hospitals health services providers' (doctors, nurses laboratory technicians and pharmacists) industrial strike thereby making the scheduling of appointments

easy. While this may be perceived as a limitation, the positive aspect of it was that the health providers were readily available for the interviews. This was advantageous in that I was able to collect a lot of data within a very short time as compared to the times when they would be attending to field rounds, in this case the Reproductive Health Coordinators, who are always attending workshops, conferences and supervisory roles.

The negative impact, on the other hand, was their inclination to paint an exaggerated picture of the prevailing situation in the health sector because of their dissatisfaction. Some of the health services providers were very economical with the information they gave me because of their perceived suspicion that my research would implicate them in the fueling of the strike as a result of which they could lose their jobs. I had to promise them anonymity in exchange for their cooperation.

On the ground, key informants were interviewed in the line ministries with regard to the implementation of the laws and policies. The challenges raised by the respondents on the ground enabled me to evaluate government's performance. The effect of the laws and the policies are not felt on the ground because of failure on the part of the government to commit both manpower and financial resources towards realizing maternal health needs of internally displaced women.

The Constitution provides that any treaty or convention ratified by Kenya shall form part of the law of Kenya. Despite the fact that Kenya has ratified international instruments[25] that provide for the duty to provide protection and humanitarian assistance to internally displaced persons within their jurisdictions, it emerged in the field that there was no national policy on internally displaced persons to give effect to these international laws.

[25] UN Guiding Principles on Internal Displacement of 1998

3.5 Conclusion

Generally, I found the data collection methods discussed above effective. The validity or otherwise of the data collected was scrutinized through continuous triangulation.

CHAPTER FOUR:

4.0 FINDINGS AND DISCUSSIONS:

4.1 CHALLENGES OF MATERNAL HEALTH CARE: Realities in the Camps

4.2 Introduction

The findings are presented in two parts:

Chapter Four focuses on the lived realities of the internally displaced women in accessing affordable quality maternal health services. It further analyzes the maternal health care challenges in greater depth with respect to international human rights standards and elaborates on the differences and/or similarities of the observations found by other authors.

Chapter Five illustrates the state's compliance with its international and constitutional obligations. This chapter discusses the findings made and their impact on the legal and policy initiatives dealing with maternal health care in the context of internal displacement.

4.3 Economical and Geographical Access to Health Facilities

Access to health facilities was assessed in terms of economic and geographical access in accordance with the international principles of health. The type of road to the health facility, the means of transport and the ability to afford transportation cost influenced significantly accessibility to the health facilities. The Pipeline, Vumilia and Ebenezer camps are located in very remote areas.

The distance from Pipeline camp to the highway is approximately 2 kilometres (km); and 3km and 4km in the case of Vumilia and Ebenezer camps respectively. The distances from the

highway to the health facility is approximately 15km, 45km, and 46km respectively. This is as illustrated below.

Figure 5: Distance in Kilometres from the camps to Provincial General Hospital (PGH).

Camp	To Nakuru/Nairobi Highway	To PGH
Pipeline	2km	15km
Vumilia	3km	45km
Ebenezer	4km	45km
Githima	2km to PGH	

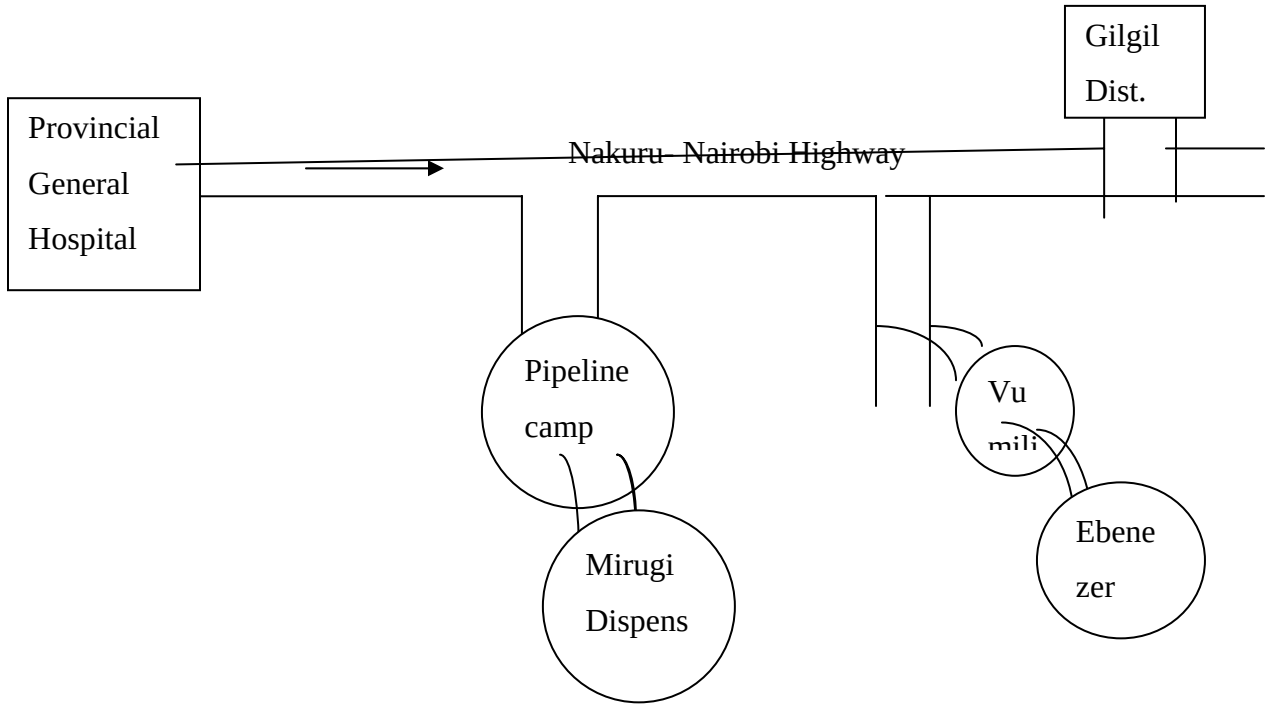
The study revealed that a majority of the internally displaced women do not attend the antenatal clinic (ANC) or give birth in a health facility because of the difficult geographic terrain, relatively long distance to be covered to the health facility and the cost of public transport. This scenario was aptly captured by a female respondent thus;

> I wish we could be provided with transport or a doctor to be available here in the camp. My labour began very early in the morning, at around 4am and I delivered at 6am in the camp. The distance from the camp to the highway is quite a stretch, a pregnant woman in labour cannot walk that long.

From my own observation and experience during the research period, the roads to the camps from the highway are rough and inaccessible[26] when it rains. The women reported that they walk by foot to the highway from where they get a public means of transport. Motorcycles are used to facilitate the process from the camps to the highway.

[26] My supervisor and I got stuck in the mud on our way to the camp on her supervisory visit. We had to leave the car behind and walked all the way to the camp.

Figure 6: A map showing general location of the camps from the referral hospital (Provincial General Hospital). (Not drawn to scale)



The distance from the camps to the highway is all weather roads which become inaccessible when it rains. The only mode of transportation from the camps to the highway is motor cycles which are not appropriate in situations of pregnancy. This was well captured by the Provincial Director of Medical Services in his assertion that;

> There are various challenges that we encounter with regard to the provision of reproductive health services in the Province. For instance, distance to the nearest health facility. Fully equipped health facilities are not within reach to many people.

A male respondent from Pipeline camp while affirming the views of the Director, explained that;

> The antenatal and delivery services are only provided by Provincial General Hospital Nakuru 20kms from here. With regard to accessibility, the Provincial hospital is not a walking distance away, one has to use public transport (matatu). This requires money which we do not have.

> There is another clinic Mirugi which offers antenatal care at a relatively cheaper fee of Kshs. 50/= but it does not have delivery services.

(UNFPA, 2004) opines that in developing nations, the nature of roads to health facilities account for the delays that contribute to the development of pregnancy complications and maternal deaths. The difficulties in walking could influence the women in deciding to use or not to use the public health facilities. A study carried out by Lule, et al. (2005) in Malawi revealed that the distance between the women's households and the health facilities is a barrier to health facility deliveries. A majority of internally displaced women, in support of this view, asserted that they could use the health facilities for delivery if they were nearer.

Different measures have been adopted by countries to address the issue of accessibility. According to Lule, et al (2005), in some countries, pregnant women from remote areas are encouraged to stay in the maternity waiting homes[27] at the end of nine months until labour starts, then they move to the delivery room. Maternity waiting homes which are typically built near hospitals provide a place where women can go near the time of delivery to have easy access to skilled deliveries.

The use of the waiting homes is widely viewed as a potential strategy to increase health facility deliveries especially among the very poor. For instance in Cuba waiting homes contributed to increased facility deliveries from 63% to 99% because women who were not accessing the facility due to distance were able to deliver in the facility (Lule, et al. 2005). This would be of such valuable assistance to the internally displaced women if such houses were available at the referral hospital.

The study also found that the cost of transport, from the camps to the health facilities which is by public service vehicles was not affordable. The internally displaced persons mainly depend on casual jobs which do not provide them with enough funds to save in order to use in times of need such as during labour. Their financial status accounts for the inability of women to afford

[27] In Zimbabwe they are referred to as 'waiting mothers' facilities and in Zambia they are referred to as waiting mothers' homes.

transportation cost to health facilities. Margaret, one interviewee, in support of this finding stated that;

> Just like the women in Vumilia camp, there is no clinic in this camp. The nearest hospital is approximately 20km away. There are matatus (public service vehicles) to Nakuru and Gilgil town but you need money. The fare from the highway to Nakuru is Kshs. 130/= (US$1.6) and to Gilgil is roughly Kshs. 60/= (US$0.7). The transport and the money you will use for treatment is just too high for us to afford. Most of us use a short cut road which is hilly and very rough.

The measures adopted by various countries to address this challenge of inaccessibility may apply in the internal displacement situations but only if they can economically sustain the initiatives. The internally displaced women are already in a disadvantaged position and special attention is required when addressing their needs. There is a need to ensure that properly equipped health facilities are within walking distance from or within the camps.

4.4 Quality of Antenatal and Delivery Services: Lack of Skilled Attendance

According to World Health Organization (2004), all pregnant women need to have access to skilled care throughout pregnancy, delivery, post partum and post natal periods. Canavan (2008:3) explains that 'a skilled birth attendant' is an accredited health professional such as a midwife, nurse or doctor who has been educated and trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage, or refer obstetric complications. Ideally, skilled attendants are required to live in and are part of the community they serve. They must be able to manage normal labour and delivery, perform essential interventions, start treatment and supervise the referral of mother and baby for interventions that are beyond their competence or not possible in a particular setting.

This concern is echoed by the National Reproductive Health Policy (NRHP)[28] which seeks to ensure that all pregnant women, including the poor and hard to reach, have access to skilled care

[28] National Reproductive Health Policy, October, 2007

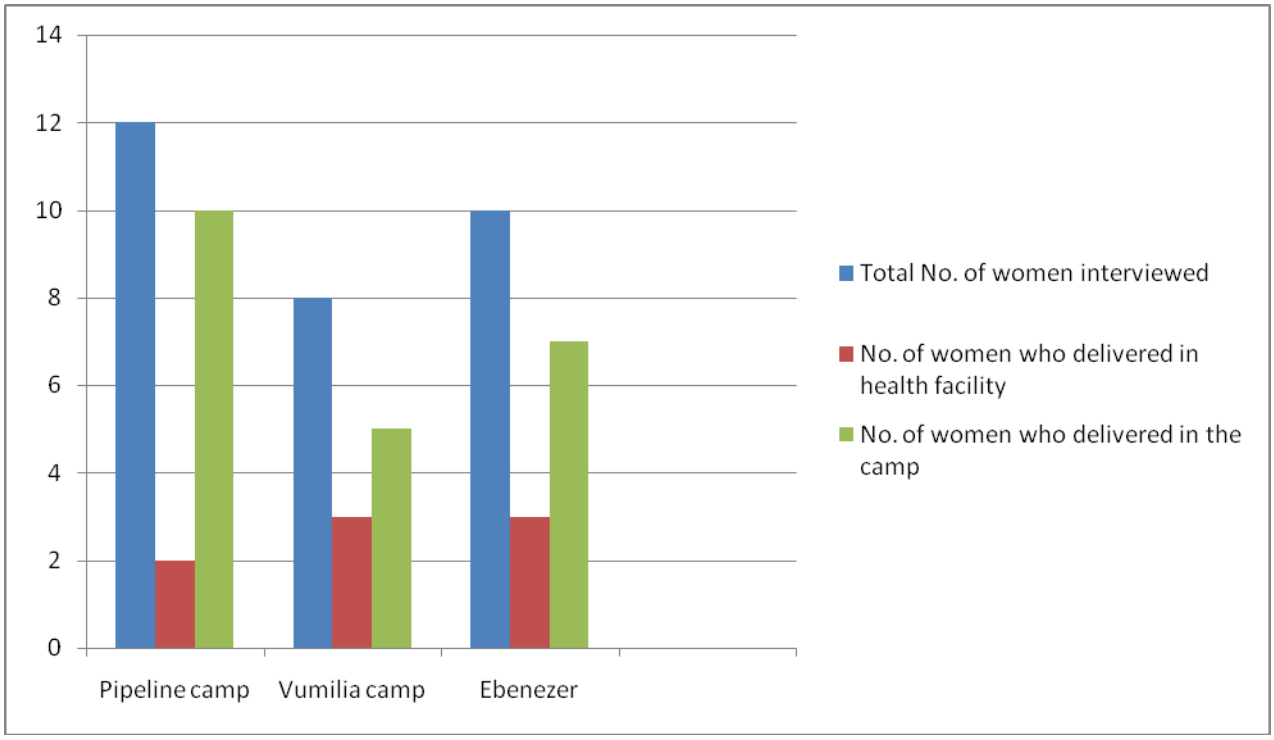
throughout pregnancy, delivery, post partum, post natal periods and that there is increased access to both comprehensive and basic emergency obstetric care to meet minimum international standards.

In spite of the positive commitments by the Ministry of Health, my findings revealed that the internally displaced women lack access to safe antenatal and delivery services. Elizabeth, one of the birth attendants in the camp in support of my findings stated that:

> When it comes to giving birth, it is done in the camp. I am one of the women who attends to births in the camp. I do not have any training. I apply what I have experienced as a woman while giving birth.

Deliveries in the camps are attended to by untrained women like Elizabeth, friends or relatives. Out of the 12 women interviewed in Pipeline camp, 10 delivered in the camp while 2 delivered at Provincial General Hospital (PGH); out of 8 women interviewed in Vumilia camp, 3 delivered in hospital while 5 delivered in the camp; and out of the 10 women interviewed in Ebenezer camp, 7 delivered in camp while 3 delivered in a health facility.

Figure 7: Place of Delivery by Respondents



The majority of the women who delivered in the camp cited lack of money, the prohibitive cost of maternal health care and the lack of transport as some of the obstacles preventing them from accessing quality services.

The District Reproductive health Coordinator explained that the safe motherhood component has various pillars and among them are the focused antenatal and safe deliveries. Focused antenatal requires at least four visits; the first one should be as soon as a woman learns that she is pregnant. These visits enable the health care providers to assess the health safety of the pregnant woman; HIV status, nutrition, danger signs for instance, bleeding, high blood pressure and malaria. She further asserted that;

> The internally displaced women have no access to quality antenatal care and delivery services because there are no well equipped maternity facilities within their reach Levels 2 & 3 facilities which are the

> dispensaries and health centres have no maternity services. Consequently, they have to come to Provincial General Hospital which is far away from the camp. Levels 2 & 3 of the health facilities are not properly equipped, in that some lack laboratory facilities. Therefore the health status of the pregnant women may not be known early enough.

The health facilities easily accessible by the internally displaced women are not well equipped to handle deliveries. The Mirugi dispensary only offers antenatal care (ANC) but at a cost. The clinic in Pipeline camp does not cater for maternal health care.

Lack of skilled attendance during pregnancy and at delivery increases the risk of complications of delivery outcomes, thereby threatening the lives of not only the baby but also the mother. This is because the birth attendants in the camps are un-trained in contemporary skills needed to assist the pregnant women and also to monitor her and the baby before, during and after delivery. The consequence of unskilled maternal services was well expressed by a female respondent thus;

> I delivered here in the camp with the help of the women like Elizabeth. I did not deliver safely because I developed complications which up to now affect me. Upon delivery, I could not walk for almost a week. I was just indoors. I cannot explain what is ailing me and I do not know which hospital to go to because I have no money. I have been taking pain killers ever since hoping that one day I will have enough money for medical attention.

Echoing these views Catherine, a female respondent from the Pipeline camp, recounted her sad experience as follows;

> My child is two months old. I only went to the clinic once. I delivered at home after which the child developed complications. Those who helped me in delivery had no skills. They held the kid wrongly, that is why the child developed complications. I took the child to hospital but to date, I have not been able to buy the medicine which were prescribed by the doctor.

The findings also revealed that the rate of child mortality in the camps is very high. The exact magnitude of the problem is however unknown due to lack of reliable data on infant deaths. The research revealed that the rate of children falling sick immediately upon delivery is very high and some of the children die due to poor delivery skills and the lack of means to handle emergencies

for instance resuscitations. It also emerged that pregnancy related complications and complications before birth which are preventable if detected early through the antenatal clinic visits are not adequately addressed in the camps. In shedding light on these findings, a female respondent lamented as follows;

> Children also die in large numbers, approximately four deaths per ten births. This is just an approximation because no one follows up to record the births and deaths in the camp. We do not have any medical knowledge, thus we cannot explain what causes the infant deaths. Some children appear premature while others have birth defects and injuries.

Naomi, one of the interviewees, told the story of how she lost her baby;

> I conceived sometime last year, in 2011. I did not attend clinic for antenatal care because going to clinic requires a lot of money which is hard to come by considering other needs of the family. When the time came for me to deliver, the baby took a long time to come out and finally when it came out it did not cry. The child just lay still. It was around 5am in the morning and I had no money with me, there is nothing we could have done.

UN Office for the Coordination of Humanitarian Affairs (UNOCHA) 2004, in Georgia, observed that many of the clinics serving IDPs, especially in rural areas, often lack modern and adequate medical equipment and other resources. In a 2004 report UNOCHA noted that quality healthcare services are largely inaccessible to IDPs, mainly because of the high costs involved. The quality of medical treatment for IDPs is negatively influenced by the insufficient material technical base of healthcare institutions for IDPs and the lack of medicines.

4.5 Implications of Socio-Economic Realities on Maternal Health Services

The international standards enjoin states to provide maternal health services at a price that is economically accessible to the IDPs which could include the provision of free services for those who require it. The Ministry of Health through its National Reproductive Health Policy (NRHP), 2007, seeks to remove barriers (geographical, socio – cultural, economic, legal or regulatory) that impede access to skilled care for the poor and hard to reach women. The internally displaced

women are not only poor and hard to reach but they are also geographically and economically disadvantaged. They are usually torn from their source of livelihood due to displacement.

This study revealed that the IDPs (women and men) lost property which included houses, farms, crops, jobs and businesses. The properties were either razed to the ground or the owners forcefully evicted and their properties taken over by the attacking groups. While loss of property is applicable to both men and women, loss of farm crops, cattle and chicken affected women more since a good number depended on the same for their livelihood. Women also suffered loss of jobs in the hotel industry, tea and wheat plantations, and the running of small businesses, like selling vegetables and fruits, due to forceful displacement. This reality of loss was aptly painted by one respondent who described her experience thus;

> I was a farmer before the post election violence (PEV), I had 4 acres of land. The land is still there but I cannot go back because I have built four houses since 1992 and every time there is an election, the houses are burnt. I hear those who remained are the ones cultivating the land. Here in the camp, I have no source of livelihood. The food provided by government is not enough, 6 kilograms of maize and 6 kilograms of beans per household every month.

The loss of livelihood was also pointed out by a female respondent who stated that;

> Before the PEV, I used to sell imported second hand shoes and this I would supplement with a small scale business of selling porridge (*uji*) in the market. This was destroyed. I need quite a lot of money to set up the same business again. I would like very much to sustain myself but I do not have the means.

For the women who lost their businesses, they cannot set up businesses afresh because they lack capital and they cannot get loans from financial institutions as they have no collateral. This was aptly expressed by one female respondent thus;

> I do not have any meaningful source of money just like many of the women here in the camp. Initially, my parents set up a business for me. I used to sell second hand clothes. Due to PEV, I lost everything. The stock that I had and now I cannot afford capital to start up once again.

The inability to afford certain expenses required in accessing quality health services is attributed to the poor economic status due to casual jobs or not being employed at all. Most of the women depend on irregular casual jobs. Some households have women (widowed or abandoned by their husbands) as the sole breadwinners. As for the married women, they depend on their husbands who also depend on casual jobs. The main casual jobs include, washing clothes at Kshs. 150/= (US$2) per wash, tilling farm Kshs. 100/= (US$1.5) per day and construction work for men at Kshs. 3000/= (US$47) per month. The insufficiency of the casual jobs was aptly pointed out by one female respondent thus;

> The casual jobs are not constant, today you may get but tomorrow there is none. I wash clothes and dig farms which earn me kshs. 150/= (US$2)per wash and digging is costed kshs. 100/= (US$1.5) per day.

With regard to user fees, the women who used the health facilities incurred substantial costs even though the user fees are supposed to be low in the government run health facilities. The internally displaced women have to dip into their pockets to pay for treatment cards, drugs, laboratory examinations, as well as other expenses associated with medical care. To deliver in a health facility minimum charges are Kshs. 2,000/= (US$25) - Kshs. 3,000/=. (US$37.5) ANC charges range at Kshs. 150/= (US$2) – Kshs. 300/= (US$3.7). These costs are prohibitive for a woman who does not have any source of income as was aptly described by a female respondent thus;

> I did not attend clinic regularly because I did not have money. I wash clothes and dig farms which earn me kshs. 150/= per wash and digging is costed per day at kshs. 100/=. I am all alone and I have to provide for my family. The money is hardly enough for our daily needs. This way I cannot afford to deliver in the hospital where I am required to pay at least Kshs. 3,000/=. I know of the dangers of delivering away from the health facilities but there is nothing I could do. I have seen women bleed helplessly and children die in large numbers but we just leave it to God.

The District Reproductive Health Coordinator concurred that these are the realities on the ground. As she confirmed that;

> Delivery at the government maternities range between Kshs. 2,000/= to 3,000/= at least. This, I admit is a lot for most people taking into account that majority of the Kenyan population live below the poverty line.With regard to affordability, the sum of Kshs. 2,000/= and 3,000/= is a hefty amount considering they do not have any source of income. The amount is a lot even for a common *mwananchi* (citizen).

Even though a considerable number of women were engaged in productive casual jobs for income, a number of them are unemployed and they depend totally on their husbands. This made them vulnerable in terms of making decisions to utilize better health services available during pregnancy and delivery.

The study revealed that the overall needs of the family took precedence over the women's need for maternal health care. The unemployed women depended totally on the income from their husbands casual jobs which were inadequate for the entire family needs. The study unearthed that due to their poor economic circumstances a considerable number of women resolved not to seek skilled services. Nyokabi adding to this finding stated;

> You know I have to look at my husband's pocket, whether he can afford the clinic expenses. Presently, I am not working or doing any business, therefore I totally depend on my husband's casual jobs. Life is quite hard here in the camp. The children are now in high school. They need school fees and my husband alone cannot sustain this. There are no clinics here in the camp therefore one has to travel either to Nakuru Provincial General Hospital (PGH) or Gilgil district hospital. At the hospital the services are not free, we pay for the cards for treatment which goes for kshs.100/= and other necessities like laboratory tests are also costed. These require money which I do not have. I would consider a lot before I put another need for my husband to handle.

Many countries in Africa and abroad are working towards reducing financial barriers to health care generally with special emphasis on high priority services and vulnerable groups. The Internally Displaced Persons (IDP) Law of Georgia (adopted 1996) provides that vulnerable IDPs are entitled to free medical treatment, with benefits including basic medicines and in-patient services. Although it appeared that a majority of IDPs have publicly provided health care benefits, and enjoy relatively good access to and availability of health services, much evidence suggests that the overall health status of IDPs is far worse than that of the general population.

In Colombia, for instance, an IDP Law (387/97, passed in 1997) established that IDPs should have access to health services to the maximum of the funds available and a 2000 regulation guaranteed that registered IDPs would have free and unlimited access to health care and medicines.

In order to curb economic inaccessibility of maternal health services, the government of Ghana initiated and implemented free delivery services. The women were enrolled in the National Health Insurance Scheme (NHIS) without paying a premium and they were encouraged to visit established and accredited health facilities for free (Ghana MOH, 2004). In a study carried out by Bhutta, et al. (2009) it was observed that local government in Mauritania sponsors and administers the obstetric insurance programme and waives costs for the poorest women.

These interventions are expected to result, among others, in the increase in quality pregnancy care, and the reduction in complications developed due to financial barriers to quality care.

Various changes have been made to the user fee regime in Kenya. In 2007, deliveries were announced to be free, but this could not be implemented because the health facilities did not receive enough funding from central government to enable them to provide free services. The government has since introduced a fee waiver scheme which benefits the needy in society. This well intentioned initiative does not achieve much because of mismanagement. An interview with the social worker revealed that the hospital administration does not encourage free services and the patients are encouraged to pay at least a portion of the hospital bill in order for it to be waived. These initiatives, if well managed and implemented, would have gone along way in alleviating the problems experienced by the internally displaced women in accessing affordable maternal health care.

One of the priority actions that the Ministry of Health, through its NRHP, 2007, seeks to achieve is to ensure that all women, have access to reproductive health information, counselling and services. The study revealed however that the internally displaced women have not been informed at all. This was confirmed by the community health worker that the workload was too

heavy for her and that she needed resources, like a motor vehicle, in order to serve the entire population, in her words she expressed;

> The community that I serve is quite large. I can barely serve 20% of the households. I not only serve the women but the entire population, men and children included. If it were possible, I would visit the camps often but there are also others who need my attention. Ideally as a community health worker, I am supposed to visit the camps thrice in a week but I cannot afford it. I do not have a vehicle to move around. The area that I am serving is quite big.

Lack of reproductive health information has implications for the achievement of better health status since being informed is likely to improve the internally displaced women's ability to comprehend health issues. For example, the women have a belief that it is the first pregnancy only that requires special attention, antenatal care and delivery in health facility. The community health worker, while disagreeing with this belief, had this to say;

> I have also heard about the myth that it is only first pregnancy that can have complications therefore. The subsequent ones one need not attend clinic. All these are false because each pregnancy is unique by itself and they pose different complications. I would say that such myths come about due to inadequate access by women to reproductive health information. When there is a gap in information then the community tries to fill it up with such uninformed allegations.

Other factors which hamper dissemination of reproductive health information were highlighted by the District Reproductive Health Coordinator thus;

> On the policy, with regard to access to reproductive health information, counseling and services, this is done in accordance with the availability of funds. As health care providers we do our best to educate the population. We try to ensure that all pregnant women, including the poor and 'hard to reach' have access to skilled care as per the Policy, but there are many challenges that prevent this from happening. For instance, there is a shortage of nurses and skilled health care providers.

In the context of this study, therefore, informed women are in a better position to appreciate the importance of skilled services.

4.6 Availability of Maternal Health Services

Quality maternal care implies the presence of adequate and appropriately trained health services providers, whether in a health facility or through domiciliary care. Adequately furnished health facilities, in most developing countries should have the minimum amount of equipment for managing pregnancies.

In Kenya, the National Reproductive Health Policy (NRHP), 2007 provides for the strengthening of the capacity of the health system at all levels for efficient and effective delivery of services for the newborn, including resuscitation, infection prevention and the promotion of early and exclusive breastfeeding. This target is, however, far from being realized because Levels 2 & 3 facilities, which are the dispensaries and the health centres, are inadequately equipped to provide antenatal care and delivery services. These are the facilities nearest to the people.

I found that there are no antenatal and post natal care clinics in the camps. Pipeline camp has a clinic which is not equipped to handle maternal health care but only meant for treating simple illnesses like colds and it is able to administer pain killers. The attendants come twice in the week, on Mondays and Fridays. A respondent from Pipeline camp explained as follows;

> On the issues of maternal health care, there are no antenatal and post natal care clinics in this camp. There is a clinic constructed here in the camp but it is meant for simple illnesses like colds and to administer pain killers. The attendants come twice in the week, on Mondays and Fridays.

The nearest health facility to the camps is the government run Mirugi dispensary which lacks basic equipment for management of deliveries, for instance, delivery beds. There is only one referral hospital, Provincial General Hospital (PGH), which serves the entire province.

According to Provincial Reproductive Health Coordinator, there is a need to equip the dispensaries and the health centres, which are facilities within the reach to the community, in order to enhance their capacity to provide maternal health services.

In an assessment carried out by International Medical Corps (IMC), 2006 in Iraq it was found that 10 percent of IDPs reported that there were no health care services in their area of displacement, 70 percent said they had not been visited by a health care worker within the past 45 days, and 55 percent had not been involved in any vaccination campaigns (IMC, 2007).

In Uganda also the limited availability of functioning public health and health-care facilities, goods and services were by no means the only problems identified in the northern Uganda IDP camps, but they contributed significantly to the serious humanitarian emergency in the camps, despite the long-running and large-scale presence of the relief community (UNHCR, 2004).

A study in Mexico revealed that many of the maternal deaths in Mexico could be prevented if women had access to quality health services during pregnancy, delivery and the post-partum period. Information collected from a strategy development tool identified a variety of problems related to skilled delivery attendance, including; the lack of sufficient qualified personnel to attend to deliveries, especially during the night shift (UNFPA, 2004).

4.7 Conclusion

From the foregoing discussion, it is patently clear that, in spite of the elaborate legal and policy provisions, internally displaced women face specific inter-related and interdependent challenges in their access to affordable quality maternal health care. The study revealed that a majority of pregnant women neither attend ante natal clinics nor deliver in health facilities. The health facilities are economically and geographically inaccessible to the women. The cost of medical care is unaffordable to the women taking into consideration their economic vulnerability. There are no health facilities within the camps and the ones within the women's reach are not adequately equipped to provide maternal health services.

I argue that the challenges faced by the women in accessing quality affordable maternal health care calls for more than just laws. It also calls for the acknowledgement of the special status and concomitant vulnerabilities of the internally displaced women.

CHAPTER FIVE:

5.0 FINDINGS AND DISCUSSIONS:

5.1 STATE INACTION: Legal and Human Rights Standards vis a vis the State's Compliance

5.2 Introduction

Once it happens, internal displacement brings about a set of circumstances that renders those affected highly vulnerable. Its pernicious effects on individuals, families and communities are wide ranging and include impoverishment and exclusion from health services. It is for these reasons that the international and regional instruments on internal displacement enjoin member states to pay special attention to the unique needs and vulnerabilities of the IDPs, especially the reproductive roles of the internally displaced women.

This implies that the government should put in place adequate legislative, policy and budgetary measures to ensure that functioning maternal health services and goods are available; that they are safe and affordable and that they are within physical reach for all the internally displaced women.

5.3 Inadequate Focus on Maternal Health Needs: It calls for more than just laws.

> As IDPs we feel we have been beaten twice, by the violence and by the government. The government is not concerned with our wellbeing at all[29].

The Constitution provides that any treaty or convention ratified by Kenya shall form part of the law of Kenya[30]. Despite the fact that Kenya is a signatory to the international and regional

[29] The words of one female respondent from Githima camp. Focused group discussion held at the Chief's office, Githima, Nakuru.

instruments on internal displacement and which therefore form part of her laws, it emerged in the field that the government has failed to develop a clear plan of action and a national policy to protect and assist the internally displaced persons.

Currently, the IDPs issues are dealt with on an ad hoc basis through the line ministries concerned. In the present study, the Ministry of Health (MOH) is the ministry responsible for the provision of maternal health services to the internally displaced women. The MOH has its own challenges, for instance, inadequate budgetary allocation, with which it grapples. In most urban and rural settings in Kenya, the health facilities which are nearer to the common citizens are inadequately equipped and, in some instances, the facilities are essentially unavailable (Kenya Demographic and Health Survey, 2008/09).

The research period coincided with a countrywide industrial strike by health services providers whose grievances had striking similarities with my findings with regard to maternal health care challenges in the internally displaced persons camps. The health services providers raised concerns with the whole health sector and, their grievances included the facts that medical care was very costly and the health facilities were inadequately equipped. There was also a shortage of staff and there were no essential commodities, like gloves and drugs, in the health facilities.

[30] Article 2(6)

Figure 8: Photograph of some health services providers during a countrywide industrial action on 5th December, 2011.

In the context of the present study, the Provincial Reproductive Health Coordinator, highlighted a number of the challenges which prevent women from accessing affordable quality maternal health services in the province thus:

> For instance there is shortage of nurses and skilled health care providers.
> -Erratic supply of commodities
> -Shortage of staff to provide quality services.
> -Poor infrastructure- this hampers access to health facilities and referral system.
> -Budgetary allocation is inadequate

The shortage of health services providers in the context of displacement was confirmed by Community Health Worker in whose jurisdiction the Pipeline camp is situated thus;

> The community that I serve is quite large. I can barely serve 20% of the community. I not only serve the women but the entire population, men and children included. If it were possible, I would visit the camps often but there are also others who need my attention.

Logically, the MOH cannot afford the additional burden that internal displacement brings upon an already resource poor environment.

According to DFID 2008 report, the target is that there should be at least 2.3 trained health workers per 1,000 population by the year 2015. This gives an 80% coverage of skilled birth attendants. This is a challenge to many developing countries due to the shortage of human resources. For instance, in Cameroon, the ratio of health professional is 1 to 4,000.

The study found out also that the internally displaced women are not given any special treatment but are considered to be part of the wider community in the provision of health services. This view was expressed in a group discussion at Pipeline camp thus;

> With regard to affordability, we are not given any special attention as IDPs in the health facilities. The health providers do not consider that we are disadvantaged in any way and we pay fees just like any other person.

The lack of attention to the IDPs was also reiterated by the District Reproductive Health Coordinator that the IDPs form part of the community in which they live in and the same applies to services whereby they are required to pay for the services, just like any other person. This reaffirms my argument that the internally displaced women have unique needs and heightened vulnerabilities that are distinct from the general population and which require special attention.

5.4 Inadequacy in Policy and Budgetary Allocations

The health services providers interviewed attested that the problems plaguing the health sector in Kenya lies with the lean budgetary allocation to the Ministry of Health. The Provincial Reproductive Health Coordinator stated that the reproductive health programs in the province rely on donor funding. In her words; she said:

> Due to inadequate budgetary allocation by the Central government, we depend mainly on donors, the AIDS, Population, and Health Integrated Assistance Project (APHIA) has been of tremendous help to us. For the

> poor, we would wish to provide maternity services free of charge but there are other requirements that the government does not provide for that are requisite for the daily running of a health facility; for example, security, detergents, casual employees and cotton wool to mention but just a few. That is why in most of the facilities cost sharing is exercised to enable their running.

While donors are an important funding source in many African countries, donor funding is often unreliable and unsustainable in the long term. It is for this reason that the Kenyan government should strive to take a serious approach towards complying with her human rights and constitutional obligations to realize the right to the highest attainable standard of health, including reproductive health, without excessive reliance on donor funding.

The Committee on International Covenant on Economic, Social and Cultural Rights (ICESCR) adopted a progressive approach in recognition of the fact that limited state resources can preclude states from immediately achieving the right to the highest attainable standard of health. The Committee however warns against complacency and reiterates the obligation to move as expeditiously and effectively as possible towards the goal of realizing the right to health. Similarly Chapman (1996:23) opines that the obligation under international human rights standards to realize the right to health progressively conveys the need for continuous progress rather than inaction or regression.

As indicated in the literature review, Kenya has regressed and/or adopted a lazy approach towards her human rights and constitutional commitments. The study carried out to assess the progress towards the Abuja target for government spending on health care in Eastern and Southern Africa, (Govender V, Mclntyre D., Loewenson R., 2008) observed that Kenya is the farthest from the Abuja target, with only 5% of government resources going to health services in 2006 and with no consistent increase in government spending.

This finding was confirmed by the Kenya National Health Accounts 2009/10 report showing a decline in government's expenditure on health from 8% of its total budget in 2001/02 to 4.6% in 2009/10**.** The Permanent Secretary in the Ministry of Medical Services, while releasing the report, expressed that:

> Close to 40 per cent of people who are sick do not seek health care because of cost.

The achievement of 15% government expenditure on health in some countries in the East and Southern region, as illustrated in the literature review, signals the feasibility of Kenya reaching the target with the required political will.

Apart from Kenya's laxity in the health sector, the same lax attitude has been extended to the adoption and implementation of the National IDP Policy which has been in draft form since March, 2010. The draft policy, unveiled in Nairobi on 17 March, 2010 draws from the United Nations Guiding Principles on Internal Displacement and the African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa.

It adopts a comprehensive definition of the concept of internally displaced persons addressing those displaced by the armed conflict, situations of generalized violence violations of human rights or natural or man-made disasters. The policy's objectives: are to minimize internal displacement and its effects by providing an enabling environment for upholding rights and entitlements of the internally displaced; to promote integrated and coordinated response mechanisms to address the causes and effects of internal displacement; to assist in the safe and voluntary return of the internally displaced; and to guide the development of sectoral programs for recovery through rehabilitation and reconstruction of social and economic infrastructure in support of the return and resettlement of IDPs[31].

It fosters progress in security, peace building and reconciliation efforts to create harmony amongst communities[32] which is crucial for speedy resettlement and reintegration of the internally displaced persons back into the community. The draft policy recognizes the civil and political as well as economic, social and cultural rights; assistance in food rations, provision of

[31] Page 1 of the draft Policy.
[32] Pages 22, 24 & 31 of the draft IDP Policy

shelter/housing, clean and safe water in adequate quantities and, of particular significance to this study, is the provision of health care[33] to the internally displaced persons.

The draft policy, provides for an elaborate institutional framework which gives clear roles to stakeholders. Issues of health are dealt with elaborately, including the provision of free maternal health services. These services are to be provided through existing national public health systems and regulatory frameworks, but with a clear recognition of the IDPs unique needs and vulnerabilities. The policy further proposes the creation of an IDP Fund, which experts hope will increase accountability, as there will be one kitty from which evolving IDP needs can promptly be met.

The head of department in the Ministry of State for Special Programmes (MOSSP) asserted that there was a need to speed up the adoption and implementation of the national IDPs Policy. He further stated that the internally displaced persons are set to enjoy greater protection under the policy.

Other countries in the region have since adopted national IDPs policies[34].

5.5 Conclusion

Kenya is a signatory to various international and regional instruments that provide for the protection and assistance to the IDPs and, more importantly, the recognition that the internally displaced women have unique needs and heightened vulnerabilities that are distinct from the general population and which require special attention. The needs and rights of the IDPs are not, however, addressed adequately at policy level. The Draft National Policy on IDPs in Kenya

[33] Page 34 of the draft IDP Policy

[34] In Uganda, National Policy for IDPs, 2004 was developed in August 2004 primarily to address the needs of those displaced.

-In Liberia, Declaration of the Rights and Protection of Liberian Internally Displaced Persons (2002) seeks to monitor, protect and manage the treatment of the internally displaced.

-Sudan's National Policy on Internal Displacement (2009) recognizes the civil and political as well as economic, social and cultural rights o the country's internally displaced persons.

affirms the right to health in situations of displacement but it only remains a draft, as it has not been adopted.

CHAPTER SIX:

6.0 CONCLUSION AND INTERVENTIONS

6.1 CONCLUSION: Where does the buck stop?

In my conclusion I reiterate Delport's opinion that the law is a necessary, but somewhat limited, instrument for social change. She asserts that without **activism**, awareness raising, **political commitment**, **strategic and effective policy as well as sufficient budgetary allocation,** law alone is not likely to bring about significant improvements in the lives of women in developing countries (Delport, E. 2011:152). (emphasis mine)

There is explicit provision on the right to reproductive health in the constitution and an impressive reproductive health policy, yet the internally displaced women still face a myriad of challenges in their access to quality and affordable maternal health services. The study revealed that a majority of pregnant women neither attend ante natal clinics nor deliver in health facilities. The births are attended to by unskilled attendants within the camps. The health facilities are economically and geographically inaccessible to the women. The cost of medical care is unaffordable to the women, taking into consideration their economic vulnerability. There are no health facilities within the camps and those that are within the women's reach are not adequately equipped to provide maternal health services.

In the context of the present study, despite the international and regional instruments on internal displacement recognizing the uniqueness and vulnerability of internally displaced women, the government of Kenya has failed to move with the speed necessary to assist and protect the IDPs in general, and particularly, the vulnerable groups like women. Without special consideration for the internally displaced women, they are obliged to compete with Kenya's ordinary citizens for inadequate or essentially unavailable maternal health services.

The study revealed that the budgetary allocation for the Ministry of Health is very small and that most of the reproductive health programmes are dependent on donor funding. Donor funding is couched in terms of the donor's objectives and not necessarily reflective of the needs of the community. This was well illustrated by the District Reproductive Coordinator thus;

> The budgetary allocations for the Ministry of Health are very small. Our services are donor driven, that means they have to adhere to the donor's objectives. Should the funding stop the provision of services also cease.

The study concluded that the government has also failed to provide resources, both in forms of manpower and finance, to facilitate the implementation of the reproductive health policy in accordance with the constitutional and human rights commitments. This failure concurs with the radical feminist opinion that legislation on its own can do little to improve the real situation of women (Bryson,V.,1998).

The Kenya Human Rights Commission (KHRC) (2011) report aptly opined that the governance systems are hindered by the lack of political will either to implement the existing laws and policies or complete those in draft form like the national IDPs policy.

I argue in this study that in order to ensure that the women have access to quality and affordable maternal health services, the buck must stop with the Kenyan government. The government should not only take appropriate legislative measures but also administrative, social and educational measures to ensure that the internally displaced women have access to quality and affordable maternal health services. The government should strive to bring its budgets in line with its constitutional and international human rights commitments.

The challenges of maternal health care in internally displaced persons camps can be addressed adequately only if the requisite political will is translated into effective action. Both the state and non-state actors have collaborative and complimentary roles to ensure that all the needs for IDPs are managed within the set human rights standards and structures in the society. However, the Government bears the primary obligation while the rest can only play supportive and secondary roles.

This conclusion informs my interventions.

6.2 INTERVENTIONS

6.2.1 Resettlement of the IDPs

> Complete healing and integration will not be realized until all the persons displaced by the post election violence are resettled. It is indeed a great shame that three years after the violence there are people still living in tents and other ramshackle camps.[35]

Failure to resettle the IDPs has been widely attributed to the indifference by the government and the political class to provide durable solutions to IDPs. The resettlement of the IDPs cannot be emphasized. It should be treated on a priority basis. All the respondents wanted to leave the camps because life there is unbearable. From my own observations, the tents are now very old and torn. I witnessed leaking roofs, cooking in the rain, lack of privacy and congestion in the camps. The desperation for resettlement was expressed by one respondent thus;-

> We would like to be resettled urgently. If there is no land in Kenya, then its better if we are settled in another country.

The IDPs have expressed unwillingness to return to their previous farms as they complain that they have now experienced displacement four times: in 1992, 1997, 2002 & 2007. UN Guiding Principles on Internal Displacement, Principle 15 provides that IDPs have the right to be protected against forcible return to, or resettlement in, any place where their life, safety, liberty and/or health would be at risk. The resettlement programmes should therefore incorporate the views of the IDPs and where their safety is at stake then alternative parcels of land should be purchased for them.

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[35] Rev. Peter Karanja, 'Quote' in *Sunday Nation*, December 5, 2010, p. 2

6.2.2 Adoption and Implementation of National IDPs Policy

In order to protect IDPs, the national policy should also be adopted and implemented.

The Constitution provides that any treaty or convention ratified by Kenya shall form part of the law of Kenya[36]. In essence, the international instruments on internal displacement ratified by Kenya therefore form part of the national laws. What remains is for the state to adopt and implement the policies that have direct or indirect implications for the protection, assistance and justice for IDPs: e.g. the Draft National Policy on IDPs, the National Land Policy, the National Cohesion and Integration Act (2008); the International Crimes Act (2009), the International Crimes Act, Disaster Policy, Human Rights Policy and Peace and Conflict Policy, among others. This will offer durable solutions to both the root causes and manifestations of this problem in Kenya.

Apart from the protection and assistance to IDPs, the draft national policy recognizes the IDPs' vulnerabilities and need for support. It seeks to find a durable solution to the perennial IDPs' problem. Internally displaced people (IDPs) in Kenya are set to enjoy greater protection under a national policy that also aims to prevent future displacement and to fulfil the country's obligations under current international IDP law.

6.2.3 Increase Budgetary Allocation

Another recommendation is to increase government's budgetary allocation for health. A decline in the government's expenditure on health implies that the citizens have to dig deeper into their pockets every time they access medical care. An increased allocation of funds will ensure that the user fees are affordable and, if possible, services are offered free of charge to vulnerable groups, such as the internally displaced women.

[36] Article 2(6) of the Constitution

In order to ensure that the internally displaced women can access affordable quality maternal health services, the government needs to bring its budgets and programs into line with its constitutional and international human rights commitments. This will ensure that maternal health services are provided free of charge, as is the practice in other African countries, as illustrated in the literature review.

6.2.3.1 EQUIPPING OF HEALTH FACILITIES

Increased budgetary allocation will also ensure that the health facilities, like the dispensaries, health centres and clinics within the camps, which are nearer to the women, are adequately equipped to provide antenatal care and handle deliveries. This will improve accessibility and quality of the services. This recommendation was aptly stated by the Community Health Worker serving the Pipeline camp;

> We also require more maternity facilities to be constructed and fully equipped near the camps. There is a dispensary near the camp, Mirugi, but it is not well equipped for maternity purposes.

6.2.3.2 EMPLOYING MORE PERSONNEL (COMMUNITY HEALTH WORKERS, NURSES AND DOCTORS)

The Provincial Reproductive Health Coordinator admitted that the community health worker is only able to cover 20% of the households due to a shortage of staff and logistics. The government has not employed personnel in a while now due to a shortage of funds to cater for their salaries. An increased budgetary allocation will ensure that more personnel are employed. This, in turn, will address the shortage of skilled care available to the internally displaced women.

6.2.4 Dissemination of Reproductive Health Information

> The women need to be educated on matters of health. If women's knowledge is enhanced, then they would be able to take good care of themselves[37].

One of the priority actions set out in the reproductive health policy is to ensure that all women have access to reproductive health information, counselling and services. Appropriate health information will enable the women to make informed decisions concerning their reproductive health needs, in particular, the importance of antenatal care and the utilization of skilled delivery services. The women and men should be informed of issues concerning pregnancy and delivery in a language and in a manner that the community understands. Appropriate methods, such as basic simple materials, should be employed. The government should increase the provision of the necessary resources to the Ministry of Health to enable the community health workers to carry out the dissemination of information efficiently.

[37] The words of community health worker during interview held at District Reproductive Health Coordinator's office in Nakuru.

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APPENDIX

POCKET WOES | HIV and malaria account for half of budget

Rising health costs take toll on families

Kenyans spend over Sh3,000 per person a year from Sh2,000 a decade ago, says government report

BY LUCAS BARASA
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A shrinking health budget is pushing families to spend more money on health compared to 10 years ago, a new government report has said.

The money spent on health per person has increased from Sh2,636 in 2001/02 to Sh3,203 per year, according to Kenya National Health Accounts 2009/10 report released yesterday.

The increased spending follows a decline in government's expenditure on health from eight per cent of its total budget in 2001/02 to 4.6 per cent in 2009/10.

"Total health expenditure as a percentage of the Gross Domestic Product has remained nearly constant, at 5 per cent since 2001/02," the report launched by Medical Services permanent secretary Mary Ngari in Nairobi said.

3,203

Amount of money in shillings spent on health per person in 2009/2010.

> "Close to 40 per cent of people who are sick do not seek health care because of cost"
>
> **Medical Services PS Mary Ngari**

Ms Ngari said one of the major challenges for Kenya's health system would be how to protect the poor from the catastrophic health costs and to ensure that this group receives healthcare services whenever need arises.

"We are already aware that close to 40 per cent of people who are sick do not seek healthcare because of cost," she said.

The report indicated that the health sector continues to be predominantly financed by private sector sources including by households' out-of-pocket spending.

The public sector financing has remained constant over the last decade, at about 29 per cent of the total health expenditure, while the contribution of donors has more than doubled, from 16 to 35 per cent.

The report says public health facilities continue to be the major providers of health care.

HIV/Aids and malaria each accounted for 25 per cent of total health expenditure in 2009/10 while reproductive health and tuberculosis accounted for 14 and one per cent, respectively.

DOCTORS STRIKE
PAY HIKE DEMAND

Doctors strike enters day

Medics demand pay hike, tell State to improve public hospitals and equip them to stem deaths

By STANDARD TEAM

Even as the Government announced it has released Sh1.3 billion for doctors, they insisted the would not call-off the strike.

Yesterday, the doctors said they were also pushing for improvement of poor state of public hospitals.

Kenya Medical Practitioners, Pharmacists and Dentist's Union (KMPDU) claimed that 26 women die due to pregnancy related complications daily, 339 children under five succumb to preventable and treatable ailments and 400 infants due to lack of warmth and clean water.

"We wish to state that public health facilities are inadequate. Outpatient departments are crowded while inward patients are sharing beds and spending nights on cold floors," said KMPDU Secretary General Boniface Chitayi.

He said public hospitals lack basic equipment that are required to prevent unnecessary deaths yet the Government over that last three years has decreased funds to health institutions.

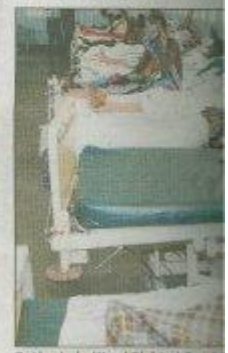
"We do not have basic supplies to work with. We have to send patients to buy gloves and emergency medications. The commonest drug in our hospitals that is used to treat all conditions, including diabetes, malaria, hypertension and pneumonia, is out of stock," said Dr Chitayi.

Medical Services Assistant minister Kazungu Kambi told Parliament the Treasury disbursed the money and would pay it out in three phases as extraneous allowances from January for the striking doctors.

MPs were angered by Government's slow reaction to the strike as patients continued to suffer.

A patient waits to be attended to at Coast General Hospital in Mombasa, yesterday. [PHOTO: MAABUD MOHAMED]

Striking doctors stage a sit-in outside the Ministry of Finance offices, Nairobi, on Monday, to demand pay increment. [PHOTO: EVANS HABIL/ STANDARD]



Patients in Ward Eight at Coast attention, yesterday. [PHOTO: M

HARASSING

Kimilili MP Simiyu Eseli, who is also a doctor, accused the Government of being insensitive to medics' plight and harassing the 95 doctors participating in the industrial action.

Dr Eseli said the Government has historically taken advantage of the doctors' Hippocratic Oath to protect or preserve life to underpay them "believing they will not strike."

His Bokomani counterpart Bonny Khalwale, also a medical doctor, claimed that the money was intended to "hoodwink" medics as it was to be shared with clinical officers, nurses and non-medical support staff.

Gichugu MP Martha Karua said it is wrong for the Government to ignore the doctors yet the strike was taking a toll on people's lives.

"We ask the Government to talk to these doctors. This will alleviate the suffering of patients that is currently on in hospitals," she said.

The strike began on Sunday at midnight following the collapse of negotiations between the Government and the KMPDU.

The doctors said it was unfortunate that the per capita allocation for patients in public hospitals is Sh41 per day, which is expected to purchase three meals.

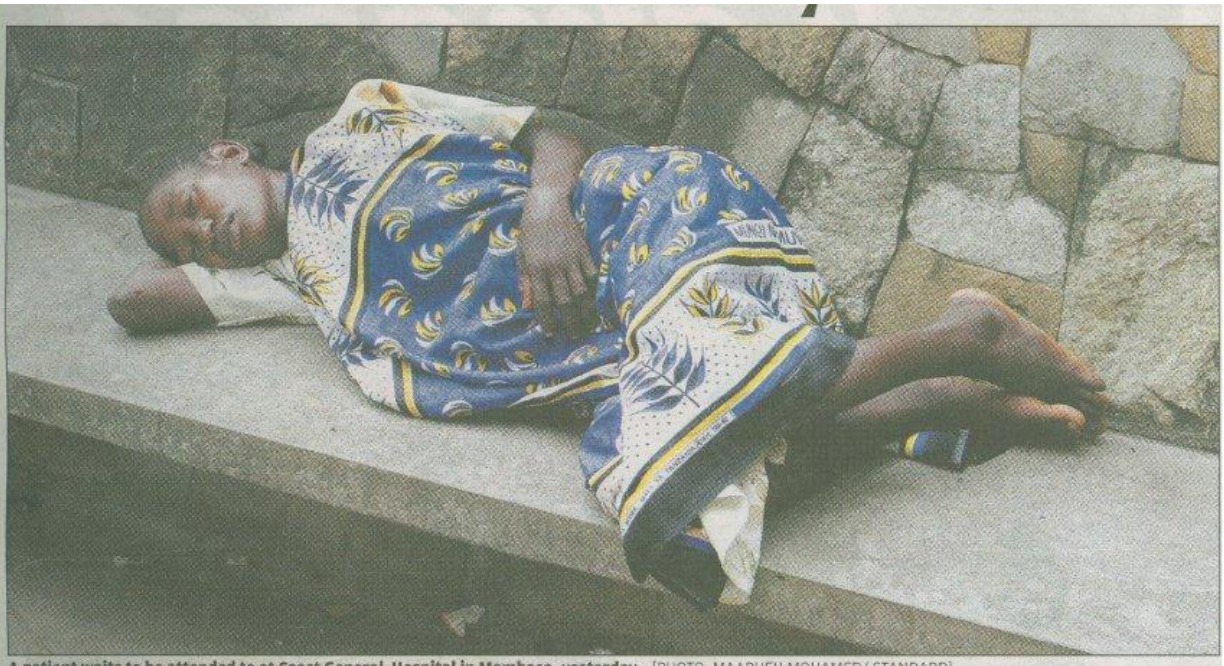
"A malnourished child is allocated Sh33 per day. There is no food that can be bought for a child who is malnourished with that amount of money," said KMPDU Chairman Victor Ngawi.

They urged President Kibaki, Prime Minister Raila Odinga and Medical Services Minister Anyang' Nyong'o to initiate dialogue.

"This is not a political matter and should not be politicised. Th nothing political in stating that dent doctors in public hos should be paid or that financia cation to health care be raised," Dr Ngawi.

Meanwhile, the Central Orga tion of Trade Unions (Cotu) has the Government to dialogue striking doctors saying their dem were justified.

Cotu Secretary General Fr Atwoli said many Kenyans who not afford health care services private institutions were suf



A patient waits to be attended to at Coast General Hospital in Mombasa, yesterday. [PHOTO: MAARUFU MOHAMED/ STANDARD]

Striking doctors stage a sit-in outside the Ministry of Finance offices, Nairobi, on Monday, to demand pay increment. [PHOTO: EVANS HABIL/ STANDARD]

Patients in Ward Eight at Coast General hospital in Mombasa wait for medical attention, yesterday. [PHOTO: MAARUFU MOHAMED]

DOC
PAY

Doctors: Key talks to end strike collapse

Continued from P1

carried home, and stand the risk of being taken to quacks and traditional healers. After a day of renewed protests by thousands of doctors in Nairobi and across the country, top officials of the Ministries of Medical Services, Public Health, and Finance cobbled together a new payment package, which failed to impress the striking doctors.

The strike called by Kenya Medical Practitioners Pharmacists and Dentists Union (KMPDU) enters its fourth today, with health workers calling for a raft of changes, including a 300 per cent salary increase.

In the hurriedly convened meeting out of which both parties worked out empty-handed, Assistant Minister for Medical Services Kazungu Kambi offered the doctors Sh30, 000 extraneous allowance that would be paid in two phases, instead of the earlier proposal of payment staggered in three phases.

> "These are people who conduct surgeries, run hospitals but receive zero pay from the Government. We cannot accept such blatant slavery

The Government raised its figure allocated for extraneous allowances for medical personnel, including doctors, from Sh1.35 billion dangled last week to Sh1.9 billion with effect from this month.

In the new proposal, doctors and other medical staff in public hospitals would have received the first phase of the extraneous allowance this month and the second phase in June, next year.

This would have meant medical practitioners receive Sh15,000 from this month and the balance of similar amount from June, next year.

EXTRANEOUS ALLOWANCE

The earlier proposal would have given doctors the same amount, but staggered across three years, meaning their earnings would move from Sh10, 000 in the first year, then to Sh20, 000 in the next, and finally Sh30, 000 in the third year.

"We cannot accept these figures. They are not different from the earlier offer. The new proposal fails to address our concerns and did not go far enough. The strike is still on," said KMPPDU chairman Victor Ng'ani.

KMPPDU announced doctors would return to the streets on Monday to push on for their demands.

DOCTORS STRIKE
PAY HIKE DEMAND

Treasury offers Sh1.3 billion

Pain as critical services remain unavailable

By ALLY JAMAH

The pain caused by the ongoing strike by doctors continues to worsen for patients as critical emergency services remain unavailable.

"Only God knows how much we are suffering. I have been waiting to be treated for almost six hours. No one has attended to me. The Government and the doctors must reach an agreement quickly. When two elephants fight, it is the grass that suffers," said Mwaroro Anyangu, an elderly lady who was waiting for treatment at Kenyatta National Hospital, Nairobi yesterday.

And a parent from Isiolo told The Standard he was shocked to receive a call from Mathare Mental Hospital in Nairobi asking him to pick his mentally-ill son.

"My son was admitted a month ago suffering from severe mental illness. I am now confused. I don't know what to do. The boy needs specialised treatment that he can't get in Isiolo," the parent, who did not want to be named, said.

At Mama Lucy Kibaki District Hospital in Nairobi's Kayole estate, patients were few. Hospital officials suspected many patients may have opted to stay at home because of the strike.

The Medical Superintendent Julius Ogato declined to talk to The Standard saying he was not authorised to speak to the media.

But sources within the hospital's administration revealed all the 15 medical officers in the facility were not working.

"If the strike drags on for many days, things will become difficult for us. Currently, things are not so bad because we don't have many patients seeking treatment," they said.

At KNH, a planned press conference to reveal the impact of the strike was cancelled at the last minute without explanation.

The CEO Richard Leserian said the hospital is working hard to maintain essential services.

About 100 consultant doctors are said to be offering treatment in the facility. Admission and processing of patients documents was notably slow at KNH.

However, operations at Mbagathi District Hospital in Nairobi were relatively smooth, with most medical officers on duty and attending to patients.

TAKE RESPONSIBILITY

A visit to several private hospitals in Nairobi's Eastlands area including Victoria Clinic reported an increase in patients.

"I have seen several ladies who were receiving treatment in Kenyatta National Hospital. They decided to come here despite the relatively higher fees we charge," said an official of Victoria Clinic.

Meanwhile, Kenya Medical Practitioners Pharmacists and Dentists Union (KMPDU) Secretary General Boniface Chitavi said he has not been contacted by Government officials to renew stalled negotiations.

"We have not received any official or unofficial proposals from any quarter. We will push on with this strike till our demands are met. The Government should take responsibility for the suffering Kenyans are going through," he said.

The strike began on Sunday at midnight following the collapse of negotiations between the Government and the KMPDU.

Doctors are demanding a 300 per cent pay increment.

Benches at Nyeri Provincial General hospital were empty yesterday as most patients stayed away. [PHOTO: GEORGE MULALA/ STANDARD]

> "Only God knows how much we are suffering. I have been waiting to be treated for almost six hours. No one has attended to me.

Long queues absent after patients desert hospitals

By STANDARD TEAM

Patients kept off some health facilities in Central and Western provinces.

At the Nyeri Provincial General hospital the normal long queues were conspicuously absent and the benches were vacant.

Wheelchairs that are used to carry critically ill patients lay idle and nurses and the interns were busy attending to inpatients.

A check in major towns in Mt Kenya showed many doctors kept off the health facilities and instead attended to the patients in private clinics.

John Mwangi said he woke up with a fever but opted not to seek treatment at the provincial hospital.

"I have spent Sh600 consultation fee and the doctor in the clinic has prescribed some medication for me which I cannot afford for now. The clinic is too expensive compared to the public hospitals," Mr Mwangi told *The Standard*.

Dr Charles Kigo of Murang'a District Hospital, admitted the number of patients visiting the health facility had sharply declined.

"On daily basis, more than 700 patients turn up for services but on Monday, only 300 showed up. I am assuring our clients we have mobilised enough staff to cater for them," said Kigo.

The situation was the same at Embu Provincial General Hospital.

At Kakamega Provincial General Hospital the pharmacy which remained closed on Monday was opened yesterday by medical interns who kept on closing for fear of being spotted by the striking doctors.

– *Reports by Boniface Gikandi, Joseph Muchiri, Ndung'u Waitualem and Grace Wekesa*